**DESERT/MOUNTAIN SPECIAL EDUCATION LOCAL PLAN AREA**
**DESERT/MOUNTAIN CHARTER SPECIAL EDUCATION LOCAL PLAN AREA**
17800 HIGHWAY 18 • APPLE VALLEY, CA 92307
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# Occupational Therapy Referral

This form is for teachers, parents, or other persons involved with students who have a suspected need for specialized Occupational Therapy services

## STUDENT INFORMATION

☐ **INITIAL REFERRAL** ☐ **TRANSFER REFERRAL** Referral Date: _____

Student Name: _____ Date of Birth: _____ Age: _____

Disability: ... _____ Grade: _____ Gender: ☐ Male ☐ Female

Medical Diagnosis: _____

School Site: _____ Teacher Name: _____

District of Attendance: ... _____ District of Residence: ... _____

Parent/Guardian: _____

Home Phone: _____ Work Phone: _____ Other Phone: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Special education services student is currently receiving: _____

Specific time and day the student can be observed performing skill/activity of concern: _____

## INDICATE STUDENT NEEDS IN THE FOLLOWING AREAS:

1. FINE MOTOR
   - ☐ Difficulty manipulating fasteners on clothing as compared to age appropriate peers
   - ☐ Difficulty drawing and coloring as compared to peers
   - ☐ Difficulty cutting or using scissors as compared to peers
   - ☐ Other: _____

   *What is the student expected to do that he/she is unable to do regarding fine motor/self tasks?* _____

   *What interventions have been tried to date? Over what period of time?* _____

2. VISUAL PERCEPTION
   - ☐ Difficulty discriminating colors, shapes, doing puzzles as compared to peers
   - ☐ Letter reversals after the first grade
   - ☐ Difficulty distinguishing designs, numbers, or letters
   - ☐ Other: _____

   *What is the student expected to do that he/she is unable to do regarding V-P tasks?* _____

   *What interventions have been tried to date regarding V-P? Over what period of time?*

3. HANDWRITING (attach sample)
   - ☐ Has not established hand dominance after age four
   - ☐ Writes and prints slowly as compared to classmates
   - ☐ Spaces letters/words poorly
   - ☐ Writing is jerky and not fluid
   - ☐ Uses incorrect letter size
   - ☐ Applies to much pressure/too little pressure on writing instruments
   - ☐ Other: _____

   *What is the student expected to do that he/she is unable to do regarding his/her writing skills?* _____

**Student Name:** _____ **Date of Birth:** _____

*What interventions have been tried to date? Over what period of time?* _____

4. GROSS MOTOR

- ☐ Observable poor balance
- ☐ Difficulty with walking, hopping, jumping, or running as compared to peers
- ☐ Difficulty catching and throwing as compared to peers
- ☐ Appears stiff and awkward in his/her movements
- ☐ Clumsy, seems not to know how to move his/her body
- ☐ Bumps into people and things, falls out of chair
- ☐ Difficulty negotiating playground equipment as compared to peers
- ☐ Poor desk posture (slumps, leans on arm, head too close to work, and other hand does not assist)
- ☐ Tripping or falling on playground or rough terrain
- ☐ Other: _____

*What is the student expected to do that he/she is unable to do regarding gross motor tasks?* _____

*What interventions have been tried to date? Over what period of time?* _____

5. SENSORY PROCESSING

- ☐ Has difficulty with noise
- ☐ Is tactile defensive (will not touch messy objects/does not like to be touched)
- ☐ Displays unusual need to touch objects/textures
- ☐ Crashes into objects/rough with people or objects
- ☐ Puts objects in mouth
- ☐ Seeks excessive movement/has difficulty sitting still
- ☐ Other: _____

*What is the student expected to do that he/she is unable to do regarding his/her self-care skills?* _____

*What sensory interventions have been tried to date? Over what period of time?* _____

**ADDITIONAL INFORMATION**

List any specialized equipment that the student uses: _____

Other comments: _____

Referred By: _____ Relationship to Student (parent, teacher, etc.): _____

Signature: _____ Date: _____

Special Education Director Signature: _____ Date: _____

PLEASE ATTACH A COPY OF THE STUDENT'S LATEST PSYCHOLOGICAL REPORT, CURRENT IEP REFERRING FOR AN OT ASSESSMENT AND ANY ADDITIONAL INFORMATION SUCH AS DOCTOR REPORTS, SPEECH/LANGUAGE REPORTS, PREVIOUS OT REPORTS, ETC.

**PLEASE NOTE: INCOMPLETE REFERRALS WILL BE RETURNED FOR COMPLETION AND RESUBMISSION.**