

## **Children's Health School Services Program Occupational Therapy/Physiotherapy Referral Guide for Teachers**

### **Request for Eligibility Assessment:**

Fill out Children's Health School Services (CHSS) Referral Form and accompanying two page Teacher Checklist completely, either electronically or using a black pen (otherwise legibility on the fax is poor). Indicate whether this is a New or Re-Referral.

***If this is a new referral: Obtain Consent of the parent.*** Complete the CHSS Referral Form and have the Principal/Designate sign it and complete both pages of the Teacher Checklist and fax both documents to LHIN using the number provided on the form.

***If this is a re-referral: Obtain Consent of the parent.*** Call the ESC LHIN Care Coordinator to discuss the reason for the re-referral. Please consider the following:

- Has there been a change in medical status (i.e., diagnosis, medications, seizures, etc.) that impacts physical participation in school routines?
- Is there need for equipment?
- Have behavioural/attention issues improved/resolved?
- Has there been a change in environment (i.e., school transfer)?
- If there are no changes, what prompted the re-referral?
- Have you reviewed the previous therapy reports and were the previous therapy recommendations implemented?
- Were foundation motor skills in place at time of discharge (refer to therapy discharge report). If so, is there a new motor based concern or deterioration of motor skills?
- Did therapy discharge report state that a re-referral may be required as school performance demands increase?
- Is there a significant gap between academic & motor performance?

**If it is determined that the re-referral is appropriate, complete the referral form and checklist.**

**This page of the document is to be utilized as a tool only and not to become part of the health record.**

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Tel: 519 351-5677  
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Windsor Branch  
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## Children's Health School Services Program Teacher Checklist – Private School / In-Home School

Name: \_\_\_\_\_ DOB (dd/mm/yy): \_\_\_\_\_

For Occupational Therapy or Physiotherapy referrals. Please complete electronically or use **black pen** to **check the areas of concern** where the student has difficulty meeting curriculum expectations.

### General Motor Skills

- Getting on and off bus safely and independently
- Tripping or falling more than expected while walking or climbing stairs
- Participating safely in emergency evacuations
- Participating safely in gym, at recess/on playground/fieldtrips
- Traveling required distances and with expected energy level
- Managing doors independently (e.g., turning handle, pushing open)
- Demonstrates unusual alignment of body, limbs, joints
- Poor posture at desk
- Complaints of pain following or during activity

### Self-Care

- Accessing bathroom/equipment required for safety
- Managing clothing during toileting routine
- Difficulty with outdoor clothing
- Managing fasteners (zippers, buttons, snaps)
- With snack/lunch activities (e.g., opening containers, self-feeding)

### Handling of Classroom Materials

- Consistent hand preference
- Grasping Pencil
- Using appropriate pencil pressure (Indicate:  too heavy  too light)
- Grasping scissors
- Drawing with detail
- Tracing, colouring, following a path
- Cutting accuracy
- Hand tremors
- Difficulty with hand strength (i.e., strength of grasps, opening containers)
- Handling classroom fine motor materials (e.g., craft and science materials, math manipulative, etc.)
- Handling work materials (e.g., pencil sharpener, paper, binders, pencil case, erasers, etc.)

Name: \_\_\_\_\_ DOB (dd/mm/yy): \_\_\_\_\_

## \*Written Communication

- Size and position of letters and numbers
- Printing on the line
- Spacing between letters and words
- Keyboarding/computer access

**\*Note:** If problems with paper and pencil tasks have been indicated, please attach a single current sample of typical work clearly marked with student's name and date completed.

### 1. Please list the three tasks that you most want assessed by the therapist:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

### 2. What task modifications/strategies have already been employed by the teacher/school personnel to assist the student with the problem tasks that you have listed? Please note which ones have been successful.

### 3. Please comment on the child's general classroom performance in terms of:

**Academics:**

**Social/Behaviour:**

**Attention:**

**Strengths/Interests:**

### 4. Current school-based interventions/supports:

- IEP  IPRC  LST/LSST  Other:
- EA support (if checked, please note how much time):
- DSW support (if checked, please note how much time):
- Other:

Name: \_\_\_\_\_ DOB (dd/mm/yy): \_\_\_\_\_

5. List any other investigations/interventions past or planned (academic, psychometric) and attach any current reports that support request for assessment.

6. Are there any identified health concerns (i.e., vision, hearing, etc.) diagnosis which could impact therapy?

7. Please list any equipment that is currently in place to support the student.

\_\_\_\_\_  
Teacher Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Name of School

\_\_\_\_\_  
Date (dd/mm/yy)