UPSTATE MUSIC THERAPY CENTER LLC
401 Penbrooke Dr., Bldg. #3, Suite SE
Penfield, New York 14526
Phone 585-377-1000

MUSIC THERAPY ASSESSMENT REFERRAL FORM

Name of Child _____ D.O.B. _____

Referral Date _____ Disability(s) _____

Name of Center Based Program _____

Contact _____ Phone_____

Parent Name(s) _____

Address _____

Phone: Home _____ Work _____ Cell _____

School District _____

List the primary and secondary areas of needs for this child/student:

Primary: _____

Secondary: _____

List therapies that the child/student is currently receiving:

_____

Physical or Behavioral Limitations: (that will limit the child during the evaluation, eg. vision, hearing, motoric, medical, sensory)

_____

_____

_____

Mode of Communication (eg. switches, Dynavox, sign language, vocalizations, picture symbols, gestures, body movement, word combination, complete sentences)

_____

_____

_____

List all observed significant responses to music

_____

_____

_____

P**lease include contact person/teacher & phone number for scheduling evaluation**

_____

The most recent IEP must accompany this form.
When completed, please return to : Amy Thomas, LCAT, MT-BC - Director