

OCCUPATIONAL AND PHYSICAL THERAPY REFERRAL CHECKLIST

Each child referred should have a SIGNIFICANT problem preventing him/her from benefiting from the educational program.

Child's Name _____ School _____ Teacher _____
Date _____ Grade _____ Birth Date _____
Referred by _____ Other services receiving _____

1. Does the child exhibit a readily observable physical disability hindering his/her functioning in the classroom? Please check:
 - Tremor
 - Difficulty with accessing playground equipment
 - Difficulty with ascending/descending stairs
 - Unable to participate in PE activities
 - Muscle weakness
 - Abnormal posture
 - Abnormal gait
 - Has diagnosed neuro-muscular disorder (cerebral palsy, muscular dystrophy)
 - Requires use of wheelchair, crutches, braces for mobility
 - Experiencing equipment problems (size, functioning parts)

2. Does the child demonstrate difficult in self-help skills?
 - Feeding**
 - Difficulty holding utensils
 - Drools/no lip closure
 - Not drinking from cup
 - Other, please explain
 - Dressing**
 - Tying shoes
 - Manipulating clothing for toileting
 - Fasteners
 - Other, please explain
 - Bathroom Skills**
 - Toileting
 - Hand washing/drying
 - Lunchroom Skills**
 - Carrying tray
 - Scooping
 - Cutting food
 - Finishing lunch in a timely manner

3. Does the child have difficulty completing assignments due to poor handwriting skills/abilities *which interfere with school performance?*
 - Inappropriate grasp of pencil/crayon
 - Difficulty copying prewriting shapes
 - Reversals of letters following 1st grade
 - No hand dominance established
 - Illegible handwriting
 - Lines drawn are too light or too faint
 - Uneven spacing between words/letters
 - Writings are not adequately placed on age-appropriate paper
 - Switches hands at midline of body
 - Difficulty copying from near? From far?

4. Does the child demonstrate difficulty with motor performance and/or perceptual motor skills, *which interfere with school performance*?
- Appears uncoordinated, clumsy
 - Withdrawn from other children
 - Poor eye contact with people or task
 - Easily frightened by noise or movement
 - Does not like to be touched
 - Highly distractible, short attention span, cannot sit still
 - Difficulty following directions
 - Not established hand dominance (6+ years)
 - Difficulty with tracing or copying
 - Difficulty eye tracking: turns head instead of eyes
 - Other, please explain
5. Does the child demonstrate difficulty with sensations *which interfere with school performance*?
- Limited food preferences; please list _____
 - Difficulty tolerating clothing tags in shirts, seams in socks/pants
 - Reluctance to get hands messy/dirty
 - Reluctance to touch things
 - Difficulty bearing weight into hands/feet
 - Reluctance/avoidance of playground equipment which rotates/spins
 - Perseveration on equipment which spins/rotates
 - Preoccupation with rotating wheels
 - Difficulty moving fluidly in space/knowing where body is in relation to itself and environment (consistently bumping into kids in line, hugging too hard...)
6. Times for observation:
- Meal or snack times _____ Writing _____
P.E. _____ Recess _____
7. What do you see as the most challenging area for this student within the school environment?
- Social
 - Communication
 - Motor
 - Sensory
 - Behavior
 - Cognitive
 - Other, please list _____
8. What information might an OT and/or PT provide to assist you in working with this student?
9. Please list the educational goal and objective(s) from this student's IEP that you feel cannot be met without the support of this related service. **THIS INFORMATION IS REQUIRED.**
- _____
- _____
10. Please list any additional comments or concerns you have that were not addressed.
- _____
- _____
- _____

When this form is completed, please circle your school's therapist and return to him/her at ESU 10.

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