

**LUZERNE INTERMEDIATE UNIT 18
OCCUPATIONAL AND PHYSICAL THERAPY DEPARTMENT**

REQUEST FOR DOCTOR'S ORDERS

Student Name _____ Date _____

Parent Name _____

Address _____

Therapist(s) Name _____

School Building _____

It has been recommended that the above student receive occupational - physical therapy for the ____ / ____ school year. Physical and/or occupational therapy is provided only to those students who cannot function in their educational settings without support. An Individualized Education Plan (IEP) has been established which includes the following goals/treatment plan:

I have received this request for Doctor's Orders and am aware that these services cannot begin until this form is returned to the Luzerne Intermediate Unit with the Physician's signature.

Parent's Signature _____ **Date** _____

These services **CANNOT** be implemented without approval from the physician.

Please check the appropriate box and sign below:

I do recommend _____ therapy as described above.

I do not recommend _____ therapy as described above.

**** IMPORTANT ** - PLEASE LIST ANY PRECAUTIONS / LIMITATIONS:**

Physician's Name, Address, Telephone Number (Please Print)

Physician's Signature _____ Date _____

Please return to:
OT / PT Department
Luzerne Intermediate Unit 18
368 Tioga Avenue - PO Box 1649
Kingston, PA 18704