Occupational Therapy Referral

Rev. 2/22/18

Student:	DOB:	Teacher/Grade	Grade:	Date:

INSTRUCTIONS:

1. Check only AREA(s) OF CONCERN on the left which impact how the student is performing academically. If more than one area, put an asterisk (*) next to the area of most concern.

2. Report how student performs the corresponding ACTIVITY by checking the appropriate column (unable, needs help, etc.).

✓	AREAS OF CONCERN	*ACTIVITY*	Unable to complete	Needs more help	Student is unsafe	Slower than peers
☐	**HANDWRITING Significant Deficits** ***-After age 6 -After direct instructions -After structured handwriting program***	**Letter Size**				
		Writing Tool Grip				
		Letter Formation				
		Line Placement				
		Spacing Within or Between Words				
☐	***FINE MOTOR***	**Hand Dominance R/L**				
		Crossing the Midline				
		Coordinated Use of Both Hands				
		Manipulating Small Objects				
		Cutting Skills				
		Coloring Within Lines/Tracing				
☐	**VISUAL SPATIAL – VISUAL MOTOR**	**Getting On/Off Bus**				
		Copying From the Blackboard				
		Omit Letters, Words, or Sentences				
		Following Visual Demonstrations				
☐	**SELF CARE**	**Dressing and/or Undressing**				
		Using Buttons, Zippers or Laces				
		Opening Food Containers				
		Organizing Personal Space				
			Always	**Frequently**	**Occasionally**	**Never**
☐	**SENSORY BEHAVIOR**	**Overly Sensitive to Touch**				
		Always Moving Unable to Stay Still				
		Dislikes Textures: Finger Paint, Clay, Shaving Cream, etc.				
		Chewing on Clothes or Objects				
		Bumps Into Peers In Line				
		Overly Sensitive to Noise				
		Distractible or Short Attention Span				
		Dislikes Active Play				
		Difficulty With Visual Attention				
		Fearful on Playground Equipment				
		Does Things in Inefficient Way				
		Emotional Outburst or Aggression				

How is student performing academically? ☐Above Grade Level ☐At Grade Level ☐Below Grade Level

Briefly describe if there are behavioral issues that you believe affect student' performance in areas of concern:

_____

Student currently is on a: ☐ IEP ☐ 504 Plan ☐ Neither

By signing this form, the parent is giving the therapist permission to work with their child outside of the classroom. OT/PT is a related service, not a standalone service. Student must be identified as having a disability that interferes with education under the criteria of IDEA. Eligibility is not based on specific test scores or discrepancies, rather on whether the unique expertise of the therapist is required for the student's educational participation. Medical diagnosis itself does not determine eligibility under IDEA. The disability must "adversely affect the child's educational performance"

Parent Signature: _____;

Program Specialist/Counselor Signature: _____