ADDITIONAL INFORMATION FOR THERAPY REFERRAL (OT/PT)

School-Based Rehabilitation Services

Quinte Children's Treatment Centre

- Secure electronic upload (please see instruction on our website *www.quintectc.com*) ***or*** Fax to 613-961-2517

Questions? Call 613-969-7400 ext. 2784

Student Name:

Date of Birth: *(dd-mmm-yyyy)* Grade:

Known Diagnosis(es):

Student's Needs / Classroom Functional Goals:

Please describe the main reason(s) for referral and how this influences school performance (i.e., What classroom functional activities is the student struggling with?)

Is the student unable to attend school without the requested intervention? ☐ **Yes** ☐ **No**

What are the student's strengths?

Please specify the outcomes you wish the student to achieve as a result of the OT or PT intervention.

General Classroom Skills (ex: able to follow verbal or written instructions, transitions between activities, follow classroom rules and routines, etc.)

☐ Not a concern

The student will be able to:

ADDITIONAL INFORMATION FOR THERAPY REFERRAL (OT/PT)

Student's Name ***DOB:*** *(dd-mmm-yyyy)*

Handle Materials and Manipulates (ex: hand preference, pencil grasp and control, use of classroom tools such as scissors, erasers, rulers, keyboarding, etc.)

☐ Not a concern

The student will be able to:

Written Communication (ex: legibility, organization, use of technology, efficiency, scribing, etc.)

☐ Not a concern

The student will be able to:

General Organization Skills (ex: organizes tasks and school materials, stores and retrieves learning tools and materials, transitions between tasks, persists or requests assistance, etc.)

☐ Not a concern

The student will be able to:

Self-Care Skills (ex: bathroom routines, hygiene, manage clothing and fasteners, open and close containers, feed self, clean up after self, etc.)

☐ Not a concern

The student will be able to:

ADDITIONAL INFORMATION FOR THERAPY REFERRAL (OT/PT)

Student's Name ***DOB:*** *(dd-mmm-yyyy)*

Self-Regulation (ex: challenges managing emotions and regulating behaviour)

☐ Not a concern

The student will be able to:

Environment (ex: able to access stairs, able to safely get on and off bus, able to access locker, able to move freely throughout the school environment, able to sit comfortably at desk)

☐ Not a concern

The student will be able to:

Mobility/Functional Gross Motor Skills (ex: able to walk without difficulty, falling or losing balance, move between chair and floor smoothly, sit to stand with control, maintain upright posture at desk or floor, good endurance; participate in physical education class, playground activities)

☐ Not a concern

The student will be able to:

Gross Motor Skills/Ball Skills/Coordination (ex: able to catch a ball, throw a ball, bounce a ball, able to hop on one foot, two foot jump)

☐ Not a concern

The student will be able to:

ADDITIONAL INFORMATION FOR THERAPY REFERRAL (OT/PT)

Student's Name ***DOB:*** *(dd-mmm-yyyy)*

Are there any safety concerns? ☐ Yes ☐ No

In Yes, please describe:

Has there been a recent change in the student's health status? ☐ Yes ☐ No

In Yes, please describe:

Classroom Tools and/or Resources in Place

Is there an IEP in place? ☐ Yes ☐ No

What tools (ex: sensory equipment, seating, or environmental modifications) have you tried in the past to support the student's performance and what were the outcomes?

Is there any specialized equipment currently in place to support the student? Please describe:

Splints/Braces	
Mobility Aids (walker, crutches, bike, etc.)	
Wheelchair (power or manual)	
Transfer Equipment (Portable or ceiling, slings, transfer board)	
Specialized seating/positioning equipment (chair, stander)	
Feeding or dressing aids	
Toileting, bathroom aids (bars, stool, seat, change table)	
Oral communication aids (FM system, PECS, Proloquo2go)	

ADDITIONAL INFORMATION FOR THERAPY REFERRAL (OT/PT)

Student's Name ***DOB:*** *(dd-mmm-yyyy)*

Written communication aids (Assistive technology, pencil grips, slant board)	
Assistive technology (computer, iPad, switches)	
Sensory equipment (Chewlery, fidgets, TheraBand, weighted lap blanket)	
Equipment to support focus/attention (hokki stool, rocker chair, fidgets, timer)	

Special Education Strategies and Supports Available:

Is the student working at grade level? ☐ Yes ☐ No If No, at what grade level is the student working?

Is the student in a regular classroom or other specialized class? If in a specialized class, please indicate the type of class.

What (if any) other resources have been accessed to support this child? (Behaviour Team, Children's Mental Health, Ontario Autism Program (OAP) School Board Resources, etc.)

Has this student been seen previously by Quinte Children's Treatment Centre or School-Based Rehabilitation Services (LHIN)?

☐ Yes ☐ No ☐ Unsure

If Yes, what services did they receive, when (Year) and for how long?

Occupational Therapy	
Physiotherapy	
Speech Language Therapy	

Have the previously recommended Strategies been implemented successfully? Please specify why or why not.

ADDITIONAL INFORMATION FOR THERAPY REFERRAL (OT/PT)

Student's Name ***DOB:*** *(dd-mmm-yyyy)*

Is there anything else you wish to share with the Occupational Therapist/Physiotherapist?

☐ **Referral has been review with SBRS OT**

THIS BOX **MUST BE** CHECKED BEFORE CONSIDERATION OF THIS REFERRAL

Signature of person completing form:

Date: *(dd-mmm-yyyy)*

****Please attach and submit with SBRS Referral Request form***