Earlywood Educational Services

REQUEST FOR OT/PT SCREENING

To be completed by team member(s) requesting consult and returned to OT/PT Department

Date of Request: _____ IEP: Yes No

Students Name:_____Birthdate: _____

School:_____Teacher: _____

School Phone #:_____Grade: _____

Good time to talk to teacher: _____

Request made by: _____

CHECK ANY AREA OF CONCERN AND ATTACH SAMPLES OF FINE MOTOR WORK

Coloring	Feeding	Walking (clumsy, tripping, falling, etc.)
Cutting	Toileting	Gym participation (running, jumping)
Handwriting	Seating	Low visual motor test scores
Sensory	Playgound Safety	Other: _____

Signature of Parent: _____ Date:_____

Signature of Teacher:_____ Date:_____

STEP 2: This section to be completed by OT or PT

Date Received by Therapist: _____

Consulted with: _____

OT Evaluation Needed: Yes No

Date the consent for evaluation was sent:_____by: _____

PT Evaluation Needed: Yes No

Date the consent for evaluation was sent:_____by: _____

Gave Recommendations: _____

Signature of Occupational Therapist:_____Date: _____

Signature of Physical Therapist:_____Date: _____