

Occupational Therapy Pre-Referral Form

Please use this form as a guide to help you think about how this student compares to other children of similar age and experience. This is meant to help you appropriately refer this student to the appropriate occupational therapy service.

Student: _____ Grade: _____ Birth date: _____

Completed by: _____ Date: _____

Classroom concerns: _____

Student's strengths/interests _____

Check areas that this student stands out significantly from other students:

___ability to stay in seat

___pencil grasp

___ sitting tolerance on floor

___legibility of handwriting

___ waiting/walking in line

___frequency of letter/number reversals

___ navigating classroom/playground

___paper management skills

___space between self and others in line

___neatness of backpack/desk/locker

___ability to handle transitions

___ability to tie shoes

___tolerance of noise

___tolerance of movement

Please direct any questions to the occupational therapist or leave a message in the occupational therapy mailbox in the office. Thank-you