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

STUDENT INFORMATION:	
Name:	**Date of Birth:** *(mm/dd/yyyy)*

The following referral criteria MUST BE MET to proceed with referral:

- ☐ Concern is related to student's ability to access or participate in the curriculum
- ☐ In-school teams have been considered and/or consulted for internal resources/supports for concerns related to: self-injurious behaviours, flight risk, property destruction, aggression and/or mental health prior to initiating this referral.
- ☐ Caregiver has consented to this referral and agrees to support implementation of recommendations provided by Occupational Therapist.
- ☐ Referral has been reviewed with SBRS OT and signed below prior to submission.

FUNCTIONAL AREA(S) OF CONCERN:	
☐	Fine Motor/Written Communication – Concern:
☐	Self-Care Skills – Concern:
☐	Equipment/SEA – Concern:
☐	Accessibility and Positioning – Concern:
☐	Sensory – Concern:

MANDATORY: Please describe reason for referral and how it is AFFECTING Safety, CURRICULUM ENGAGEMENT &/or PARTICIPATION:

Prioritize top 3 functional goals for this referral?

1.	
2.	
3.	

SERVICE HISTORY:		
Has the student previously received SBRS OT? ☐ Yes ☐ No	**Year of Discharge:**	
Has the school been using the strategies developed by the therapist and are they still working? ☐ Yes ☐ No		
Have you connected with parents and previous teachers to review interventions? ☐ Yes ☐ No		
What has changed? Describe in detail.		

Completed by (school staff):	**Date:**	
Email:	**Phone:**	**Ext:**
School:		
COMPLETED BY PATHWAYS STAFF ONLY:		
Reviewed by:	**Date:**	
Initials/Signature:	☐ **T2**	☐ **T3**

Additional Information/Comments: