OT/PT CLINIC SCHOOL AGE REFERRALS

Department of Special Education
Lincoln Public Schools

Student No. _____ Family No. _____ Grade _____ School _____

Child's Name _____ Date _____

Birthdate _____ Referred by _____ Phone _____

Parents/Guardians _____

Address _____

Phone Home _____ Office (Mother) _____ (Father) _____

Concern _____

_____

MDT-1 _____ Therapist _____ Other Testing _____

Verification _____ Date _____

Verification _____ Date _____ Verification _____ Date _____

OT/PT Clinic Date _____ Time _____ New _____ Re-eval _____ MDT _____ Report _____

Results _____

_____ Coordinator called _____

RETURN TO ANNA AT BOX 43 OR E-MAIL ameza@lps.org

SP0023
8/06

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