CONSULTATION REQUEST

TO BE COMPLETED PRIOR TO ANY REQUEST FOR EVALUATION

☐ **OCCUPATIONAL THERAPY** ☐ **PHYSICAL THERAPY** ☐ **TEACHER OF DEAF**

DATE___________ **REQUESTEDBY**____

SCHOOL____________ **STUDENT STATE ID #__(MUST BE 10 DIGITS)** _________________

LAST NAME________________ **FIRST NAME** _________________________________

DATE OF BIRTH_____________ **GRADE**___________________________________

ADDRESS ____

PARENT/GUARDIAN NAME(S):____

HOME PHONE #________________ **CELL PHONE #**__________________________

STUDENT'S PRESENT LEVEL OF FUNCTIONING AND REASON FOR REQUEST:

DOES THE STUDENT CURRENTLY RECEIVE SPEECH? ☐ **YES** ☐ **NO**
NAME OF THERAPIST:____

DOES THE STUDENT CURRENTLY RECEIVE OT? ☐ **YES** ☐ **NO**
NAME OF THERAPIST:____

DOES THE STUDENT CURRENTLY RECEIVE PT? ☐ **YES** ☐ **NO**
NAME OF THERAPIST: ____

PROJECTED IEP MEETING DATE: ____

SUPERVISOR: ______________________________ **DATE** _____________________
Director of Student Support Services

SPEECH THERAPIST: ____

OCCUPATIONAL THERAPIST: ____

PHYSICAL THERAPIST: ____

TEACHER OF THE DEAF: ____