



2020/21 Helping Hands Therapy Discharge Notification Form

Effective Date of Discharge: _____

Please check the service(s) from which the student was discharged:

<input type="radio"/> OT	<input type="radio"/> PT	<input type="radio"/> ST
--------------------------	--------------------------	--------------------------

Student Information

Child's Name:	DOB:
School Name:	County/City District Name:

Please check the reason for discharge:

<input type="checkbox"/>	Student has met all therapy goals, and is successfully participating within the classroom
<input type="checkbox"/>	Student has withdrawn from the above school district
<input type="checkbox"/>	Parent/Guardian/Family request
<input type="checkbox"/>	Other (please specify):

We the undersigned acknowledge that the above-named student has been discharged from the therapy services noted and agree with the reason given.

Signature _____
Parent/guardian

Date _____

Signature _____
Occupational Therapist

Date _____

Signature _____
Physical Therapist

Date _____

Signature _____
Speech Therapist

Date _____

Signature _____
Case Manager/School Representative

Date _____

NOTE: please fax copy with therapist(s)' and at least one parent/guardian OR school representative signature to Helping Hands Therapy at the Direct Fax number listed below. Original copy can be kept at school.

Contact: **Caseload Coordinator**

• Phone: 334/624-3950 • Fax: 334/624-3960 • email: schools@helpinghands-therapy.com