SCHOOL BASED REHABILITATION SERVICES

Physiotherapy Teacher Checklist

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

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

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

Gait/Walking Pattern	**Balance**
☐ Unable to heel-toe walk ☐ Stumbles and falls more frequently than others the same age ☐ Habitually walks up on toes	☐ Trouble maintaining balance ☐ Makes no attempt to catch him/herself when falling
Stairs	**Range of Motion**
☐ Difficulty getting on/off school bus ☐ Difficulty completing stairs or accessing the playground safely	☐ Has extreme tightness that limits range of motion ☐ Hypermobile – too much movement in joints
Ball Skills	**Endurance**
☐ Difficulty bouncing, catching or throwing a ball	☐ Tires easily with routine tasks, complains of fatigue

Coordination

☐ Poorly developed sense of rhythm, can't play clapping games
☐ Lacks reciprocal arm and leg movements when walking or running
☐ Unable to coordinate full body movements like galloping, skipping, or jumping jacks
☐ Moves awkwardly, large movements are clumsy

Strength

☐ Difficulty opening doors	☐ Unable to jump in place or hop on one foot
☐ Appears to have poor overall body strength, is "floppy"	☐ Slumps to one side or slides forward in chair

PAIN:

☐ Complains of pain after activity such as recess or gym
☐ Complains of pain without activity such as sitting at desk for long periods of time

Describe (i.e. frequency/location/when it occurs):

MOBILITY:

What is the child/youth's mobility status?

☐ Independent ☐ Independent with aids ☐ Supervision Required ☐ Dependent with aids

Please list current equipment in place to support the student.

What equipment has been implemented or trialed with this student?

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Student Name: _____ D.O.B. _____

Is the student's ability to access the curriculum affected in the following areas?					
☐ **Recess**	☐ Not at all	☐ Infrequent	☐ Sometimes	☐ Always	☐ Unable to Access
Describe in Detail:					
☐ **Gym**	☐ Not at all	☐ Infrequent	☐ Sometimes	☐ Always	☐ Unable to Access
Describe in Detail:					
☐ **Classroom**	☐ Not at all	☐ Infrequent	☐ Sometimes	☐ Always	☐ Unable to Access
Describe in Detail:					

SAFETY:

Is there a safety issue? ☐ **No** ☐ **Yes** (Check all that apply.)

☐ Stairs	☐ Daily	☐ Weekly	☐ Monthly
☐ Falling	☐ Daily	☐ Weekly	☐ Monthly
☐ Transfers	☐ Daily	☐ Weekly	☐ Monthly
☐ Mobility	☐ Daily	☐ Weekly	☐ Monthly
☐ Gym	☐ Daily	☐ Weekly	☐ Monthly
☐ Play Equipment/School Environment	☐ Daily	☐ Weekly	☐ Monthly

If yes, please describe in detail:

HISTORY:

Has the student previously received SBRS PT? ☐ 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:

☐ In-classroom Supports ☐ Equipment Recommendations ☐ Training/Consultation with staff

☐ Assistance with SEA Claim (i.e. specialty equipment needs, etc.) Describe:

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.