SCHOOL BASED REHABILITATION SERVICES

Physiotherapy Teacher Checklist

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

REFERRAL INFORMATION:	
Name:	**DOB:**

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

- ☐ Concern is related to student's safety
- ☐ Concern is related to student's ability to access or participate in the curriculum
- ☐ Caregiver has consented to this referral and agrees to support implementation of recommendations provided by Physiotherapist

Prioritize top 3 goals for this referral. (Required)	
1.	
2.	
3.	

<u>MANDATORY:</u> Describe in detail the presenting **SAFETY** concerns (i.e. stairs, falling, transfers, mobility, gym, play equipment, school environment).

Mobility Status: (examples of aids include orthotics, walker, wheelchair, etc.):			
☐	Independent	☐	Independent with Aid(s) – Describe:
☐	Supervision Required – Describe:		
☐	Dependent with Aid(s) – Describe:		

Equipment/SEA:	
☐	Is this student requiring new or adapted equipment? – Describe:
☐	Please list current equipment in place to support the student. – Describe:
☐	Equipment has been implemented or trialed with this student. – Describe:

Other Area(s) Of Concern:	
☐	Accessibility and Positioning – Concern:
☐	Classroom – Concern:
☐	Recess – Concern:
☐	Gym – Concern:
☐	Bus – Concern:

HISTORY:		
Has the student previously received **SBRS PT**?	☐ 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:	**Date:**	
Email:	**Phone:**	**Ext:**
Signature:		

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

Additional Information/Comments: