



THREE OAKS PUBLIC SCHOOL

SPECIAL EDUCATION SERVICES REFERRAL

Student's Name: _____ Birth Date: _____

Address: _____ School Year: _____

Personal Care Services

- Eating
- Personal Hygiene
- Mobility / Transferring
- Toileting
- Monitoring & Implementing Behavioral Plan

COMMENT: _____

Speech and Language Therapy

- Articulation
- Language
- Fluency
- Voice
- Augmentative / Alternative Communication

COMMENT: _____

Physical Therapy

- Balance Coordination
- Passive / Active ROM
- Developmental Training
- Gait Training, Mobility
- Strengthening and/or Conditioning Exercise

COMMENT: _____

Occupational Therapy

- Developmental Training
- Feeding / Oral Motor
- Sensory Integration
- Fine Motor

COMMENT: _____

Nursing / Health Services

- Gastrostomy Tube Feeding
- Homebound Educational Services
- Medication Administration (PRN)
- Nasal / Oral Suctioning (PRN)
- Nebulizer Treatments (PRN)
- Oxygen

Other: _____

COMMENT: _____

I concur with the recommended services as indicated above.

Physician or *Licensed Practitioner's Signature

Date

Physician or *Licensed Practitioner's Name: _____