|  |
| --- |
| Therapist Details |
| Name: |  | D.O.B. |  |
| Position: |  |
| Organisation: |  |
| Organisation Address: |  |
| Email Address: |  |
| Phone Contacts: | (w)  |  | (m) |  |

A *Request for Therapy Service Provision During School Hours* is to be completed by parents. Information should be completed after reading the *Mainsbridge School – Guideline for the Provision of Therapy Services in School* document*.*

|  |  |  |  |
| --- | --- | --- | --- |
| Student Name |  | Class Teacher |  |
| Service Provision Requested: |
| [ ]  Speech Therapy | [ ]  Occupational Therapy | [ ]  Physiotherapy |
| [ ]  Other: |
| Expected outcome or goal of therapy service |
|  |
| Will there be a clear link between the therapy service goal and PLP goal? | Yes [ ]  | No [ ]  |
| Frequency of Service | Session Length | Duration of Service |
| [ ]  Weekly | [ ]  30 minutes | [ ]  Term One |
| [ ]  Fortnightly | [ ]  60 minutes | [ ]  Term Two |
| [ ]  Monthly | [ ]  Other: | [ ]  Term Three |
| [ ]  Once or twice per term | [ ]  Term Four |
| Available times: Monday to Friday **1:30-2:30pm ONLY** |
| Please select your preferred day Monday 🞏Tuesday 🞏Wednesday 🞏Thursday 🞏Friday 🞏  |
| [ ]  I understand that a decision will be made regarding the provision of therapy services during school hours after a review of its appropriateness with the class teacher and the student’s parents or carers. [ ]  I understand that should no suitable times or learning spaces be available in the student’s class the service cannot commence. The request will be placed “on hold” and reviewed at the end of each semester.  |
| **Therapist Signature:** |  | **Parent Signature:** |  |
| **To be completed by Mainsbridge School** |
| Status of Service Provision Request |
| [ ]  Approved | [ ]  Declined | [ ]  On Hold |
| **Principal Signature:** |  |
| Time and Date of first session |
|  |