

SBRS Physiotherapy Teacher Checklist

Please submit with Principal Referral form

STUDENT INFORMATION:	
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 Recess/Playground Gym Classroom Bus Transfers Mobility	Describe: Describe: Describe: Describe: Describe: Describe: 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 maintaining an upright posture at desk or when sitting on the floor	Difficulty transferring from standing to the floor and vice versa Difficulty opening doors

Name:

DOB:

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

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