



SCHOOL BASED REHABILITATION SERVICES

Physiotherapy Teacher Checklist

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 www.pathwayscentre.org

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

REFERRAL INFORMATION:		
Name:	DOB:	(mm/dd/yyyy)
The following referral criteria MUST BE MET to proceed with referral: <input type="checkbox"/> Concern is related to student's safety <input type="checkbox"/> Concern is related to student's ability to access or participate in the curriculum <input type="checkbox"/> Caregiver has consented to this referral and agrees to support the implementation of recommendations provided by Physiotherapist <input type="checkbox"/> For students in Grade 2 or above, the referral has been discussed with and approved by the SBRS physiotherapist.		
Prioritize top 3 goals for this referral. (Required)		
1.		
2.		
3.		
MANDATORY: 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.):		
<input type="checkbox"/>	Independent	<input type="checkbox"/> Independent with Aid(s) – Describe:
<input type="checkbox"/>	Supervision Required – Describe:	
<input type="checkbox"/>	Dependent with Aid(s) – Describe:	
Equipment/SEA:		
<input type="checkbox"/>	Is this student requiring new or adapted equipment? – Describe:	
<input type="checkbox"/>	Please list current equipment in place to support the student. – Describe:	
<input type="checkbox"/>	Equipment has been implemented or trialed with this student. – Describe:	
Other Area(s) Of Concern:		
<input type="checkbox"/>	Accessibility and Positioning – Concern:	
<input type="checkbox"/>	Classroom – Concern:	
<input type="checkbox"/>	Recess – Concern:	
<input type="checkbox"/>	Gym – Concern:	
<input type="checkbox"/>	Bus – Concern:	
HISTORY:		
Has the student previously received SBRS PT ?		Yes <input type="checkbox"/> No <input type="checkbox"/> 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



SBRS - Physiotherapy Teacher Checklist

Student Name:

D.O.B:

Additional information/comments: