CLARKSVILLE
MONTGOMERY COUNTY
SCHOOL SYSTEM

OCCUPATIONAL THERAPY REFERRAL INFORMATION

Student Name:_____School: _____

Teacher/Program: _____

Is this student enrolled in preschool? (circle) Yes No

If yes, does this student attend the am or pm session? (circle) AM or PM

1. What IEP goal(s) is the team having a difficult time achieving that you may need OT as a related service to support? In order to save time, you can write the goal # from Easy IEP.

   _____

   _____

   _____

2. Have modifications and/or accommodations been tried? (circle) Yes No
   If yes, explain

   _____

3. Check all areas of concerns impacting student's performance:

   ☐ Self-care Skills (This includes clothing management, toileting, and school hygiene).

   ☐ Feeding and Oral Motor Skills (This includes refusal to eat, fussy eaters, use of utensils, opening containers, and managing a lunch tray).

   ☐ School Functional Skills (This includes accessing the following; locker, drinking fountains, backpacks, lunch room, classroom materials, etc).

   ☐ Sensory Processing Skills (This includes attention, sitting in their seat, standing in line, emotional outbursts, chewing on non-food items, rocking, self-injurious behaviors, excessive seeking of movement, avoiding touch or movement, low tolerance of auditory or visual input, inability to plan motor movements, problems with transitioning, and lack of awareness of personal space).

   ☐ Fine Motor Skills (This includes cutting, coloring, grasping, and able to use school tools, using both hands together).

   ☐ Visual Motor/Perceptual Skills (This includes legibility of handwriting, ability to copy near/far, speed of handwriting, reversals, difficulty with patterns or puzzles, eye-hand coordination and visual skills for tacking, ability to focus on work, and visual awareness).

*****NOTE: Please return completed forms related to therapy services to <u>Psychological Services</u>.**