SCHOOL BASED REHABILITATION SERVICES

Occupational Therapy Teacher Checklist

1240 Murphy Road Sarnia, ON N7S 2Y6
519-542-3471 TOLL FREE 1-855-542-3471 FAX 519-542-4115
www.pathwayscentre.org

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

STUDENT INFORMATION:		
Name:	**Date of Birth:** *(dd/mm/yyyy)*	
School:	**Grade:**	**Classroom Number:**
Resource Teacher:	**Email:**	
Teacher:	**Email:**	
Strengths/Interests and Favourite Qualities of Student (Required):		

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

Sensory

- ☐ Responds negatively to touch, noise, taste and texture of food and/or clothing
- ☐ Difficulty sitting still; may fidget, rock, turn during meals or when doing school work
- ☐ Frequently tries to escape the classroom environment
- ☐ Overly sensitive to noises, lights, movement

Executive Functioning Skills

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

Self-Care Skills

- ☐ Safety concerns with bathroom/equipment for toileting
- ☐ Lack of independence with toileting skills
- ☐ Trouble removing/putting on clothing during toileting
- ☐ Limited independence to feed self during lunch/snacks
- ☐ Struggles to put on/remove outdoor clothing
- ☐ Struggles with fasteners (zippers, buttons, snaps)
- ☐ Struggles to open containers for lunch/snacks
- ☐ Poor level of hygiene

Social Skills and Emotional Regulation (Must significantly impact participation or have other areas of concern)

- ☐ Plays by self ☐ Parallel Play ☐ Plays with others
- ☐ Has outbursts or becomes aggressive with frustration
- ☐ Difficulty resolving conflict without teacher intervention
- ☐ Demonstrates limited imagination/creativity during play
- ☐ Adult Directed Play ☐ Plays repetitively
- ☐ Does not spend time with friends when possible
- ☐ Struggles to maintain appropriate "personal space"
- ☐ Interacts or participates in groups less than others

Handling Materials and Manipulatives

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

SCHOOL BASED REHABILITATION SERVICES
Occupational Therapy Teacher Checklist

Student Name: ______________________________ D.O.B. ___________________

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

Prioritization of Concerns (Choose headings above):	**Additional concerns if not listed:**
1. ____ 2. ____ 3. ____	

FUNCTION:	
Please comment on student's general classroom performance in the following areas:	
Academics:	
Social/Behaviour/Attention: (Elaborate from checklist)	

Do these issues affect the student's ability to access the curriculum?		
☐ Not at All	☐ Infrequent (< ¼ of the time)	☐ Sometimes (< ½ of the time)
☐ Often (regularly < ¾ of the time)		☐ Almost Always (regularly > ¾ of the time)
Describe in Detail:		

What time of day is most challenging?		
	Time(s)	Describe
☐ 1st block		
☐ Midday		
☐ Last block		
☐ Outdoor recess/gym		
☐ Indoor recess/gym		
☐ Other (*Elaborate):		

Please check appropriate box if strategy has been tried:		**Unsuccessful**	**Sometimes Works**	**Always Works**
EA for support		☐	☐	☐
Sensory Breaks	☐ As needed ☐ Time(s):	☐	☐	☐
	☐ Sensory Room ☐ Time(s):	☐	☐	☐
	☐ Other (*Elaborate):	☐	☐	☐
Modified /Specialty Seating		☐	☐	☐
AAC/PECs for communication		☐	☐	☐
Visual Support (e.g. Schedule/Letter Strip/Sight Words)		☐	☐	☐
Alternative Learning Space		☐	☐	☐
Scribe for Written Output		☐	☐	☐
Technology for Written Output		☐	☐	☐

SCHOOL BASED REHABILITATION SERVICES
Occupational Therapy Teacher Checklist

Student Name: ______________________________ D.O.B. ___________________

Other:	☐	☐	☐
List current equipment in place to support the student.			

Please comment on student Safety Concerns:

☐ Demonstrates self injurious behaviour
☐ Makes unsafe choices / unsafe impulses
☐ Demonstrates explosive behaviour
☐ Other:
☐ Violent towards adults
☐ Seeking dangerous activities
☐ Struggles with transfers / mobility

Does child receive EA support? ☐ No ☐ Yes, amount:

HISTORY:

Has the student previously received SBRS OT? ☐ Yes ☐ No	**Year(s) of Service:**

Has the school been using the strategies developed by the therapist and are they still working? ☐ Yes ☐ No

Have you connected with parents/caregivers and previous teachers to review interventions? ☐ Yes ☐ No

What has changed? Describe in detail.

ADDITIONAL INFORMATION:

Who in the school will be responsible for follow up of recommendations provided by the therapist? (Required)

Contact Information/email: Phone: Ext.

Best Time to be Reached:

Request to Specifically Support:

☐ Assistive Technology for Written Output
☐ Sensory Equipment Recommendations
☐ Supports/Strategies for personal care needs
☐ Assistance with SEA Claim (i.e. specialty equipment needs, etc.)
☐ In-classroom Supports
☐ Classroom Sensory Diet
☐ Training/Consultation with staff

Completed by:	**Date:**	
Email:	**Phone:**	**Ext:**
Signature:		

Note: Not all items checked above will be treated by an SBRS therapist;
Based on the concerns identified, needs will be prioritized and goals developed.