Clear Form

SBRS Occupational Therapy Teacher Checklist

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

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

Please note direct services are not appropriate for the following items under Ministry identified SBRS OT Scope of Practice:

- 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)
- Behavioural and/or mental health concerns that are the primary barrier to functional participation

Prioritize top 3 functional goals for this referral.

1.
2.
3.

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

Specialized equipment currently in place

- ☐ Wheelchair (power, manual)
- ☐ Splints/Braces
- ☐ Transfer equipment (i.e. portable or ceiling lifts, slings etc.)
- ☐ Specialized seating/positioning equipment (i.e. adapted chair, foot support, stander etc.)
- ☐ Self Care Aids (Feeding/Dressing/Toileting)
- ☐ Oral Communication Aids (i.e., PECS, AAC, Proloquo2go, etc.)
- ☐ Other:

AREAS OF CONCERN AFFECTING FUNCTIONAL CURRICULUM ENGAGEMENT AND PARTICIPATION

If concerns noted, check applicable boxes below.

Access to School Environment and Specialized Equipment

- ☐ Unable to move freely throughout the school environment (entry/exit to building and/or specific spaces like classroom or bathroom)
- ☐ Unable to utilize existing classroom equipment (i.e. chair and/or desk)
- ☐ Requires specialized equipment or support to access and engage in daily activities at school

Classroom Participation/ Executive Functioning Skills

- ☐ Struggles to focus in the presence of distraction
- ☐ Approaches tasks in an unorganized/impulsive manner
- ☐ Unable to complete multistep activities (as appropriate for age)
- ☐ Does not persist when performing a challenging task
- ☐ Struggles with transitions between tasks
- ☐ Has difficulty initiating/completing work independently
- ☐ Has difficulty following classroom rules/routines
- ☐ Difficulty following verbal or written directions
- ☐ Unable to keep track of personal belongings/learning materials and tools
- ☐ Frequently requests assistance
- ☐ Does not complete work in a timely manner
- ☐ Desk and school materials are unorganized

Handle Materials and Manipulatives

- ☐ Inconsistent hand preference
- ☐ Non-functional scissor grasp or poor cutting accuracy
- ☐ Weak pencil control for drawing, tracing, colouring
- ☐ Difficulty assembling puzzles
- ☐ Does not use age appropriate detail when drawing
- ☐ Difficulty using regular keyboard successfully
- ☐ Struggles to manipulate tools (eraser, math/art/science materials)
- ☐ Non-functional pencil grasp/pressure (☐ heavy ☐ light)

Written Communication

- ☐ Poor letter formation
- ☐ Does not complete written work in a timely manner
- ☐ Refusal to complete writing tasks
- ☐ Illegible printing
- ☐ Print size is large
- ☐ Printing contains reversals
- ☐ Requires scribing
- ☐ Print has poor spatial organization (spacing, use of baseline, discriminative letter sizing and placement)

Self-Care Skills

- ☐ Safety concerns with bathroom/equipment for toileting
- ☐ Struggles to open containers for lunch/snacks
- ☐ Lack of independence with toileting skills/bathroom routine
- ☐ Struggles to put on/remove clothing
- ☐ Limited independence in cleaning up after meals
- ☐ Struggles with fasteners (zippers, buttons, snaps)

Sensory (must significantly affect the student's ability to access the curriculum and are not behaviour based)

- ☐ Difficulty sitting still
- ☐ Frequently tries to escape the classroom environment
- ☐ Responds negatively or sensitive to the following:
  ☐ touch ☐ noise ☐ smell ☐ clothing ☐ movement ☐ lighting ☐ other:
  Seeks out specific sensations or types of input:
  ☐ touch ☐ noise ☐ smell ☐ clothing ☐ movement ☐ lighting ☐ other:

Engagement in Curriculum

Is the student meeting grade-level expectations? ☐ yes ☐ no

If no, explain further:

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

☐ No assistance ☐ Verbal assistance ☐ Physical assistance

Additional comments:

What time of day is most challenging?

☐ 1st block ☐ Midday ☐ Last block

☐ Outdoor/recess gym ☐ Indoor recess/gym ☐ Other (Elaborate):

Describe in detail:

Please comment on student Safety Concerns:

- ☐ Equipment unsafe/poor fit
- ☐ Demonstrates self injurious behaviour
- ☐ Makes unsafe choices/unsafe impulses
- ☐ Demonstrates explosive behaviour
- ☐ Property Destruction
- ☐ Other:
- ☐ Struggles with transfers/mobility
- ☐ Aggression towards peers and/or adults
- ☐ Seeking dangerous activities
- ☐ Exit-Seeking Behaviours

Name: DOB:

UNIVERSAL CLASSROOM TOOLS/ STRATEGIES IN PLACE						
Please check appropriate box if strategy has been tried:		**Unsuccessful**	**Sometimes Successful**	**Always Successful**	**N/A**	**Tools Currently in Place**
EA for support		☐	☐	☐	☐	☐
Sensory Breaks	Time(s): Location: ☐ Sensory space ☐ Classroom ☐ Hallway ☐ Other:	☐	☐	☐	☐	☐
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)		☐	☐	☐	☐	☐
Visual Support (e.g. Schedule/Timer/Letter Strip/Sight Words)		☐	☐	☐	☐	☐
Written Communication Aids (Pencil Grips, Slant Board, Personal Word Wall, Scribe for written output, Assistive Technology such as computer, iPad or switches etc.)		☐	☐	☐	☐	☐
Alternative Learning Space		☐	☐	☐	☐	☐
FM System		☐	☐	☐	☐	☐
Other:		☐	☐	☐	☐	☐

Additional Information/Comments:	
REFERRAL PRIORITY:	
Occupational Therapist_____ (name) has reviewed and approved this referral and assigned the following priority: ☐ **Tier 2** ☐ **Tier 3**	
Completed by:	**Date:** (dd/mm/yyyy)
Email:	
Phone number:	**Ext:**
Signature:	

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