Cris A. Rowan BScOT, BScBi
Registered Occupational Therapist
Paediatrics, Geriatrics & Ergonomics

OCCUPATIONAL THERAPY **REFERRAL**

Student Information: Date: _____

Name: _____ School: _____

Teacher: _____ SETA: _____

Grade: ____ Date of Birth: _____ Siblings: _____

Parent/Guardian Name(s): _____

Mailing Address: _____ Phone (H): _____

Home Address: _____ Phone (W): _____

Family Physician: _____ Phone: _____

Referral Information:

Name: _____ Agency: _____

Have parents been notified? (Yes ( ) No ( ) By? _____

Is *Consent to Obtain/Release Information and Assess* form signed by parents? Yes ( ) No ( )
Has *School-Aged Checklist for OT/PT Services* form been completed? Yes ( ) No ( )

Specialists or Agencies Involved:
(e.g., Sunny Hill, BC Children's, Pediatrician, Neurologist, Ministry for Children and Families, etc.)

_____

_____

_____

Support Personnel Involved:
(e.g., Speech Pathologist, Psychologist, Hearing/Vision Impaired Teacher, etc.)

_____

_____

_____

Diagnosis (be specific):

_____

_____

Pertinent Medical History (include seizures and medications):

_____

_____

_____

Principal's Signature: _____

Resource Teacher's Signature: _____

(see next page)

6840 Seaview, Sechelt, BC V0N 3A4 • *email:* crowan@suncoastot.com • *website:* **www.suncoastot.com** • *Tel:* 604-885-0986 • *Fax:* 604-885-0389 • *Cell:* 604-740-2264

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Reason for Referral (be specific):

Primary Concern of School:_____

_____

Primary Concern of Family: _____

_____

Physical Concerns: Are physical limitations causing safety concerns? Yes ( ) No ( )
Please expand: _____

_____

Are any of the following areas of concern? If yes, please expand.
- Feeding (choking, frequent colds, G-Tube) Yes ( ) No ( ) _____
- Mobility (wheelchair, walking) Yes ( ) No ( ) _____
- Equipment (walker, splints) Yes ( ) No ( ) _____
- Transfers (desk, toilet, floor) Yes ( ) No ( ) _____
- Catheterization Yes ( ) No ( ) _____
- Seizures Yes ( ) No ( ) _____

School Performance Concerns:
Behaviour: Yes ( ) No ( ) _____

Attention: Yes ( ) No ( ) _____

Organization: Yes ( ) No ( ) _____

Follows directions: Yes ( ) No ( ) _____

Learns new skills: Yes ( ) No ( ) _____

Directionality and spatial concepts: Yes ( ) No ( ) _____

Vision: Yes ( ) No ( ) _____

Hearing: Yes ( ) No ( ) _____

Social Skills: Yes ( ) No ( )_____

Is there a marked discrepancy between verbal and written ability? Yes ( ) No ( ) _____
_____
Student strengths: _____
Grade level in: Math _____ Reading _____ Writing _____

Does the student:
- Experience frustration with classroom expectation? Yes ( ) No ( ) _____
- Have grade level problem solving abilities? Yes ( ) No ( ) _____
- Use coping strategies (e.g., avoidance)? Yes ( ) No ( ) _____
- Have poor self esteem? Yes ( ) No ( ) _____
- Have any special interests? Yes ( ) No ( ) _____
- Have **fine motor** difficulties? Yes ( ) No ( ) If yes, please circle which difficulties: cutting, printing/writing, laces/buttons/zippers, orienting work on paper, other _____
- Have **gross motor** difficulties? Yes ( ) No ( ) If yes, please circle which difficulties: throwing/catching, coordination, running, balance, P.E., other _____

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