****

**PRESCHOOL SCHOOL OCCUPATIONAL THERAPY EVALUATION**

**OF FUNCTION AND PARTICIPATION**

 **RATING IN COMPARISON TO CLASSMATES**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Student:**  | **NYC ID:**  | **DOB:**  | **Age:**  | **Grade:**  |
| **District / Borough / School:** | **Class Program: Gen Ed \_\_­\_\_ ICT \_\_\_\_ Special Class \_\_\_\_ Class Size / Ratio \_\_\_\_**  |
| **Disability Classification:**  | **Diagnosis:** | **Alerts:** |
| **Parent / Guardian:**  | **Telephone #:**  | **Medication:** |
| **Primary Physician:**  | **Telephone #:**  | **Means of Mobility:** |
| **Evaluator’s Name:** | **Date of Evaluation:** | **Evaluator: DOE \_\_\_ Agency \_\_\_** |
| **Referred by:** | **Teacher:** | **Date of Previous IEP:**  |
| **Referral Type: Initial \_\_\_\_ (no previous IEP) Add OT to IEP \_\_\_\_ 3 Year Review \_\_\_\_ Requested Review \_\_\_\_ Turning 5 \_\_\_\_** |
| **Services Receiving:** |  | **Paraprofessional** **\_\_\_crisis \_\_\_\_ health \_\_\_ mobility** |  | **OT** |  | **PT** |  | **Speech** |  | **Counseling** |  | **Other** |
| **Existing OT Mandate:**  | **Test Accommodations:** |
| **Assistive Devices or Technology / Adaptive Equipment: *(note if in need of repair)*** |

|  |
| --- |
| **METHOD OF EVALUATION** |
|  | **Classroom Observation** |  | **Clinical Observation** |  | **Parent Report** |  | **Teacher Report** |  | **Review of** **Documents** |  | **Student Interview** |  | **Para Interview** |
|  | **DTVP-3** |  | **VMI** |  | **PFMA** |  | **MAP** |  | **PEDI****HELP** |  | **SPM-P****Sensory Profile** |  | **Other** |

|  |
| --- |
| **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 |

|  |
| --- |
| **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 IN COMPARISON TO PEERS:** *Based on OT Teacher Report*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **School Activity** | **Above** | **Comparable** | **Below** | **School Activity** | **Above** | **Comparable** | **Below** |
| **Learning Readiness**  |   |  |  | **Emergent Math** |  |  |  |
| **Prewriting / Writing Readiness**  |   |  |  | **Playground / Gym** |  |  |  |
| **Emergent reading**  |  |  |  | **Attendance** |  |  |  |

**CLASSROOM OBSERVATION**

|  |
| --- |
| Text here |

**SOCIAL PARTICIPATION AND EMOTIONAL REGULATION:** *Based on observations in classroom & during evaluation, and/or OT Teacher Report & Parent Report*

***Developing friendships, working cooperatively, identifying feelings & managing emotions, demonstrating self-awareness, demonstrating socially appropriate behaviors, making responsible choices, expressing needs, etc.***

|  |
| --- |
| Text here |

**SCHOOL READINESS & WORK BEHAVIORS:** *Based on observations in classroom & during evaluation and/or OT Teacher Report & Parent Report*

***Following directions, rules, and routines, sustaining effort to complete tasks, attending to lessons and work, solving problems, completing work on time, organizing materials, completing work independently, making decisions, etc.***

|  |
| --- |
| Text here |

**STUDENT INTERVIEW**

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

|  |
| --- |
| Text here |

**STUDENT STRENGTHS**

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

|  |
| --- |
| Text here |

|  |
| --- |
| **Section 3: SKILL ASSESSMENT** |

|  |  |  |  |
| --- | --- | --- | --- |
| **ACCESS / MOVEMENT** | **SUPPORTS** **School Function** | **Difficulty noted,** **DOES NOT significantly impede function** | **Difficulty noted, SIGNIFICANTLY impedes function** |
| **Adjusts position for comfort / maintains posture** |  |  |  |
| **Accesses all areas of building with or w/o equipment** |  |  |  |
| **Moves without fatigue / keeps pace with class** |  |  |  |
| **Moves safely in school / on stairs / crowded hallways** |  |  |  |
| **Displays underlying range of motion, strength, tone, coordination, and motor planning to access school** |  |  |  |

 **\_\_\_\_\_ No significant difficulties noted**

 **\_\_\_\_\_** **Description of difficulties, and underlying skills that impact participation**

|  |
| --- |
| Description here |

|  |  |  |  |
| --- | --- | --- | --- |
| **ACTIVITIES OF DAILY LIVING** | **SUPPORTS** **School Function** | **Difficulty noted,** **DOES NOT significantly impede function** | **Difficulty noted, SIGNIFICANTLY impedes function** |
| **Uses bathroom / manages hygiene** |  |  |  |
| **Manages clothing / fasteners**  |  |  |  |
| **Uses utensils / opens containers / carries tray**  |  |  |  |
| **Manages personal belongings / book bag** |  |  |  |
| **Displays underlying hand manipulation, bilateral coordination, and organizational skills for ADLs** |  |  |  |

 **\_\_\_\_\_ No significant difficulties noted**

 **\_\_\_\_\_** **Description of difficulties and underlying skills that impact participation**

|  |
| --- |
| Description here |

|  |  |  |  |
| --- | --- | --- | --- |
| **MANAGEMENT OF CLASSROOM TOOLS & MATERIALS** | **SUPPORTS** **School Function** | **Difficulty noted,** **DOES NOT significantly impede function** | **Difficulty noted, SIGNIFICANTLY impedes function** |
| **Demonstrates hand preference for coloring / drawing** |  |  |  |
| **Coordinates hands / fingers to manipulate small items** |  |  |  |
| **Controls movement of crayon / pencil** |  |  |  |
| **Uses classroom tools / scissors / glue / paintbrush** |  |  |  |
| **Displays underlying hand stability, manipulation, coordination, grasp and bilateral skills for class tool use** |  |  |  |

 **\_\_\_\_\_ No significant difficulties noted**

 **\_\_\_\_\_** **Description of difficulties and underlying skills that impact participation**

|  |
| --- |
| Description here |

|  |  |  |  |
| --- | --- | --- | --- |
| **PRE-WRITING & WRITING Glasses** \_\_**YES**\_\_**NO**  | **SUPPORTS****School Function** | **Difficulty noted,****DOES NOT significantly impede function** | **Difficulty noted, SIGNIFICANTLY impedes function** |
| **Sorts pictures / puzzle pieces / letters** |  |  |  |
| **Colors / draws shapes** |  |  |  |
| **Draws figures / pictures** |  |  |  |
| **Writes / copies some letters and numbers** |  |  |  |
| **Sustains visual focus on storybooks / activities** |  |  |  |
| **Displays underlying visual motor, visual perceptual, and motor coordination skills for school tasks** |  |  |  |

 **\_\_\_\_\_ No significant difficulties noted**

 **\_\_\_\_\_** **Description of difficulties and underlying skills that impact participation**

|  |
| --- |
| Description here |

|  |  |  |  |
| --- | --- | --- | --- |
| **SENSORY SKILLS FOR LEARNING** | **SUPPORTS** **School Function** | **Difficulty noted,** **DOES NOT significantly impede function** | **Difficulty noted, SIGNIFICANTLY impedes function** |
| **Auditory: Responds appropriately to environmental sounds** |  |  |  |
| **Visual: Responds appropriately to visuals during instruction** |  |  |  |
| **Tactile: Responds appropriately to touch and various textures**  |  |  |  |
| **Proprioception: Adjusts force when handling or moving objects** |  |  |  |
| **Vestibular: Sits without excessive rocking, bouncing, or spinning** |  |  |  |
| **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)** |  |  |  |

 **\_\_\_\_\_ No significant difficulties noted**

 **\_\_\_\_\_** **Description of difficulties, and underlying skills that impact participation**

 **If significant difficulty is noted, indicate over-responsiveness or under-responsiveness**

|  |
| --- |
| Description here |

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

**CONSIDERATIONS**

|  |
| --- |
| ***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.**PRE-WRITING** skills that are developmentally appropriate may include practice writing names, some letters and numbers. An emphasis on handwriting is not considered developmentally appropriate for preschool students. OT addresses pre-writing only when the underlying components (motor, visual and perceptual) of handwriting readiness significantly impede function and the student requires intervention beyond basic classroom instruction and practice. **WORK BEHAVIOR, SOCIAL PARTICIPATION & EMOTIONAL REGULATION** 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. |

**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*** |
| 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** |
|  | **Graduation from OT is recommended as IEP goals have been met / performance can no longer be improved by OT** |

|  |  |
| --- | --- |
|  | **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** |