

## Occupational / Physical Therapy Referral Form for INA

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Person making request: \_\_\_\_\_ School: \_\_\_\_\_  
Teacher's email: \_\_\_\_\_ Date of Request: \_\_\_\_\_

Does student currently have an IEP?      Yes / No      Eligibility: \_\_\_\_\_  
Is student eligible for:                      IEP: Yes / No      504 plan: Yes / No  
Does student wear glasses?                  Yes / No      Compliant with glasses?      Yes / No  
Current family physician/pediatrician:      Clinic: \_\_\_\_\_

Prior to this request, list *at least three* interventions that you have tried (each intervention should be tried for at least 2 weeks):

**Intervention 1)** \_\_\_\_\_  
Date started: \_\_\_\_\_ Date ended: \_\_\_\_\_  
Was this intervention effective? Explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Intervention 2)** \_\_\_\_\_  
Date started: \_\_\_\_\_ Date ended: \_\_\_\_\_  
Was this intervention effective? Explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Intervention 3)** \_\_\_\_\_  
Date started: \_\_\_\_\_ Date ended: \_\_\_\_\_  
Was this intervention effective? Explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Main reason for this referral: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\*\*\*\*\* **Required Signatures** \*\*\*\*\*  
Building Principal / SEA: \_\_\_\_\_ Date: \_\_\_\_\_  
Teacher: \_\_\_\_\_ Date: \_\_\_\_\_

Attach documentation from 3 interventions, e.g. work samples, incident reports, and any other relevant information and forward to your SEA.