**Colonial School District**

**Occupational Therapy Department**

**Pre-Referral Teacher Checklist**

*Please attach work samples and return with completed form to Occupational Therapist’s mailbox.*

Occupational Therapist: OT Initials/Date Received\_\_\_\_\_\_\_\_

Student Name: Completed By:

School/Grade/Program: \_ Date Completed:

**Please circle to indicate if the items below are occurring:**

|  |  |
| --- | --- |
| **YES NO** | Below Standards The difficulties noted with the student are affecting their ability to meet standards in the classroom. |
| **YES NO**  **YES NO** | Handwriting Without Tears The HWT curriculum, paper and terminology are being used daily with the student.  The student has a letter/number strip on their desktop |
| **YES NO**  **YES NO**  **N/A no glasses** | Vision ScreeningThe student has passed a vision screening from the nurse. The student wears their glasses on a consistent basis in the classroom. |
| Bottom at back of the seat  Head Erect  Desk Height should be between navel and chest  Child should be able to put chin in palms while keeping elbows on desk | Classroom Desk Positioning and Location Proper seating and support are important to classroom learning. If a student is not properly seated, you may observe difficulties including (but not limited to) messy handwriting, inattentiveness, fidgeting, slumped posture and falling.  Below are some key points you can use to check to see if your student(s) are positioned properly for optimal classroom functioning: |

Hips bent to a 90° angle

Knees bent to a 90° angle

Feet flat on the floor

|  |  |
| --- | --- |
| **YES NO**  **YES NO** | The student is properly seated and supported at their desk/table as described above.  The student is close to and directly facing instruction. |
|  |  |
| **YES NO**  **YES NO** | Organizational Skills Clutter has been removed and the student only has what is needed for the current task on their desk.  The student is provided with a regularly scheduled time to clean out their desk and book bag. |
| **YES NO** | Provide Short Breaks Between Activities The student has scheduled movement breaks throughout the school day between activities. |

Please indicate how many letters/numbers the student can identify:

\_\_\_\_\_/26 capital \_\_\_\_\_\_/26 lowercase \_\_\_\_\_\_/\_\_\_\_\_\_\_ numbers

Please indicate how many sounds the student can identify:

\_\_\_\_\_/ 21 Consonant sounds \_\_\_\_\_/ 5 short vowels \_\_\_\_\_/ 5 long vowels

What is the student’s current spelling/Words Their Way Level? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate the student current MP grades: Math\_\_\_\_\_\_\_\_ Reading\_\_\_\_\_\_\_\_\_ Writing\_\_\_\_\_\_\_\_

Please check any of the following that applies for this student:

\_\_\_\_\_has an IEP \_\_\_\_\_has a 504 \_\_\_\_\_ is in SBT \_\_\_\_\_RTI Tier 2 \_\_\_\_\_RTI Tier 3 \_\_\_\_\_ELL

***Please check areas in which this child significantly stands out from classmates:***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Ability to stay seated |  |  | Management of clothing |
|  | Waiting/Walking in line |  |  | Management of backpack/lunchbox |
|  | Personal Space |  |  | Management of clothing fasteners |
|  | School Mobility (trips, bumps things) |  |  | Management of locker |
|  | Walks with tray in cafeteria |  |  | Ability to open snacks and drinks |
|  | Ability to handle transitions |  |  | Scissor Skills |
|  | Ability to keep hands to self |  |  | Pencil Grasp |
|  | Reaction to environment (ie: over reacts to noises, movement, touch) |  |  | Legibility of writing (sizing, spacing, line placement) |
|  | Fidgets frequently |  |  | Handwriting letter formations |
|  | Ability to locate desired items in desk |  |  | Frequent letter/number reversals (after 1st grade) |
|  | Attention to task |  |  | Paper management skills |
|  | Neatness of desk, folders |  |  | Quality of pencil pressure (too hard or too light) |
|  |  |  |  | Ability to organize (writing, drawings, numbers) on a page |

Additional Comments/ Concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you discussed your concerns with the student’s parent? YES / NO

If yes please indicate what type of communication you have had with the parent regarding your concerns.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What strategies / interventions have you tried in the classroom to address your concerns?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide some days/times (at least 3) that would be good for an observation if needed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupational Therapist Response (to be completed by the occupational therapist):

\_\_\_\_\_ No Observation needed at this time

\_\_\_\_\_ OT Observation Recommended please obtain parent permission on the attached sheet and return

to the OT Parent permission OT Initials/Date Received\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Please refer to the SBT Team

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupational Therapist Date