EDUCATIONAL SERVICES UNIT

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Burlington County Special Services School District
20 Pioneer Blvd., Westampton, NJ 08060-3824
www.edservicesunit.com
(609) 702-0500

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Related Services

Individual Student Request Form

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

Services
- ☐ OT
- ☐ PT
- ☐ Speech

No individual student services will be provided without an IEP or 504 Plan

Consultation
- ☐ OT
- ☐ PT

Screen for Evaluation
- ☐ OT Screen
- ☐ PT Screen

(To determine need for evaluation and/or to provide general recommendations. Include observation, teacher interview and report writing. * hourly rate applies)

Evaluation
- ☐ PT
- ☐ Speech- Language
- ☐ Speech- Artic
- ☐ Speech Language with Artic
- ☐ OT
- ☐ OT w/Sensory
- ☐ Sensory Profile** Last OT Eval Date: _____ (w/in 18 mos)
- ☐ Attendance at Meeting Date:_____

ESY Services
- ☐ OT
- ☐ PT
- ☐ Speech

Student Name: **Teacher:** **Grade:**
DOB: **Case Manager:**
NJ SID #: **Case Manager #:**
District: **Email:**

School Name: **School Schedule:**
(Where services are to be provided) **(Days/hours of student's attendance)**
School Phone #:

Parent/Guardian: **Date Parent Permission Obtained:**
Address:
Home #: **Cell #:**
Work #: **E-Mail:**

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** **Expected IEP Date:** ☐
Treating Therapist's Name: **Work #:** **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 bdecker@burlcoschools.org

EDUCATIONAL SERVICES UNIT ONLY

Date Received: _____ Date Reviewed: _____ Accept____ Decline _____ Wait List ____
Notes: Notified District: ____/____/____ By letter ___ Email ___ Phone ____ Who: _____
Therapist Assigned: OT _____ PT_____ SLP_____
IEP Date Received:_____ Copied to: OT _____ PT _____ ST _____ Date: _____ Scanned: _____ Filed _____