



Related Services

Individual Student Request Form

Please fill out form in its entirety in order to expedite request

<p>Services</p> <input type="checkbox"/> OT <input type="checkbox"/> PT <input type="checkbox"/> Speech	<p>Consultation</p> <input type="checkbox"/> OT <input type="checkbox"/> PT <p>Screen for Evaluation</p> <input type="checkbox"/> OT Screen <input type="checkbox"/> PT Screen (To determine need for evaluation and/or to provide general recommendations. Include observation, teacher interview and report writing. * hourly rate applies)	<p>Evaluation</p> <input type="checkbox"/> PT <input type="checkbox"/> Speech- Language <input type="checkbox"/> Speech- Artic <input type="checkbox"/> Speech Language with Artic <input type="checkbox"/> OT <input type="checkbox"/> OT w/Sensory <input type="checkbox"/> Sensory Profile** Last OT Eval Date: _____ (w/in 18 mos) <input type="checkbox"/> Attendance at Meeting Date: _____	<p>ESY Services</p> <input type="checkbox"/> OT <input type="checkbox"/> PT <input type="checkbox"/> Speech
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No individual student services will be provided without an IEP or 504 Plan

<p>Student Name: _____</p> <p>DOB: _____</p> <p>NJ SID #: _____</p> <p>District: _____</p>	<p>Teacher: _____</p> <p>Case Manager: _____</p> <p>Case Manager #: _____</p> <p>Email: _____</p>	<p>Grade: _____</p>
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<p>School Name: _____ <small>(Where services are to be provided)</small></p> <p>School Phone #: _____</p>	<p>School Schedule: _____ <small>(Days/hours of student's attendance)</small></p>
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<p>Parent/Guardian: _____</p> <p>Address: _____</p> <p>Home #: _____</p> <p>Work #: _____</p>	<p>Date Parent Permission Obtained: _____</p> <p>Cell #: _____</p> <p>E-Mail: _____</p>
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Reason for Evaluation/Service: *(IMPORTANT- To determine appropriate testing, please list specific concerns/observations that are impeding child's function in school)*

Evaluations: Initial Re- Evaluation
 Treating Therapist's Name: _____ Work #: _____ Expected IEP Date: Email: _____

Individual Student Service Request Information			
	Frequency/Duration	Start Date	End Date
Occupational Therapy			
Physical Therapy			
Speech Therapy			

IEP attached IEP will be sent Evaluation Plan w/Parental Consent

Note: Out of county rate applies to the location where the services are provided. Destination charge for services rendered outside of Burlington County for non-Burlington County School Districts will be calculated in time. For further details see PSA.

CST Director/Principal: _____ Date: _____
 (My signature and date indicates permission for district to be billed and that I have read and acknowledged the Related Services Billing and Program Descriptors).

Please return form to: Related Services Department Fax: 609-702-9033 or email bvermes@burlcoschools.org

EDUCATIONAL SERVICES UNIT ONLY			
Date Received: _____	Date Reviewed: _____	Accept _____	Decline _____
Notes: Notified District: ____/____/____		By letter _____	Email _____ Phone _____ Who: _____
Therapist Assigned: OT _____		PT _____	SLP _____
IEP Date Received: _____	Copied to: OT _____	PT _____	ST _____
Date: _____	Scanned: _____	Filed _____	