

BSED MOTOR SUPPORT STAFF

Requesting Service for:

Occupational Therapy (fill out page 2) Physical Therapy (fill out page 2) Assistive Technology (fill out page 3) Physically Impaired (fill out page 3)

Complete for all Referrals:

Pupil's Full Name _____ D.O.B. _____
Teacher _____ Grade _____
Parent(s) Name _____ School _____
Primary Physician _____ Room _____

ECSE	<input type="checkbox"/>	AM	<input type="checkbox"/>	Days of Week	Mon	Tues	Wed	Thurs	Fri
KNDG	<input type="checkbox"/>	PM	<input type="checkbox"/>						

Medical Diagnosis Yes No List Diagnosis _____
Physician _____

Does child receive medical therapies? Yes No Where _____

Special Equipment/Services (i.e. orthotics, para) _____

Primary disability as listed on IEP/IFSP (if applicable) _____

Please include further concerns regarding how the student's motor skills impact their academic success:

BSED Motor Staff:

Physical Therapists:

DeAnna Dunsmoor 257-7357
Michelle Schluender 223-7417
Lisa Wenner 257-7390

Occupational Therapists:

Valerie Hommderding 257-7397
Dawn Mathiasen 257-7358
Cassie Sandstrom 257-7356
Belinda Tysver 257-7391

Assistive Technology/Physically Impaired Consultant:

Kelly Peterson 257-7371

BSED Fax #: 320-252-1316

OT/PT Pre-Referral Checklist

These lists of activities are intended to serve as a guideline to identify motor-related problems that are interfering with a student's functioning in an education program. **Place an X on area of concern and fill in blanks as necessary.**

Student Name _____

I. GROSS MOTOR: Moving within the environment/locomotor skills

<input type="checkbox"/> Rolling	<input type="checkbox"/> Walking	<input type="checkbox"/> Walk Backwards	<input type="checkbox"/> Bumps into Furniture
<input type="checkbox"/> Stairs/Bus	<input type="checkbox"/> Jumping	<input type="checkbox"/> Climb on Objects	<input type="checkbox"/> Playground Equipment
<input type="checkbox"/> Toe Walk	<input type="checkbox"/> Running	<input type="checkbox"/> Falls off Chair	
<input type="checkbox"/> Crawling	<input type="checkbox"/> Skipping	<input type="checkbox"/> Rides Trike	
<input type="checkbox"/> Balance	<input type="checkbox"/> Transitions	<input type="checkbox"/> Unusual Walking Pattern	

Interventions Tried: _____

II. FINE MOTOR: Hand Skills

<input type="checkbox"/> Hand Dominance _____	<input type="checkbox"/> Pencil Grasp _____
<input type="checkbox"/> Letter/Number Formation _____	<input type="checkbox"/> Scissor Use _____
<input type="checkbox"/> Developmental Strokes	<input type="checkbox"/> Midline Crossing
<input type="checkbox"/> Coloring	<input type="checkbox"/> Object Manipulation
<input type="checkbox"/> Legibility during written work	<input type="checkbox"/> Keyboarding Skills

Interventions Tried: _____

III. SENSORIMOTOR: Sensitive to Sound Touch

<input type="checkbox"/> Seeks movement _____	<input type="checkbox"/> Falls off Chair
<input type="checkbox"/> Avoids movement _____	<input type="checkbox"/> Excessive chewing/Mouths objects
<input type="checkbox"/> Seeks touch	<input type="checkbox"/> Fidgets
<input type="checkbox"/> Clumsy	
<input type="checkbox"/> Easily distracted by: Auditory Stimulation Visual Stimulation	

Interventions Tried: _____

IV. FUNCTIONAL SKILLS

Bus Loading & Unloading		Coats On/Off
Assistance during bus rides		Difficulty with fasteners
Traveling to Classroom		Locker Skills
Carrying Books		Backpack Skills

AT/PI PRE-REFERRAL SUMMARY

Requested Service

<input type="checkbox"/>	Posture/Seating	<input type="checkbox"/>	Funding Assistance
<input type="checkbox"/>	Assistance with Evaluation	<input type="checkbox"/>	PI
<input type="checkbox"/>	Equipment Loan		

Type of AT requested (check all that apply)

<input type="checkbox"/>	Switch adapted toys	<input type="checkbox"/>	Aug com device w/voice output
<input type="checkbox"/>	Manual communication board/system	<input type="checkbox"/>	Wheelchair mounts
<input type="checkbox"/>	Computer access/software	<input type="checkbox"/>	Curriculum/lesson plan ideas
<input type="checkbox"/>	Low tech vision aids	<input type="checkbox"/>	Assistance with Evaluation
<input type="checkbox"/>	Amplification system	<input type="checkbox"/>	Other, please specify
<input type="checkbox"/>	Writing aids	<input type="checkbox"/>	

Type of AT Currently Used (check all that apply)

<input type="checkbox"/>	Switch adapted toys	<input type="checkbox"/>	Aug com device w/voice output
<input type="checkbox"/>	Manual communication board/system	<input type="checkbox"/>	Wheelchair mounts
<input type="checkbox"/>	Computer access/software	<input type="checkbox"/>	Curriculum/lesson plan ideas
<input type="checkbox"/>	Low tech vision aids	<input type="checkbox"/>	Assistance with Evaluation
<input type="checkbox"/>	Amplification system	<input type="checkbox"/>	Other, please specify
<input type="checkbox"/>	Writing aids	<input type="checkbox"/>	

What is your main area of concern with this student?

<input type="checkbox"/>	Writing	<input type="checkbox"/>	Vision
<input type="checkbox"/>	Communication	<input type="checkbox"/>	Hearing
<input type="checkbox"/>	Reading	<input type="checkbox"/>	Cognitive
<input type="checkbox"/>	Seating & positioning	<input type="checkbox"/>	Organization/Independent work skills
<input type="checkbox"/>	Motor/Mobility		