Children's TREATMENT CENTRE OF CHATHAM-KENT

Occupational Therapy/ Physiotherapy Teacher Checklist

Student Name: _____ **D.O.B.:** _____(dd/mm/yyyy)

Known Diagnosis: _____ **Grade:** _____

Please note direct services may not be appropriate for the following items. Please speak to your Occupational Therapist/Physiotherapist if you have any of the concerns listed below:

- When assistive technology/resources/accommodations are already in place and successful
- Sporadic issues (not impacting day-to-day performance)
- Language-based issues (i.e. spelling, dyslexia, reading)

Student's Needs/Classroom Functional Goals:

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

Please specify the outcomes you wish the student to achieve and please rate your current level of satisfaction with the student's current performance.

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

☐ Not a concern

Current level of satisfaction: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Unsatisfied Very Satisfied

The student will be able to:

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

☐ Not a concern

Current level of satisfaction: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Unsatisfied Very Satisfied

The student will be able to:

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

☐ Not a concern

Current level of satisfaction: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Unsatisfied Very Satisfied

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

Current level of satisfaction: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Unsatisfied Very Satisfied

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

Current level of satisfaction: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Unsatisfied Very Satisfied

The student will be able to:

Sensory (must significantly affect the student's ability to access the curriculum and are not behaviour based, ex: easily upset or distracted by loud noises, bright lights, seeks out textures, tastes, rocking, swinging, or spinning)

☐ Not a concern

Current level of satisfaction: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Unsatisfied Very Satisfied

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

Current level of satisfaction: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Unsatisfied Very Satisfied

The student will be able to:

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

☐ Not a concern

Current level of satisfaction: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Unsatisfied Very Satisfied

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

Current level of satisfaction: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Unsatisfied Very Satisfied

The student will be able to:

What are the student's strengths?

Classroom Tools 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?

What strategies/ universal strategies have you tried to support the student's performance and what were the outcomes?

What other support services have been tried and who is currently involved?

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

Splints/Braces	
Mobility Aids (i.e. walker, bike, etc.)	
Wheelchair (power, manual)	
Transfer Equipment (i.e. Portable or ceiling lifts, slings, etc.)	
Specialized Seating/ Positioning Equipment (adapted chair, foot support, stander, etc)	
Feeding/Dressing Aids	
Toilet/Bathroom Aids	
Oral Communication Aids (i.e. FM system, PECS, Proloquo2go, etc.)	
Written Communication Aids (Assistive Technology, Pencil Grips, Slant Board, Alphabet Strip, Personal Word Wall, etc)	

Assistive technology (i.e. computer, iPad, switches, etc.)	
Sensory Equipment (Chewlery, fidgets, theraband around bottom of chair, weighted lap blanket etc)	
Equipment to Support Focus/Attention (Hokki Stool, Rocker Chair, Disc'o'Sit Cushion, Standing Desk, fidgets, study carrel, Time Timer)	
Other	

If the referral is to support SEA funding or other funding for technology/equipment please specify here:

Are there any safety concerns? Yes ☐ No ☐ If "Yes" please describe:

Has there been a recent change in the student's health status? Yes ☐ No ☐ If "Yes" please describe:

Classroom Strategies and Supports Available:

Has this student been seen previously by Children's Treatment Centre or School Based Rehabilitation Services?

Yes ☐ No ☐ Unsure ☐ If "Yes" what services did they receive and for how long?

Occupational Therapy	
Physiotherapy	
Speech Language Therapy	

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

What support is the student currently receiving in the classroom?

Please indicate how much assistance the student needs to complete their daily routine.

☐ No Assistance ☐ Minimal Assistance ☐ Moderate Assistance ☐ Maximum Assistance

☐ Physical Assistance ☐ Verbal Assistance

Current Interests/Involvement in Extracurricular Activities:

Does the student have any preferred hobbies or extracurricular activities that they enjoy (i.e. ex: sports, church groups, music, drama, etc)?

Describe the student's participation in social activities with their peers (both inside the classroom and outside).

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

Please attach a sample of the student's written work if you are referring the student to Occupational Therapy.

_____ _____

Completed by Signature Date

_____

Print Name

***Please attach and submit with Principal Referral form**

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