**COMPREHENSIVE OCCUPATIONAL THERAPY EVALUATION**

**OF PERFORMANCE AND PARTICIPATION**

|  |  |  |  |
| --- | --- | --- | --- |
| **Student’s Name:** | | **NYC ID:** | **DOB:** |
| **Age:** | **Grade: (**if applicable) | **Class Program: Gen Ed \_\_­\_\_ ICT \_\_\_\_ Special Class: \_\_\_\_ Class Size / Ratio: \_\_\_\_** | |
| **District / Borough / School:** | | **Disability Classification:** | **Diagnosis:** |
| **Parent / Guardian:** | | **Telephone #:** | **Special Transportation:** |
| **Primary Physician:** | | **Telephone #:** | **Alerts:** |
| **Hospital / Clinic:** | | **Telephone #:** | **Medication:** |
| **Evaluator’s Name:** | | **DOE Evaluator \_\_\_ Agency Evaluator \_\_\_** | **Date of Evaluation:** |
| **Referral Type: Initial \_\_\_\_ (no previous IEP) Add OT to IEP \_\_\_\_ 3 Year Review \_\_\_\_ Requested Review \_\_\_\_** | | | |
| **Reason for Referral:** | | | |

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| **Student Profile** | |  | **Verbal** |  | | **Non-verbal** | | |  | **Ambulatory** | | | | |  | | **Non-ambulatory** | | | | | | | |  | **Toilet Trained** | |  | **Behavioral Intervention Plan** | | |
| **Comments:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Services Receiving** | | **Paraprofessional**  **\_\_\_Crisis \_\_\_\_ Health \_\_\_ Mobility** | | | | | | | | |  | | **OT** | | |  | | **PT** | | |  | | | **Speech**  **Hearing** | | |  | **Counseling** | |  | **Health / Nursing** |
|  | | |
| **OT Mandate for Student’s Receiving Services:** | | | | | | | | | | | | | | | | | | | | **# of Years Receiving OT Services:** | | | | | | | | | | | |
| **Assistive Devices** | | **Assistive Writing Device**  **\_\_\_ Tablet \_\_\_\_ Word Processor \_\_\_ Computer** | | | | | | | | | | | | | | | | | |  | | | **Glasses**  **Visual Aids** | | | |  | **Hearing Aid**  **FM Unit** | |  | **Feeding Tube**  **Adaptive Utensil** |
|  | | |  |  |
| **Other:** | | | | | | | | **Augmentative Communication**  **\_\_\_ Communication Board \_\_\_ Picture Exchange System \_\_\_ Speech Generating Device** | | | | | | | | | | | | | | | | | | | | | | | |
| **Adaptive Aids**  **Equipment** | |  | **Manual Wheelchair** | |  | | **Power Wheelchair** | | | | |  | | **Walker** | | | | |  | | | **Crutches** | | | | |  | **Stander** | |  | **Lift** |
|  | **Orthotics**  **Prosthetics** |  | **Adaptive Seating** | |  | | **Adaptive**  **Desk** | | | | |  | | **Lap Tray** | | | | |  | | | **Adaptive Toilet** | | | | |  | **Slant board** | |  | **Positioning** |
|  |
| **Condition of Current Equipment:** | | | | | | | | | | | | | | | | | | |  | | | **Seat Cushion** | | | | |  | **Weighted Vest** | |  | **Other:** |
| **Equipment Identified as Programmatic or IEP Driven:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

**METHOD OF EVALUATION**

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|  | **Classroom Observation** |  | **Clinical Observation** |  | **Parent**  **Report** |  | **Teacher**  **Report(s)** |  | **SESIS Review**  **File Review** |  | **Student Interview** |  | **Para Interview** |  | **COSA COPM** |
|  |
|  | **PEDI / SFA**  **HELP**  **SANDI** |  | **Peabody**  **DTVP-2**  **ABLLS** |  | **HWT Screener**  **Print Tool** |  | **WOLD**  **VMI**  **Detroit** |  | **SPM**  **Sensory Profile** |  | **Vocational Self- Assessment**  **KELS** |  | **QNST – 3**  **BOT**  **GMFM** |  | **Other** |
|  |  |  |  |  |
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| **Section 1: BACKGROUND INFORMATION** |

*Based on OT Teacher Report, Parent Report, and chart review*

***Developmental & Medical History / Relevant Background Information / Reason for Referral***

|  |
| --- |
| Description here |

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| **Section 2: CLASSROOM FUNCTION & PARTCIPATION** |

**PRIMARY SCHOOL-BASED CONCERNS:** *Based on OT Teacher Report*

|  |  |
| --- | --- |
| **PRIMARY CONCERN # 1** | Text here |
| **PRIMARY CONCERN # 2** | Text here |
| **PRIMARY CONCERN # 3** | Text here |

**ADDITIONAL CONCERNS:** *Based on OT/PT Parent Checklist and/or observation*

|  |  |
| --- | --- |
| **Parent Concerns** | Text here |
| **Observational Concerns** | Text here |

**LEARNING & PARTICIPATION:** *Based on OT Teacher Report*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **OVERVIEW OF SKILL LEVELS** | **Difficulties do NOT significantly impede function** | **Difficulties SIGNIFICANTLY impede function** | **LEVEL OF SUPPORT**  Indicate***either***column that***best applies*** for each item | |
| **Needs Managed By Current Supports** | **Additional Supports Needed** |
| **Awareness / Learning Readiness** |  |  |  |  |
| **Work Behavior / Emotional Readiness** |  |  |  |  |
| **Movement / Accessibility** |  |  |  |  |
| **Activities of Daily Living** |  |  |  |  |
| **Management of Tools / Materials** |  |  |  |  |
| **Pre-writing / Writing** |  |  |  |  |
| **Sensory Skills for Learning** |  |  |  |  |
| **Prevocational / Transitional Skills** |  |  |  |  |

**CLASSROOM OBSERVATION**

|  |
| --- |
| Text here |

**AWARENESS / LEARNING READINESS**

*Based on observations in classroom & during evaluation, and/or OT Teacher Report & Parent Report*

***Opens eyes/alert to environment, responds to stimuli, responds to name/recognizes familiar people, maintains eye contact, communicates wants/needs (verbal or non-verbal), shows interest in class activities, etc.***

|  |
| --- |
| Text here |

**WORK BEHAVIOR / EMOTIONAL READINESS:** *Based on observations in classroom & during evaluation, and/or OT Teacher Report & Parent Report*

***Sustains attention/effort, follows directions/routines, develops friendships, works cooperatively, completes schoolwork and homework, manages emotions/adjusts behavior, works independently, etc.***

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| Text here |

**STUDENT INTERVIEW**

***Student interests, point of view, feelings about school, etc.***

|  |
| --- |
| Text here |

**STUDENT STRENGTHS**

***Personal, social, functional, etc.***

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| --- |
| Text here |

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| **Section 3: SKILL ASSESSMENT** |

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| --- | --- | --- | --- |
| **MOVEMENT / ACCESSIBILITY** | **LEVEL OF SKILL** | | |
| **Functional** | **Skill Emerging** | **Skill Not Present** |
| **Adjusts position as needed** |  |  |  |
| **Moves body to and from position (chair, floor, etc.)** |  |  |  |
| **Maintain posture at desk (with / without adaptive equipment)** |  |  |  |
| **Accesses all areas of building (with / without adaptive equipment)** |  |  |  |
| **Moves without fatigue / keeps pace with class** |  |  |  |
| **Carries cafeteria tray / backpack / books** |  |  |  |
| **Moves safely throughout school (stairs, halls, playground)** |  |  |  |

**Description of skills and function:**

|  |
| --- |
| Description here |

|  |  |  |  |
| --- | --- | --- | --- |
| **ACTIVITIES OF DAILY LIVING** | **LEVEL OF SKILL** | | |
| **Functional** | **Skill Emerging** | **Skill Not Present** |
| **Cooperates with / assists with personal care** |  |  |  |
| **Takes food or drink by mouth / eats varied diet** |  |  |  |
| **Uses utensils / opens containers** |  |  |  |
| **Manages clothing fasteners / dresses self / puts jacket on and off** |  |  |  |
| **Uses the bathroom / avoids toileting accidents** |  |  |  |
| **Manages personal hygiene / grooming** |  |  |  |
| **Prepares a sandwich / snack** |  |  |  |

**Description of skills and function:**

|  |
| --- |
| Description here |

|  |  |  |  |
| --- | --- | --- | --- |
| **MANAGEMENT OF CLASSROOM TOOLS AND MATERIALS** | **LEVEL OF SKILL** | | |
| **Functional** | **Skill Emerging** | **Skill Not Present** |
| **Activates switch** |  |  |  |
| **Reaches for / holds object / exhibits hand dominance** |  |  |  |
| **Uses functional grasp to hold pencil / crayon** |  |  |  |
| **Coordinates hands / fingers to manipulate small items** |  |  |  |
| **Uses classroom materials efficiently (pencil, paper, scissor, glue)** |  |  |  |
| **Organizes desk materials / packs & unpacks book bag** |  |  |  |
| **Uses keyboard / uses computer** |  |  |  |

**Description of skills and function:**

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| Description here |

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| **PRE-WRITING & WRITING**  **Glasses** C:\Users\eting21\Downloads\1458708249_checkbox_unchecked.png **YES** C:\Users\eting21\Downloads\1458708249_checkbox_unchecked.png **NO** | **LEVEL OF SKILL** | | |
| **Functional** | **Skill Emerging** | **Skill Not Present** |
| **Visually focuses on pictures / objects** |  |  |  |
| **Sorts / matches pictures & objects** |  |  |  |
| **Scribbles / imitates / copies lines & shapes** |  |  |  |
| **Colors within shapes / draws representational pictures** |  |  |  |
| **Writes letters, numbers, & name** |  |  |  |
| **Copies written material from board** |  |  |  |
| **Writes legibly / types** |  |  |  |

**Description of skills and function:**

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| --- |
| Description here |

|  |  |  |  |
| --- | --- | --- | --- |
| **SENSORY SKILLS FOR LEARNING** | **LEVEL OF SKILL** | | |
| **Functional** | **Skill Emerging** | **Skill Not Present** |
| **Visual: Visually attends / responds appropriately to sights in class** |  |  |  |
| **Auditory: Responds appropriately sounds in the environment** |  |  |  |
| **Tactile: Responds appropriately to touch and various textures** |  |  |  |
| **Vestibular: Sits without excessive rocking, bouncing, or spinning** |  |  |  |
| **Proprioception: Adjusts force when handling or moving objects** |  |  |  |
| **Taste & Smell: Responds appropriately to tastes & smells** |  |  |  |
| **Maintains personal space (e.g. doesn’t stand too close to others, controls impulses to touch objects or peers excessively)** |  |  |  |

**Description of skills and function:** *If significant difficulty is noted, indicate over-responsiveness or under-responsiveness*

|  |
| --- |
| Description here |

|  |  |  |  |
| --- | --- | --- | --- |
| **PREVOCATIONAL / TRANSITIONAL SKILLS** | **LEVEL OF SKILL** | | |
| **Functional** | **Skill Emerging** | **Skill Not Present** |
| **Attends school daily** |  |  |  |
| **Follows schedule to complete tasks** |  |  |  |
| **Shows awareness of time / manages time** |  |  |  |
| **Participates in work / volunteer assignments** |  |  |  |
| **Performs physical tasks required in current pre-vocational program** |  |  |  |
| **Makes purchase / counts change** |  |  |  |
| **Identifies realistic post high school plans** |  |  |  |
| **Navigates in the community / uses bus or train** |  |  |  |

**Description of skills and function:**

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| --- |
| Description here |

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| **Section 4: SUMMARY & RECOMMENDATION** |

**CONSIDERATIONS**

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| --- |
| ***Prior to recommending OT services, the IEP team must determine if the student meets the eligibility requirements for special education. Special education services require identification of a specific disability classification.***  **SCHOOL-BASED OT SERVICES** are designated for eligible students whose difficulties significantly impede participation in school. OT services are recommended only when required for participation in the educational program. OT promotes strategies to be implemented by teachers/family for students who are not eligible for services.  **HANDWRITING** is addressed by OT only when underlying components (motor, visual and perceptual) significantly impede function and the student requires intervention beyond basic classroom instruction and practice. Written expression is influenced by skills in reading, spelling, cognition and language. OT does not directly address expressive writing skills.  **LEARNING READINESS, WORK BEHAVIORS & EMOTIONAL READINESS** are most effectively addressed by teachers within the classroom. OT supports students by providing strategies to promote work behaviors, social-emotional learning and self-regulation. |

**FOR STUDENTS CURRENTLY RECEIVING OCCUPATIONAL THERAPY: PROGRESS REPORT**

|  |  |  |
| --- | --- | --- |
| Yes | No |  |
|  |  | Did the student meet his/her IEP goals that require OT? |
|  |  | Does the student continue to show an inability to participate in school to meet educational goals? |
|  |  | Does the student have functional school goals that require OT? |
|  |  | Given their disability profile, does the student show potential for improvement toward these goals? |
| Additional comments here | | |

**SUMMARY**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Reason for referral / Brief overview of strengths & weaknesses / Impact on school function*** | | | | |
| Description here | | | | |
| ***Primary Concerns*** | | | |  |
|  | | | **Yes** | **No** |
| **PRIMARY CONCERN # 1** |  | **Is this area best**  **addressed by OT?** |  |  |
| **PRIMARY CONCERN # 2** |  | **Is this area best**  **addressed by OT?** |  |  |
| **PRIMARY CONCERN # 3** |  | **Is this area best**  **addressed by OT?** |  |  |
| **ADDITIONAL CONCERNS** |  | **Is this area best**  **addressed by OT?** |  |  |
| ***Factors contributing to difficulties and Primary Concerns / Rationale for recommendation*** | | | | |
| *If skills are not functional, indicate primary reason (not expected at current developmental level, weakness/limitations due to nature of disability, behavioral concerns, not responsive to intervention, more practice required, etc.)*  Description here | | | | |

**RECOMMENDATION:** *Final recommendations to be determined at the IEP meeting*

|  |  |  |
| --- | --- | --- |
|  | **NO** | |
|  |  | **Concerns are best addressed by the primary educational program or other methods** |
|  |  | **Current function is at an appropriate level given the nature of student’s overall learning profile / disability** |
|  | **Concerns do not significantly interfere with function and participation in school** |
|  | **IEP goals have been met** |
|  | **Performance can no longer be improved by OT through remediation or task/environmental modifications** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **YES Contingent upon meeting eligibility criteria; final recommendation determined at IEP meeting** | | | |
|  |  | **Initiate OT services** |  |  |
|  |  | **Continue OT at current mandate** |
|  |  | **Continue OT at modified mandate** |

**RECOMMENDED OT MANDATE**:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **FREQUENCY** | **WEEKLY** | **MONTHLY** | **DURATION**  15 30 45 OTHER | **GROUP SIZE**  MAX = 8 | **LOCATION**  SEPARATE / GENERAL ED / SPECIAL ED |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**SUGGESTIONS TO CONSIDER / STRATEGIES TO PROMOTE FUNCTION**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Consultation with Pediatrician** |  | **Community Counseling** |  | **School Counseling** |  | **Additional Academic Supports** |
|  | **Physical Therapy Observation** |  | **Assistive Technology** |  | **Test Modifications** |  | **Speech Therapy Observation** |
| **ADDITIONAL SUGGESTIONS: *Classroom strategies / Community resources / Home programs***  Text here | | | | | | | |

|  |  |
| --- | --- |
| **EVALUATOR SIGNATURE** | **DATE** |