Prickly Pear Cooperative OT Elementary Pre-Referral Form

Student Name: Classroom Teacher: Medical Dx: DOB: Grade: Date : Case Manager: **School:**

Describe Educational Concern:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please include specific interventions/strategies that have been tried and were unsuccessful by the general education staff. A Strategy Help Book may be found on [www.pricklypearcoop.schoolwires.com](http://www.pricklypearcoop.schoolwires.com) under resources> Strategy help Book.

Strategies:

 #1:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#2:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#3:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Directions: This is a systematic decision-making tool designed for use by an IEP Team to assist in determination of appropriateness for referral to Occupational Therapy. After you have completed this process, including documenting outcomes of pre-referral interventions already tried, a school therapist will contact you to help determine if an evaluation is needed.

Areas of Concern:

1. Self-Care and Life Skills-

\_\_Unable to manage own clothes (coat/pants/boots/clothing fasteners)

\_\_ Unable to feed self.

1. Sensory Processing/Self-Regulation/Behavior

Describe Specific Behavioral concern and triggers (eg transitions is not specific):

\_\_ Does concerned behavior last longer than 30 minutes and is not re-directable and no apparent trigger. Describe frequency and time of day:

Possible triggers:

Student Overacts/Underreacts to: sounds touch movement attention/focus

 Describe specific responses:

1. Visual Perception/Visual-Motor

\_\_Unable to recognize, trace, imitate or copy designs (Vertical, horizontal, diagonal line, circle, square/ diamond).

\_\_Unable to form or recognize letters and numbers at level of peers.

\_\_Unable to write assignments within the space allowed, in the time allowed and be legible.

\_\_When able to hold and use scissors, unable to cut on a line or curve accurately.

\*Please attach writing and cutting samples.

\_\_Unable to match, sort objects or do puzzles.

\_\_Loses place when reading or writing while copying from the board.

\_\_Unable to find objects in/on cluttered desk.

1. Manipulation Skills/Fine Motor

\_\_Poor use of pencil, marker, crayon, scissors, glue, paper or book.

\_\_Poor ability to write in vertical on chalkboard/ whiteboard.

All of the following classroom based interventions must be attempted and documentation of the outcome is needed prior to a referral to OT services. (See Strategy Help Book for specific handouts/ideas)

1. Share concerns with Parent. (PTC or phone call)

Outcome:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Remove environmental barriers. Use preferred seating, change room arrangement, accessible bathroom…

Outcomes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Correct improperly fitting equipment and personal items. Use proper desk/chair size, glasses…

Outcomes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Assess impact of behavioral issues and cognition on performance, if appropriate. (Psych)

Outcome:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Adapt curriculum. Chunking work, less work/ more time… Outcome:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. List the short term educational objective(s) from the students IEP which you feel cannot be met without the support of the related services of an occupational or physical therapist:

1.

2.

3.

Thank-you for providing this detailed information on behalf of this student. It will help the therapist better determine what the concerns are and what areas need to be evaluated. Please return this to the occupational therapist.