**OT Pre-Referral Screen Age 3-5**

 Referring School District

Child’s Name DOB: Performed by: Date:

**Prior to therapy observation please assess child and complete this form**

**3 years**  **4 years** **5 years**

 Blocks: Imitates 2 block pattern Blocks: Imitates 3-4 block patterns Block: Builds stair pattern

 Squeezes: Playdoh/putty Opens simple containers Copies: Square

 Copies: Circle Copies: + Cuts: 6” Square within ¼”

 Cuts: Snips Cuts: 6” line Opposes each finger to thumb (both hands)

 Touches each finger to thumb (1 hand) Functional pencil grasp

 Consistent pencil grasp

Complete the section for your child’s age plus the section previous: (i.e.: child age 4 complete 3 and 4 y/o information)

**Scoring: + = Master Task** **0 = occasionally demonstrates** **- = not demonstrated**

**\*Sensory/Self Regulation** **COMMENTS:**

 Seeks excess cuddling Avoids touching people, food, sand, water

 Avoid getting dirty Covers ears upsets with loud noise or music

 Dislikes being off the ground Mouths objects excessively and inappropriately

 Difficulty concentrating in the midst of other activities Diagnosed visual problem

**\*Sensory Motor** **COMMENTS:**

 Avoids stringing beads, putting together puzzles, or paper/pencil tasks

 Takes longer to learn new movement games

 Difficulty picking up small objects (cheerios pegs, etc.)

 Difficulty using a spoon or fork (tend to eat finger foods)

**COMMENTS:**

**RECOMMENDATIONS:**