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 ☐ AM ☐
KNDG ☐ PM ☐

Days of Week

Mon	Tues	Wed	Thurs	Fri

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
Tim Curtis	257-7390

Occupational Therapists:

Valerie Hommderding	257-7397
Dawn Mathiasen	257-7358
Cassie Sandstrom	257-7356
Michelle Kiffmeyer	257-7391

Assistive Technology/Physical Impairment 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

☐ Rolling	☐ Walking	☐ Walk Backwards	☐ Bumps into Furniture
☐ Stairs/Bus	☐ Jumping	☐ Climb on Objects	☐ Playground Equipment
☐ Toe Walk	☐ Running	☐ Falls off Chair	
☐ Crawling	☐ Skipping	☐ Rides Trike	
☐ Balance	☐ Transitions	☐ Unusual Walking Pattern	

Interventions Trialed: _____

II. **FINE MOTOR**: Hand Skills

☐ Hand Dominance _____	☐ Pencil Grasp _____
☐ Letter/Number Formation	☐ Scissor Use
☐ Developmental Strokes	☐ Midline Crossing
☐ Coloring	☐ Object Manipulation
☐ Legibility during written work	☐ Keyboarding Skills

Interventions Trialed: _____

III. **SENSORIMOTOR:** Sensitive to Sound Touch

☐ Seeks movement _____	☐ Falls off Chair
☐ Avoids movement _____	☐ Excessive chewing/Mouths objects
☐ Seeks touch	☐ Fidgets
☐ Clumsy	
☐ Easily distracted by: Auditory Stimulation Visual Stimulation	

Interventions Trialed: _____

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

- ☐ Posture/Seating
- ☐ Assistance with Evaluation
- ☐ Equipment Loan
- ☐ Funding Assistance
- ☐ PI

Type of AT requested (check all that apply)

- ☐ Switch adapted toys
- ☐ Manual communication board/system
- ☐ Computer access/software
- ☐ Low tech vision aids
- ☐ Amplification system
- ☐ Writing aids
- ☐ Aug com device w/voice output
- ☐ Wheelchair mounts
- ☐ Curriculum/lesson plan ideas
- ☐ Assistance with Evaluation
- ☐ Other, please specify _____

Type of AT Currently Used (check all that apply)

- ☐ Switch adapted toys
- ☐ Manual communication board/system
- ☐ Computer access/software
- ☐ Low tech vision aids
- ☐ Amplification system
- ☐ Writing aids
- ☐ Aug com device w/voice output
- ☐ Wheelchair mounts
- ☐ Curriculum/lesson plan ideas
- ☐ Assistance with Evaluation
- ☐ Other, please specify _____

What is your main area of concern with this student?

- ☐ Writing
- ☐ Communication
- ☐ Reading
- ☐ Seating & positioning
- ☐ Motor/Mobility
- ☐ Vision
- ☐ Hearing
- ☐ Cognitive
- ☐ Organization/Independent work skills