Children's TREATMENT CENTRE OF CHATHAM-KENT

# SBRS Physiotherapy Teacher Checklist

**Please submit with Principal Referral Form**

Clear Form

| **STUDENT NFORMATION:** | | |
|---|---|---|
| **Name:** | **Grade:** | **DOB:** *(dd/mm/yyyy)* |

**Known diagnosis and/or any recent change to health status and/or upcoming diagnostic testing:**

**The following referral criteria must be met to proceed with referral:**

☐ Concern is related to students' safety or is related to students' ability to access or participate in the curriculum. (see areas of concern below for more information)

☐ Caregiver has provided consent for a referral to physiotherapy services at the Children's Treatment Centre of Chatham- Kent.

**Describe in detail the goals of this referral. (required)**

1)
2)
3)

**AREAS OF CONCERN:** (Select all that apply and provide additional information)

**Is there a safety concern? (Check all that apply and describe concern.)**

☐ **Stairs** Describe:
☐ **Recess/Playground** Describe:
☐ **Gym** Describe:
☐ **Classroom** Describe:
☐ **Bus** Describe:
☐ **Transfers** Describe:
☐ **Mobility** Describe:

**What is the student's transfer status?**

☐ Independent
☐ Dependent (select all that apply): ☐ One/Two person transfer ☐ Lift(portable/ceiling and sling ☐ Transfer Board

**What is the student's mobility status?** (Examples of aids include: orthotics, walker, wheelchair, stroller etc.)

☐ Independent Describe:
☐ Independent with aids Describe:
☐ Supervision required Describe:
☐ Dependent with aids Describe:

**Is the student's ability to access the curriculum affected in the following areas?** Check all that apply and describe.)

**Gait/Walking Pattern**

☐ Stumbles and falls more frequently than peers
☐ Decreased endurance/difficulties keeping up with peers

**Strength**

☐ Difficulty sitting up/sitting down at desk with control
☐ Difficulty transferring from standing to the floor and vice versa
☐ Difficulty maintaining an upright posture at desk or when sitting on the floor
☐ Difficulty opening doors

Student Name: D.O.B.:

## GROSS MOTOR

**The following difficulties are observed during gym (check all that apply):**

- ☐ Difficulty catching a ball
- ☐ Difficulty dribbling/bouncing a ball
- ☐ Unable to hop on one foot
- ☐ Unable to two-foot jump
- ☐ Difficulties following single step directions
- ☐ Difficulty throwing a ball
- ☐ Difficulty striking a ball/birdie with a racket
- ☐ Unable to balance on one foot
- ☐ Difficulties following multi-step directions

## IMPACT ON STUDENT

**How often does the student participate in gym class?**

☐ All the time ☐ Most of the time (80-90%) ☐ Some of the time (50-80%) ☐ Rarely (less than 50%)

***If selecting some of the time or rarely, please check all that apply below:**

☐ Gross motor difficulties seem to be impacting student's gym participation (i.e., avoiding participation, participating in only preferred activities, choosing not to follow instructions due to difficulties)

☐ Student appears to be experiencing some emotional and/or behavioural impact secondary to gross motor difficulties (i.e., tears, anger, frustration)

☐ Student would benefit from gym class modifications to increase their gym class participation (i.e., activity modifications, adapted equipment recommendations)

## HISTORY

**Has the student previously received SBRS PT?** ☐ Yes ☐ No

Please describe:

**Is the student on other SBRS services? (example: SBRS OT, SBRS ST)** ☐ Yes ☐ No

Please describe:

**Is the student requiring new or adapted equipment at school?** ☐ Yes ☐ No

If yes, please describe:

**Please list current equipment in place to support the student at school (ex. flexible seating, walker)**

| | |
|---|---|
| **Completed by:** | **Date:** *dd/mm/yyyy)* |
| **Email:** | |
| **Phone number:** | **Ext:** |
| **Signature:** | |