WESLACO INDEPENDENT SCHOOL DISTRICT
SPECIAL EDUCATION DEPARTMENT

Occupational Therapy / Physical Therapy / Speech Therapy
Request Form

Date Requested: _____ Date Needed: (To Be Completed By): _____

Student Name: _____ D.O.B.: _____

Identification #: _____ School: _____

Parent Name: _____ Home #: _____

Address: _____

Physician Name / Phone & Fax # (Required if requesting evaluation): _____

Diagnostician _____ Ext. _____

Type of Request

- ☐ Initial Evaluation
- ☐ 3 Year Re-evaluation
- ☐ Annual Review
- ☐ Discharge
- ☐ Equipment Evaluation
- ☐ ARD Meeting
- ☐ IEP Request
- ☐ Parent Concern
- ☐ Home Visit
- ☐ Documentation
- ☐ Progress Reports
- ☐ Closed IEPs
- ☐ Other:_____

Comments / Main Concerns---(Specify Interventions Attempted by Teacher):

_____
_____
_____
_____

***ATTACH CONSENT FORM (if applicable)**
***ALL ITEMS MUST BE ADDRESSED BEFORE PROCESSING**