

## BSED MOTOR SUPPORT STAFF

### Requesting Service for:

<input type="checkbox"/> Occupational Therapy (fill out page 2)	<input type="checkbox"/> Physical Therapy (fill out page 2)	<input type="checkbox"/> Assistive Technology (fill out page 3)	<input type="checkbox"/> Physically Impaired (fill out page 3)
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### Complete for all Referrals:

Pupil's Full Name	_____	D.O.B.	_____
Teacher	_____	Grade	_____
Parent(s) Name	_____	School	_____
Primary Physician	_____	Room	_____

ECSE	<input type="checkbox"/>	AM	<input type="checkbox"/>	Days of Week	Mon	Tues	Wed	Thurs	Fri
KNDG	<input type="checkbox"/>	PM	<input type="checkbox"/>						

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:

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### BSED Motor Staff:

#### Physical Therapists:

DeAnna Dunsmoor 257-7357  
Michelle Schluender 223-7417  
Lisa Wenner 257-7390

#### Occupational Therapists:

Valerie Hommerding 257-7356  
Dawn Mathiasen 257-7358  
Mattie Parsons 257-7397  
Belinda Tysver 257-7391

#### Assistive Technology/Physically Impaired 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

<input type="checkbox"/> Rolling	<input type="checkbox"/> Walking	<input type="checkbox"/> Walk Backwards	<input type="checkbox"/> Bumps into Furniture
<input type="checkbox"/> Stairs/Bus	<input type="checkbox"/> Jumping	<input type="checkbox"/> Climb on Objects	<input type="checkbox"/> Playground Equipment
<input type="checkbox"/> Toe Walk	<input type="checkbox"/> Running	<input type="checkbox"/> Falls off Chair	
<input type="checkbox"/> Crawling	<input type="checkbox"/> Skipping	<input type="checkbox"/> Rides Trike	
<input type="checkbox"/> Balance	<input type="checkbox"/> Transitions	<input type="checkbox"/> Unusual Walking Pattern	

Interventions Tried: \_\_\_\_\_

### II. **FINE MOTOR:** Hand Skills

<input type="checkbox"/> Hand Dominance _____	<input type="checkbox"/> Pencil Grasp _____
<input type="checkbox"/> Letter/Number Formation	<input type="checkbox"/> Scissor Use _____
<input type="checkbox"/> Developmental Strokes	<input type="checkbox"/> Midline Crossing
<input type="checkbox"/> Coloring	<input type="checkbox"/> Object Manipulation
<input type="checkbox"/> Legibility during written work	<input type="checkbox"/> Keyboarding Skills

Interventions Tried: \_\_\_\_\_

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

<input type="checkbox"/> Seeks movement _____	<input type="checkbox"/> Falls off Chair
<input type="checkbox"/> Avoids movement _____	<input type="checkbox"/> Excessive chewing/Mouths objects
<input type="checkbox"/> Seeks touch	<input type="checkbox"/> Fidgets
<input type="checkbox"/> Clumsy	
<input type="checkbox"/> Easily distracted by: Auditory Stimulation Visual Stimulation	

Interventions Tried: \_\_\_\_\_

### IV. **FUNCTIONAL SKILLS**

<input type="checkbox"/> Bus Loading & Unloading	<input type="checkbox"/> Coats On/Off
<input type="checkbox"/> Assistance during bus rides	<input type="checkbox"/> Difficulty with fasteners
<input type="checkbox"/> Traveling to Classroom	<input type="checkbox"/> Locker Skills
<input type="checkbox"/> Carrying Books	<input type="checkbox"/> Backpack Skills

## AT/PI PRE-REFERRAL SUMMARY

### Requested Service

<input type="checkbox"/>	Posture/Seating	<input type="checkbox"/>	Funding Assistance
<input type="checkbox"/>	Assistance with Evaluation	<input type="checkbox"/>	PI
<input type="checkbox"/>	Equipment Loan		

### Type of AT requested (check all that apply)

<input type="checkbox"/>	Switch adapted toys	<input type="checkbox"/>	Aug com device w/voice output
<input type="checkbox"/>	Manual communication board/system	<input type="checkbox"/>	Wheelchair mounts
<input type="checkbox"/>	Computer access/software	<input type="checkbox"/>	Curriculum/lesson plan ideas
<input type="checkbox"/>	Low tech vision aids	<input type="checkbox"/>	Assistance with Evaluation
<input type="checkbox"/>	Amplification system	<input type="checkbox"/>	Other, please specify
<input type="checkbox"/>	Writing aids	<input type="checkbox"/>	

### Type of AT Currently Used (check all that apply)

<input type="checkbox"/>	Switch adapted toys	<input type="checkbox"/>	Aug com device w/voice output
<input type="checkbox"/>	Manual communication board/system	<input type="checkbox"/>	Wheelchair mounts
<input type="checkbox"/>	Computer access/software	<input type="checkbox"/>	Curriculum/lesson plan ideas
<input type="checkbox"/>	Low tech vision aids	<input type="checkbox"/>	Assistance with Evaluation
<input type="checkbox"/>	Amplification system	<input type="checkbox"/>	Other, please specify
<input type="checkbox"/>	Writing aids	<input type="checkbox"/>	

### What is your main area of concern with this student?

<input type="checkbox"/>	Writing	<input type="checkbox"/>	Vision
<input type="checkbox"/>	Communication	<input type="checkbox"/>	Hearing
<input type="checkbox"/>	Reading	<input type="checkbox"/>	Cognitive
<input type="checkbox"/>	Seating & positioning	<input type="checkbox"/>	Organization/Independent work skills
<input type="checkbox"/>	Motor/Mobility		