KidsAbility™

SCHOOL BASED REHABILITATION SERVICES

Additional Information for Therapy Referral (OT/PT)

Client's Name: ______________________ Date of Birth: ______________________

School Name: ______________________ Class/Grade: ______________________

Does the child/youth have an Individualized Education Plan (IEP)? (If yes, please specify areas of program modification or accommodation)	☐ Yes	☐ No
Does the child/youth have an Identification, Placement and Review Committee (IPRC) designation? Please specify exceptionality:	☐ Yes	☐ No

Who recommended or initiated this referral?				
☐ Teacher	☐ Parent	☐ Psychologist	☐ School Board	☐ Private
Other (Specify):				

What are your goals for this child/youth related to this referral?	
A)	
B)	
C)	
Prioritize three areas pertaining to the referral of the child/youth in your classroom:	
A)	
B)	
C)	

Do the concerns affect the child/youth's ability to stay in the classroom for a full day? If yes, please specify.	☐ Yes	☐ No
Is this child/youth on a modified day? Please specify details of the modified day.	☐ Yes	☐ No

Do these issues affect the child/youth's ability to access the curriculum?	
☐	Mildly
☐	Moderately
☐	Unable to access any part of the curriculum

Is there a Safety Issue? Yes No Frequency of Safety Issue: Daily Weekly Monthly

If yes, please describe:

☐ Stairs	☐ Falling	☐ Transfers	☐ Play Equipment / School Environment	☐ Mobility	☐ Gym

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What is the child/youth's mobility status	
☐	Independent
☐	Independent with aids
☐	Supervision required
☐	Dependent with aids

What equipment has been implemented or trialed with this child/youth?

For children/youth having difficulty with printing/handwriting, all appropriate supports and/or adaptations must have been tried (ideally for 1 year). Please indicate, noting the results and length of time trialed:

	Supports/Adaptations	**Length of time trialed**
☐	Printing/Cursive Writing Program (specify)	
☐	1:1 Classroom Support (specify)	
☐	EA/ERW	
☐	Technology / Software Programs	
☐	Alternative Pencil Grips or Lined Paper (specify)	
☐	Other (specify)	

What Sensory resources does your school have?	**What strategies have you tried?**
☐ Sensory Room ☐ Other	☐ Sensory Breaks ☐ Sensory Diet
☐ Basic Sensory equipment	☐ Other

What resources have been accessed?

☐ IBI (Intensive Behavioural Intervention)	☐ Behavioural Team	☐ KidsAbility
☐ School Board Resources	☐ Special ED Resource Team	☐ ABA (Applied Behavioural Analysis

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What programming has been developed with the Resource Teacher?		
Has the child/youth received SHSS previously? ☐ Yes ☐ No If yes, what strategies have been put into place?		
If the child/youth has been on OT /PT service before, what has changed?:	Year of Service:	
A) Has the school been using the strategies developed by the therapist and are they still working?	Yes	No
B) Have you connected with parents and previous teachers to review interventions?	Yes	No
C) Are there strategies identified in the OSR or with the resource teacher?	Yes	No

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PLEASE CHECK ANY AREAS OF CONCERN.

FINE MOTOR / HAND SKILLS - *GRADE 1 OR OLDER	MOBILITY / ACCESSIBILITY
☐ Has not established hand dominance	☐ Tires easily with routine tasks
☐ Difficulty handling small items	☐ Stumbles, falls, bumps into objects / people when walking / running
☐ Has difficulty with puzzles, small blocks and shapes	☐ Difficulty maintaining balance in games, physical education or on the playground
☐ When using one hand, tenses or moves the other hand	☐ Difficulty with stairs
☐ Holds pencil awkwardly, presses too hard or too lightly	☐ Unable to access all areas of the school
☐ Difficulty using scissors	☐ Difficulty imitating body movements; doesn't cross midline
☐ Difficulty colouring within the lines	☐ Has extreme tightness which limits joint movement
PRINTING / WRITTEN OUTPUT	☐ Appears to have poor overall body strength; is "floppy"
☐ Is unable to draw a circle, cross, diagonal line	☐ Makes no attempt to catch himself when falling
☐ Neatness and legibility of printed work is not per educational expectations	☐ Cannot heel-toe, hop on one foot, jump in place
☐ Difficulties spacing words appropriately	☐ Difficulty bouncing, throwing, or catching a large ball
☐ Does not work from left to right when writing / reading	☐ Lacks reciprocal arm and leg movements when walking
☐ When writing, doesn't stabilize the paper	☐ Habitually walks on toes
☐ Has difficulty copying from the board	**SELF - CARE**
☐ Difficulty maintaining good sitting posture (tends to lean on desk, feet not flat on the floor)	☐ Requires assistance with toileting
☐ Difficulties with understanding directional terms (i.e., left, right, forward, backward) and positional terms (i.e., in out, on) and is older than age 9	☐ Difficulties managing outdoor clothing, gym clothing and fasteners (zippers, buttons, laces)

Not all items checked above will be treated by the SBRS therapist; based on the concerns identified, needs will be prioritized and goals developed.

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Additional Information for Therapy Referral (OT/PT)

PLEASE CHECK ANY AREAS OF CONCERN AND INDICATE FREQUENCY*

WORK BEHAVIOURS	FREQUENCY OF OBSERVED CONCERN
☐ Difficulties responding to changes in plans and expectations	☐ Always ☐ Sometimes ☐ Infrequently
☐ Requires repeated practice to learn new skills	☐ Always ☐ Sometimes ☐ Infrequently
☐ Fidgets or is constantly moving when seated in chair	☐ Always ☐ Sometimes ☐ Infrequently
☐ Difficulties keeping track of personal and school materials (i.e., Homework, shoes, backpack, lunch, notes)	☐ Always ☐ Sometimes ☐ Infrequently
☐ Difficulties following routines	☐ Always ☐ Sometimes ☐ Infrequently
☐ Requires extra time to complete tasks	☐ Always ☐ Sometimes ☐ Infrequently
☐ Verbal outbursts in classroom	☐ Always ☐ Sometimes ☐ Infrequently
☐ Aggressive response observed towards: ☐ Self ☐ Peers ☐ Staff	☐ Always ☐ Sometimes ☐ Infrequently
SENSORY	**FREQUENCY OF OBSERVED CONCERN**
☐ Responds negatively to touch, noise, taste and texture of food and / or clothing	☐ Always ☐ Sometimes ☐ Infrequently
☐ Is overly sensitive to noises, lights, movements	☐ Always ☐ Sometimes ☐ Infrequently
☐ Difficulty sitting still; may fidget, rock, turn during meals or when doing school work	☐ Always ☐ Sometimes ☐ Infrequently
☐ Frequently tries to escape the classroom environment	☐ Always ☐ Sometimes ☐ Infrequently
☐ Mouthing of non-food items (i.e. chalk, markers)	☐ Always ☐ Sometimes ☐ Infrequently

***Infrequently is approximately 1-2 times a month.**

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Which school personnel will be responsible for follow up of recommendations provided by the therapist?
Any other additional information about this child/youth that would be important for the therapist to know?

School Board ______________________________

Referral Name ______________________ **Signature** ______________________

Phone ______________________ **Ext** __________ **Date** ______________________