SCHOOL BASED REHABILITATION SERVICES (SBRS)

Additional Information for Therapy Referral (OT/PT)

Student's Name: _____ Date of Birth: _____

School Name: _____ Class Grade: _____

Who recommended or initiated this referral?				
☒ Teacher	☐ Parent	☐ Psychologist	☐ School Board	
Other (Specify):				
For schools in the P4C model: Has this OT or PT referral been discussed with the Occupational Therapist at the school ☐ Yes ☐ No				
Prioritize three areas of concern pertaining to the referral of this student in your classroom				
A)				
B)				
C)				

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

Please explain which areas of the curriculum this student is unable to access
Comments:
Is there a Safety Issue? ☐ Yes ☐ No Frequency of Safety Issue: ☐ Daily ☐ Weekly ☐ Monthly

☐ Stairs	☐ Falling	☐ Transfers	☐ Play Equipment / School Environment	☐ Mobility	☐ Gym
Please describe:					

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

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Does the child present challenging behaviours in the classroom ☐ yes ■ No

What behaviours are observed?

In which situations are these behaviours typically observed? (include frequency)
What are the typical responses to these behaviours? (E.g., offer a break, remove the demand, simplify the task) please specify.

Does the observed behaviour appear to be for the purpose of:
☐ gaining attention ☐ accessing a preferred item ☐ escaping a demand
If so, this concern should be addressed to board behavioural resources prior to completing the OT referral.

What behaviour resources have been accessed?		
☐ Behavioural Support (e.g.ABA-BCBA)	☐ CYW	☐ Special ED Resource Team
☐ Psychologist	☐ Mental Health Clinicians	☐ Other

What is the student's mobility (walking) status	
☐	Independent
☐	Independent with aids (for example, uses a walker or wheelchair independently)
☐	Supervision required (needs supervision when walking/moving about)
☐	Dependent with aids (for example, needs help to move their wheelchair)

What equipment has been implemented or trialed with this student (i.e. stander, lift, special seating, weighted equipment, etc)

For students 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:

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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)	

Does the child/youth have an Individualized Education Plan (IEP)? (If yes, please specify areas of program modification or accommodation)	☐ Yes	☐ No
What programming has been developed with the Resource Teacher?		
Has this student received OT or PT at school? ☐ Yes ☐ No Grade they received service:_____ If yes, what strategies have been put into place? Are they still in place and are they working? What has changed since they last had OT/PT?		
B) Have you connected with parents and previous teachers to review interventions?	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 such as lunch containers, puzzles, blocks, shapes	☐ Stumbles, falls, bumps into objects / people when walking / running
☐ Holds pencil awkwardly, or presses too hard or too lightly	☐ Difficulty maintaining balance in games, physical education or on the playground
☐ Difficulty using scissors	☐ Difficulty with stairs
	☐ Unable to access all areas of the school
	☐ Difficulty imitating body movements; doesn't cross midline
	☐ Has extreme tightness which limits joint movement
	☐ Appears to have poor overall body strength; is "floppy"

PRINTING / WRITTEN OUTPUT	MOBILITY / ACCESSIBILITY CONTINUED
☐ Is unable to draw a circle, cross, diagonal line	☐ Makes no attempt to catch themselves when falling
☐ Neatness and legibility of printed work is not grade-appropriate	☐ Cannot heel-toe (explain this), 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	☐ Habitually walks on toes
☐ When writing, doesn't stabilize the paper	**SELF - CARE**
☐ Has difficulty copying from the board	☐ Requires assistance with toileting
☐ Difficulty maintaining good sitting posture (tends to lean on desk, feet not flat on the floor)	☐ 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.

SCHOOL BASED REHABILITATION SERVICES (SBRS)

Additional Information for Therapy Referral (OT/PT)

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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
☐ 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 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 thi student that would be important or helpful for the therapist to know?

Please email to the secure KidsAbility Portal: https://sbrs.kidsability.org
KidsAbility Recipient: Rebecca Tucker at sbrs@kidsability.ca or FAX: 519-886-7292 Attention: SBRS - CSA