



A Program of Valley Forge Educational Services

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PHYSICAL THERAPY SERVICES – PHYSICIAN REFERRAL FORM

Student's Name _____	Date of Birth _____
Address _____	
Parent or Legal Guardian _____	

To Parents and Legal Guardians: **This form should be filled out ONLY for students who currently have PT on their IEPs.** To provide Physical Therapy treatment, a physician's referral is required. Please have your child's physician complete this form and return it to the address or fax number listed above; include **Attention: Physical Therapy Department** if you are returning the form by mail. **All highlighted areas are required.**

To the Physician: This student has been referred for:
(X) Physical Therapy Treatment to include educationally-relevant services necessary to support a special education program.

Regulations require a physician's referral for these services. Please complete the information below.

Child's Current Diagnosis or Diagnoses _____

Are there any limitations, precautions or contraindications to the services proposed above? Yes () No ()
If yes, please describe: _____

What medications is this child receiving, if any? _____

Other information which may help in the treatment of this child: _____

This referral covers the 2024-2025 school year including the summer Extended School Year 2025 program.

I prescribe the above recommended physical therapy services.

_____ Physician's Name (Print)	_____ Physician's Signature
_____ Street Address	_____ License #
_____ City, State and Zip Code	_____ Date
_____ Phone Number	