Occupational Therapy Screen Referral

Student Profile:

Date of Request: _____
Name: _____
Date of Birth: _____
Caregiver(s): _____
Caregiver Contact: _____
Grade Level: _____
Referral Source: _____
Teacher: _____

Current Services/Therapies (circle all that apply):

Speech Therapy Physical Therapy

Counseling

Other Related Services:_____

Reason for Referral:_____

_____
_____
_____
_____

Behavioral Observations: (specify impact on classroom performance):

_____
_____
_____
_____

Signature _____ Date: _____

*Please return this form to your school occupational therapist for a screen to be conducted at the earliest availability. Thank you for your time.