CAPE MAY COUNTY SPECIAL SERVICES SCHOOL DISTRICT
Ocean Academy • Cape May County High School

CONTRACTED PROFESSIONAL SERVICES REQUEST FORM

Phone: 609-465-2721 • Fax: 465-8039

Student's Name: _____ DOB: _____

Parent's Name: _____ Phone: _____

Address: _____

District/School: _____ Date: _____

Teacher/Room: _____ Grade: _____

Referred by: _____ Phone: _____ Ext. _____

E-mail: _____ Reason for Referral for Evaluation: _____

_____

Service Requested (check all that apply) Evaluation Report Due (please give specific date): _____

- ☐ Occupational Therapy Evaluation
- ☐ Physical Therapy Evaluation
- ☐ Speech and Language Evaluation
- ☐ Learning Evaluation
- ☐ Psychiatric Evaluation
- ☐ School Psychological Evaluation
- ☐ Neurological Evaluation
- ☐ Social History
- ☐ Physical Therapy Services (frequency/duration): _____
- ☐ Occupational Therapy Services (frequency/duration): _____
- ☐ Speech Therapy Services (frequency/duration): _____
- ☐ Special Education Services (frequency/duration): _____
- ☐ Autism Services (consultation/in-service training be specific): _____
- ☐ Consultation Services (type): _____
- ☐ Case Management Services (be specific, i.e. number of students): _____
- ☐ Attendance at a Meeting (type): _____
- ☐ Other: _____

Additional Comments: _____

_____

***Please fax your request to 465-8039, attention Jonathan Price, Director of Related Services. Form is also online at cmcspecialservices.org and can be e-mailed to jmjones@cmcspecialservices.org**

For Administrative Use Only

Date Request Received: _____

Assigned Itinerant Number: _____

Assigned Itinerant Provider: _____