THE VANGUARD SCHOOL
A Program of Valley Forge Educational Services

1777 North Valley Road
Malvern, Pennsylvania 19355

p 610.296.6700
f 610.296.6531

info@vanguardschool-pa.org
www.vanguardschool-pa.org

PHYSICAL THERAPY SERVICES – PHYSICIAN REFERRAL FORM

Student's Name _____ Date of Birth _____

Address _____

Parent or Legal Guardian _____

To Parents and Legal Guardians: To provide Physical Therapy evaluation or 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 physically mailing. This also will indicate your permission to evaluate your child. If IEP changes result from a new evaluation, you will be notified. All highlighted areas are required.

To the Physician: This student has been referred for:
( ) Physical Therapy Evaluation
( ) 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 _____

_____

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 2021-2022 school year including the summer Extended School Year 2022 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	