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:**

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(s) of Service:

Has the school/home been implementing the strategies developed by the therapist? Are they still working? What has changed? Describe in detail.

Completed by (school staff):	**Date:**	
Email:	**Phone:**	**Ext:**

COMPLETED BY PATHWAYS STAFF ONLY:

Reviewed by:	**Date:**	
Initials/Signature:	☐ **T2**	☐ **T3**

Additional Information/Comments: