SCHOOL BASED REHABILITATION SERVICES

Physiotherapy Teacher Checklist

1240 Murphy Road Sarnia, ON N7S 2Y6
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***Please attach and submit with Principal Referral form**

STUDENT INFORMATION:		
Name:	**DOB:**	*(mm/dd/yyyy)*
Describe in detail the goal of this referral. (required)		

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

Is the student's ability to access the curriculum affected in the following areas?

☐ **Recess**	☐ Not at all	☐ Unable to Access	Describe in Detail:
☐ **Gym**	☐ Not at all	☐ Unable to Access	
☐ **Classroom**	☐ Not at all	☐ Unable to Access	

Is there a safety issue? (Check all that apply.)

☐ Stairs ☐ Falling ☐ Transfers ☐ Mobility ☐ Gym ☐ Play Equipment/School Environment

If yes, please describe in detail:

What is the student's mobility status?

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

Is this student requiring new or adapted equipment? ☐ Yes ☐ No

Please list current equipment in place to support the student.

What equipment has been implemented or trialed with this student?

Additional Information/Concerns: (Select all that apply and provide additional information)

Gait/Walking Pattern

☐ Stumbles and falls more frequently than others the same age

Stairs

☐ Difficulty getting on/off school bus ☐ Difficulty completing stairs or accessing the playground safely

Strength

☐ Appears to have poor overall body strength, is "floppy" ☐ Difficulty opening doors

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 and previous teachers to review interventions? ☐ Yes ☐ No	
What has changed? Describe in detail.	

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

Note: Not all items checked above will be treated by an SBRS therapist