

**Occupational Therapy Request for Student Assistance**

*\*This is not considered a request for a specialized evaluation\**

**Student:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Grade/Placement:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Person Submitting the Request:** \_\_\_\_\_

**School Attending:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_ **IEP :** \_\_\_\_\_ **y/n** \_\_\_\_\_

**CONCERNS:**

**Fine Motor Skills:**

- \_\_\_ Difficulty opening containers: drink, etc
- \_\_\_ Slow/difficult manipulation of objects
- \_\_\_ Poor hand/finger strength
- \_\_\_ Uses awkward/unusual grip or pinch
- \_\_\_ Difficulty with scissor skills
- other: \_\_\_\_\_

other: \_\_\_\_\_

**Handwriting: (add samples)**

- \_\_\_ Poor pencil grip
- \_\_\_ Difficulty forming UC and LC letters
- \_\_\_ Difficulty adhering to line, size & space
- \_\_\_ Poor legibility
- \_\_\_ Difficulty copying from the board
- \_\_\_ Difficulty copying from near point

**Self-Care:**

- \_\_\_ Difficulty with self-feeding
- \_\_\_ Difficulty with dressing, fasteners
- other: \_\_\_\_\_

**Sensory Integration/Processing:**

- \_\_\_ Defensive to touch
- \_\_\_ Exhibits self-stimulating behavior
- \_\_\_ Clumsy, poor planning of movement
- \_\_\_ Does not like loud noises
- \_\_\_ Seeks movement at inappropriate times
- other: \_\_\_\_\_

Comments/Primary reason for referral to OT:

\_\_\_\_\_

\_\_\_\_\_

What interventions have been attempted:

\_\_\_\_\_

\_\_\_\_\_

**These concerns have been discussed with the parent and they are aware that the teacher will be consulting with occupational therapy for the student to be individually, briefly screened for fine/visual/sensory motor concerns.**

**Parents:** \_\_\_\_\_ **Date Contacted:** \_\_\_\_\_ **Method of contact:** phone/email/in person