



# 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:	
<b>Name:</b>	<b>Date of Birth:</b> (mm/dd/yyyy)
<b>The following referral criteria MUST BE MET to proceed with referral:</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Concern is related to student's ability to access or participate in the curriculum</li> <li><input type="checkbox"/> 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.</li> <li><input type="checkbox"/> Caregiver has consented to this referral and agrees to support implementation of recommendations provided by Occupational Therapist.</li> <li><input type="checkbox"/> Referral has been reviewed with SBRS OT and signed below prior to submission.</li> </ul>	
FUNCTIONAL AREA(S) OF CONCERN:	
<input type="checkbox"/>	Fine Motor/Written Communication – Concern:
<input type="checkbox"/>	Self-Care Skills – Concern:
<input type="checkbox"/>	Equipment/SEA – Concern:
<input type="checkbox"/>	Accessibility and Positioning – Concern:
<input type="checkbox"/>	Sensory – Concern:
<b>MANDATORY:</b> Please describe reason for referral and how it is <b>AFFECTING SAFETY, CURRICULUM ENGAGEMENT &amp;/or PARTICIPATION:</b>	
Prioritize top 3 functional goals for this referral?	
1.	
2.	
3.	
SERVICE HISTORY:	
Has the student previously received <b>SBRS OT</b> ? <input type="checkbox"/> Yes <input type="checkbox"/> 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.	
<b>Completed by (school staff):</b>	
_____ <b>Date:</b> _____	
<b>Email:</b>	<b>Phone:</b>
	<b>Ext:</b>
COMPLETED BY PATHWAYS STAFF ONLY:	
<b>Reviewed by:</b> _____ <b>Date:</b> _____	
<b>Initials/Signature:</b> _____	
<input type="checkbox"/> T2 <input type="checkbox"/> T3	



# SBRS - Occupational Therapy Teacher Checklist

Student Name:

D.O.B:

**Additional Information/Comments:**

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