Mini Miracles Pediatric Therapy
"Serving Families and their Mini Miracles"
2214 E. Fairview Ave., Johnson City, TN 37601
423-928-6464
225 Midway Medical Park, Bristol TN 37620
423-797-4555

SCHOOL THERAPY REFERRAL FORM

DATE PERMISSION TO EVALUATE SIGNED BY PARENT/GUARDIAN: _____ EVAL DUE: _____

DATE REFERRAL SENT TO THERAPIST(S): _____ MEETING DATE/TIME (IF SET): _____

STUDENT NAME: _____ DOB: _____

PARENT(S) / GUARDIAN(S): _____

STUDENT HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME/CELL PH#: _____

PEDIATRICIAN:_____PHONE: _____

SCHOOL: _____ GRADE: _____

CASE MANAGER: _____ PH#: _____ EMAIL: _____

GENERAL ED TEACHER: _____ PH#: _____ EMAIL: _____

SPECIAL ED TEACHER: _____ PH#: _____ EMAIL: _____

DOES THIS CHILD ALREADY HAVE AN IEP IN PLACE? ☐ NO ☐ YES

SPECIAL ED DIAGNOSIS: _____ THIS IS A CHANGE IN DIAGNOSIS ☐

THERAPY DISCIPLINE(S)/PRIMARY CONCERN: *(CHECK BOX OF THERAPY DISCIPLINE AND PRIMARY CONCERNS)*

☐ OT: *☐ FINE MOTOR; ☐ VISUAL PERCEPTUAL; ☐ SENSORY PROCESSING/BEHAVIOR; ☐ SELF CARE*

☐ PT: *☐ GROSS MOTOR SKILLS; ☐ MOBILITY; ☐ BALANCE; ☐ COORDINATION; ☐ SEATING; ☐ EQUIPMENT NEEDS*

☐ ST: *☐ LANGUAGE; ☐ SPEECH/ARTICULATION; ☐ SOCIAL COMMUNICATION; ☐ NON-VERBAL COMMUNICATION*

TYPE OF EVALUATION REQUESTED:

☐ INITIAL ELIGIBILTY for SERVICES **☐ 3 YEAR (TRIENNIAL) RE-ELIGIBILTY for SERVICES**

☐ ADDITIONAL THERAPY SERVICE(S) FOR CHILD WITH AN EXISTING IEP

☐ TRANSFER STUDENT (SEND IEP WITH REFERRAL FORM)**

☐ OTHER (explain): _____

***EMAIL COMPLETED FORMS TO YOUR SYSTEM ADDRESS : bvpsreferrals@minimiraclestherapy.com