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 Home and Community Care Support Services 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.

HOME AND COMMUNITY CARE SUPPORT SERVICES
Erie St. Clair

☐ Chatham Branch
Tel: 519 351-5677
Fax: 519 351-5842

☐ Sarnia Branch
Tel: 519 337-1000
Fax: 519 337-4331

☐ Windsor Branch
Tel: 519 258-8211
Fax: 519 258-6288

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)