Occupational Therapy Screening

What is a Screening: A screening provides teachers and parents a brief insight into a child's strengths and weaknesses. This verifies if they are functioning at their highest potential in the home, community, and school setting without completing a full occupational therapy evaluation.

If you are interested in having your child screened please complete the following:

Child's Name: ______________________ DOB: ________ Parents Name: ____________
Phone #: __________________________ Email: ______________________________

Please indicate areas of difficulty with the tasks below:

Gross Motor:

____ Seems weaker than peers or fatigues easily
____ Clumsy, bumps into things, falls easily
____ Movements appear stiff or awkward
____ Poor desk posture
____ Fearful of movement (swing, slide, teeter totter)
____ Avoids activities requiring balance
____ Seeks excessive movement

Fine Motor:

____ Unable to engage in finger play with songs
____ Poor pencil grasp or handwriting difficulty
____ Difficulty squeezing, pulling or rolling playdoh
____ Is unable to use both hands (such as holding the paper when drawing or cutting efficiently)

Tactile Sensation:

____ Seems to withdraw from touch (hugs, peers) or touching messy objects
____ Has trouble keeping hands to self
____ Unaware of being touched or bumped

Mouth:

____ Wet lips or drools frequently
____ Puts objects in mouth

Vision:

____ Difficulty discriminating colors, shapes, or completing simple puzzles
____ Difficulty tracing or drawing simple shapes
____ Difficulty tracking

Other:

____ Has difficulty following visual or verbal directions
____ Has big emotional reactions
____ Has difficulty socializing with peers
____ Easily distracted
____ Avoids difficult tasks
____ Dislikes change, transitions, or likes consistency
____ Impulsive
____ Sensitive or avoids certain noises

Activities of Daily Living:

____ Difficulty with large buttons or fasteners
____ Assistance with hand washing
____ Assistance with dressing and undressing
____ Toileting
____ Picky Eater
____ Dislikes teeth brushing
____ Poor sleep habits

Additional Concerns or Comments: ____
____

What to Expect: An occupational therapist with FUNctional Therapy can conduct the screen during the school day. The therapist will coordinate with the teacher to identify the most appropriate time. During the screen the therapist will observe the student, speak with the teacher, and/or complete a short assessment. Following the screen the therapist will complete a report indicating the child's strengths, areas of concern if present, if a complete OT evaluation would be beneficial, and tips to address the areas of concern. A copy of this report will be provided to the appropriate school staff and the parent(s). <u>There is a small fee of $25. Checks can be made to FUNctional Therapy</u>.

☐ <u>I consent</u> to have FUNctional Therapy, PLLC complete an Occupational Therapy Screen for my child, ________________________. A copy of the results will be provided to the child's parents and the appropriate school staff (i.e. teacher, director, etc.).

☐ I prefer for my child <u>not to be screened</u> by FUNctional Therapy, PLLC.

Parent Signature: ____ Date: ____________

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Referral for Occupational Therapy Screening

To Be Completed By The Teacher

Child's Name: ______________________________ DOB: __________________ Grade: _________
Teacher: ______________________________ Date: __________________

Please indicate areas of difficulty with the tasks below:

Gross Motor:

____ Seems weaker than peers or fatigues easily
____ Clumsy, bumps into things, falls easily
____ Movements appear stiff or awkward
____ Can't kick a ball
____ Unable to stand on tip toe
____ Poor desk posture
____ Fearful of activities moving through space (swing, slide, teeter totter)
____ Avoids activities challenging balance
____ Seeks excessive movement

Fine Motor:

____ Unable to engage in finger play with songs
____ Poor pencil grasp, drops pencil frequently
____ Difficulty squeezing, pulling or rolling playdoh
____ Is unable to use both hands (such as holding the paper when drawing)

Vision & Visual Motor Integration:

____ Difficulty discriminating colors, shapes, or completing simple 3-5 piece puzzles
____ Difficulty tracing simple objects or drawing a vertical line
____ Difficulty tracking (skipping items on worksheet, difficulty following tracks made by toy car).
____ Can't make continuous cuts with scissors

Tactile:

____ Seems to withdraw from touch (hugs, peers) or touching messy objects
____ Has trouble keeping hands to self
____ Unaware of being touched or bumped

Mouth:

____ Wet lips or drools frequently
____ Picky eater
____ Always putting objects in mouth

Auditory:

____ Always making noise
____ Very sensitive to noise
____ Covers Ears with loud noises

Other:

____ Has difficulty following visual directions
____ Has difficulty following verbal directions
____ Has difficulty socializing with peers
____ Easily distracted
____ Avoids difficult tasks
____ Dislikes change, has difficulty with transitions, like consistency
____ Impulsive
____ Has big emotional reactions

Additional Concerns or Comments:

____
____
____
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____
____

FUNctional Therapy
Providing Occupational Therapy

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