



OCCUPATIONAL THERAPY REFERRAL

Student Information:

Date: _____

Name: _____ School: _____

Teacher: _____ SETA: _____

Grade: _____ Date of Birth: _____ Siblings: _____

Parent/Guardian Name(s): _____

Mailing Address: _____ Phone (H): _____

Home Address: _____ Phone (W): _____

Family Physician: _____ Phone: _____

Referral Information:

Name: _____ Agency: _____

Have parents been notified? (Yes () No () By? _____

Is *Consent to Obtain/Release Information and Assess* form signed by parents? Yes () No ()

Has *School-Aged Checklist for OT/PT Services* form been completed? Yes () No ()

Specialists or Agencies Involved:

(e.g., Sunny Hill, BC Children's, Pediatrician, Neurologist, Ministry for Children and Families, etc.)

Support Personnel Involved:

(e.g., Speech Pathologist, Psychologist, Hearing/Vision Impaired Teacher, etc.)

Diagnosis (be specific):

Pertinent Medical History (include seizures and medications):

Principal's Signature: _____

Resource Teacher's Signature: _____

(see next page)



Occupational Therapy **Referral** (cont.)

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Reason for Referral (be specific):

Primary Concern of School: _____

Primary Concern of Family: _____

Physical Concerns: Are physical limitations causing safety concerns? Yes () No ()

Please expand: _____

Are any of the following areas of concern? If yes, please expand.

- Feeding (choking, frequent colds, G-Tube) Yes () No () _____

- Mobility (wheelchair, walking) Yes () No () _____

- Equipment (walker, splints) Yes () No () _____

- Transfers (desk, toilet, floor) Yes () No () _____

- Catheterization Yes () No () _____

- Seizures Yes () No () _____

School Performance Concerns:

Behaviour: Yes () No () _____

Attention: Yes () No () _____

Organization: Yes () No () _____

Follows directions: Yes () No () _____

Learns new skills: Yes () No () _____

Directionality and spatial concepts: Yes () No () _____

Vision: Yes () No () _____

Hearing: Yes () No () _____

Social Skills: Yes () No () _____

Is there a marked discrepancy between verbal and written ability? Yes () No () _____

Student strengths: _____

Grade level in: Math _____ Reading _____ Writing _____

Does the student:

- Experience frustration with classroom expectation? Yes () No () _____

- Have grade level problem solving abilities? Yes () No () _____

- Use coping strategies (e.g., avoidance)? Yes () No () _____

- Have poor self esteem? Yes () No () _____

- Have any special interests? Yes () No () _____

- Have **fine motor** difficulties? Yes () No () If yes, please circle which difficulties: cutting, printing/writing, laces/buttons/zipper, orienting work on paper, other _____

- Have **gross motor** difficulties? Yes () No () If yes, please circle which difficulties: throwing/catching, coordination, running, balance, P.E., other _____