IROQUOIS SPECIAL EDUCATION ASSOCIATION
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Pre-K OCCUPATIONAL THERAPY REFERRAL

On the Following Checklist:

- Please answer all questions to the best of your ability. Only mark "N/A" if the child in question is too young or too old to perform the activity.
- If you do not have all the information, please ask other staff working with the child to help complete the form.
- Please mail or give the parent a copy of the completed form.
- Please be aware that a copy of this referral will become part of the student's temporary school file and/or special education file.

Student Name: _____ **AM or PM Class:** _____

School: _____ **Birthdate:** _____

Form Completed By: _____ **Date:** _____

Classroom Teacher: _____ **Email Address:** _____

Parent Consent: _____ **Date:** _____

What are the best times to meet for the parents? _____

Please describe the problems you are seeing in the child's educational environment.

_____

_____

_____

In what way(s) do you believe this child may benefit from an Occupational Therapy Evaluation and/or services? **(If you would simply like an informal consultation with an O.T., and do not feel the child needs a full evaluation, please indicate this, and state your specific reasons).**

_____

_____

_____

Has the child ever had a Case Study Evaluation? If so, was the child found eligible for special education and what services does he/she receive?

_____

Is the Case Study Evaluation currently in progress? _____

Is the child currently receiving RtI (Response to Intervention) services? _____

Does the child have any medical diagnosis (including ADHD)? _____
Please circle “yes” or “no” for each of the following:

Compared to his/her peers, is the child ADEQUATE in:

1. Ability to tolerate light and/or unexpected touch? Yes No

   Comments:

2. Willing participation in messy activities? Yes No

   Comments:

3. Ability to enjoy movement experiences such as swinging high, spinning, bouncing:

   Does he/she avoid this? Yes No

   Does he/she crave this? Yes No

   Comments:

4. Can he/she put on/take off coat? Yes No

   Comments:

5. Use of both hands together when necessary (catching a ball, holding a cup while pouring, holding paper while cutting)? Yes No

   Comments:

6. Consistent preference for use of one hand? Yes No

   Comments

7. Can draw lines, a circle, and square? Yes No

   Comments:

8. Can cut a paper in half? Yes No

   Comments:

9. Able to maintain attention during classroom activities? Yes No

   Comments:

10. Able to eat and chew normally without noticeable difficulties such as being excessively messy, refusing certain textures, or stuffing mouth? Yes No

    Comments:

11. Able to pick up small objects using the first finger and thumb? Yes No

    Comments:

12. Able to tolerate loud noises (such as bells, sirens) or noisy environments (cafeteria, PE)? Yes No

    Comments:

Any other comments or behaviors you would like to comment on please use the following space:

_____

_____

_____