School Referral form for OT services: Preschool Age

Student Name: _____ DOB: _____/_____/_____

School: _____ Teacher: _____ Grade: _____

Teacher Instructions: Check all boxes that apply, review form with the child's parent/guardian, sign, date and submit to parent/guardian

Parent Instructions: Review form with child's teacher, sign, date, and submit this form to Sprocket Therapy Solutions via email or fax. A Sprocket therapist will contact you soon after receiving this form to either set up a free screen to determine the need for services or an evaluation to begin receiving OT services.

FINE MOTOR

_____ below age-appropriate drawing skills
_____ below age-appropriate writing grasp
_____ draws/writes with wobbly lines
_____ uses too much or not enough pressure when writing
_____ writes slowly, labored
_____ difficulty manipulating scissors
_____ difficulty with fasteners - buttons, zippers, snaps
_____ difficulty manipulating small objects
_____ needs help to open containers
_____ seems to have weak hands
_____ needs help to use utensils

VISUAL MOTOR

_____ Difficulty coloring in the lines
_____ Difficulty cutting on the line, cuts off corners
_____ Unable to copy simple designs (circle, square, triangle)
_____ Difficulty staying on the line when writing

VISUAL PERCEPTUAL

_____ Difficulty naming or matching colors, shapes, or sizes
_____ Difficulty in completing puzzles

GROSS MOTOR

_____ Seems weaker or tires more easily than same-aged children
_____ Difficulty with hopping, jumping, skipping, or running
_____ Movements are stiff and awkward
_____ Clumsy; bumps into things

ACADEMIC/ ORGANIZATIONAL BEHAVIOR

_____ easily frustrated, tantrums, cries often
_____ Cannot play independently
_____ Difficulty following routine
_____ Inappropriate peer interactions
_____ Prefers solitary play

AUDITORY LANGUAGE

_____ Overly sensitive to noise
_____ Makes strange noises, talks excessively

_____ Distracted by background noise
_____ Difficulty understanding verbal directions

MOVEMENT AND BALANCE

_____ Poor seated posture (slumps, leans on arm, head too close to work, sits on legs)
_____ Trips or falls down frequently
_____ Appears to be in constant motion, unable to sit still for an activity
_____ Poor balance during movement activities

TACTILE (TOUCH) SENSATION

_____ Seems overly sensitive to touch
_____ Has trouble keeping hands to self, will poke or push other children, touches things constantly
_____ Avoids getting hand messy (clay, finger paint, paste, sand)
_____ Seems unaware of being touched or bumped
_____ Has trouble remaining in group situations, standing in line

SELF HELF SKILLS

_____ requires excessive assistance to toilet
_____ requires excessive assistance to wash hands
_____ doesn't recognize when face/ hands are dirty
_____ cannot dress independently (excluding fasteners)
_____ difficulty drinking from an open cup, spills often

Comments: _____

_____

_____

_____

Teacher's Name (please print): _____

Teacher's Signature: _____ date: _____

Parent/Guardian's Name (please print): _____

Parent/Guardian's Signature: _____ date: _____

Parent phone #: _____

Parent email address: _____

Please submit this form to Sprocket Therapy Solutions via:

Fax #: 615 - 226 - 2839 or email: OT@sprockettherapy.com