



## Southern Worcester County Educational Collaborative

Post Office Box 517

Southbridge, Massachusetts 01550

Tel. (508) 764-8500 ~ Fax. (508) 764-2724

Visit us at: [www.swcec.org](http://www.swcec.org)

Administrative Offices  
Dudley, MA 0157

### Referral Form

Please complete and *fax* or *mail* to:

Southern Worcester County Educational Collaborative (S.W.C.E.C.)

P.O. Box 517 Southbridge, MA 01550

Attn: Dr. Melissa Manzi, DPT

Phone: 508-764-8500

Fax: 508-764-2724

#### Please check requested Assessment/Service(s):

- |  |  |
|--|--|
| <input type="checkbox"/> Adaptive PE               | <input type="checkbox"/> Orientation and Mobility              |
| <input type="checkbox"/> Assistive Technology      | <input type="checkbox"/> Vision (Functional Vision Assessment) |
| <input type="checkbox"/> Teacher of the Deaf       | <input type="checkbox"/> Vocational and Life Skills Evaluation |
| <input type="checkbox"/> Learning Media Assessment | <input type="checkbox"/> Speech Language Pathologist           |
| <input type="checkbox"/> Music Therapy             | <input type="checkbox"/> Occupational Therapy                  |
| <input type="checkbox"/> Physical Therapy          | <input type="checkbox"/> Psycho-Educational                    |

---

#### Please Print Clearly:

Today's date: \_\_\_\_/\_\_\_\_/\_\_\_\_

District; \_\_\_\_\_

Referred by: \_\_\_\_\_

Contact Number: \_\_\_\_\_ Email: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Physical Therapy Referral Form

Student's Full Name: \_\_\_\_\_

Student's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M F Student's Age: Years:\_\_\_\_ Months:\_\_\_\_

Grade:\_\_\_\_\_ School: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone #:\_\_\_\_\_

Teacher: \_\_\_\_\_ Teacher email: \_\_\_\_\_

Date Parent/Guardian permission was obtained: \_\_\_\_/\_\_\_\_/\_\_\_\_

Consultation/Assessment approved by: \_\_\_\_\_  
*(SIGNATURE OF AUTHORIZED SPECIAL EDUCATION REPRESENTATIVE)*

**\*Please submit the following forms/documentation with the Referral Form. These forms are required BEFORE an assessment can be conducted;**

## Physical Therapy:

\_\_\_\_\_ Current Individual Education Plan (IEP)

\_\_\_\_\_ **Relevant Medical Information/Reports**

\_\_\_\_\_ Pertinent Therapeutic Evaluation Documents

\_\_\_\_\_ Copy of signed Parent/ Legal Guardian Consent form

\_\_\_\_\_ List of other services student receives (if applicable)

---

---

---

---

---

---

---

---