Turn Center
1250 Wallace Blvd., Amarillo, TX 79106
(806) 353-3596 Fax: (806) 3534927

Occupational Therapy/ Physical Therapy Evaluation Referral

Consent Form: Yes___No__
Prescription: Yes___No__
Due Date:______________

Student: ______________________ Parent/Guardian:______________________

Home Address: ______________________ City: ______________ St: ______ Zip: ________

D.O.B. ______________ Home Phone: ______________

School: ______________ Grade: ______________ Teacher: ______________

Teacher Email: ______________________

Physician: ______________________ Medical/Eligibility Diagnosis:______________________

Date of Last Annual ARD: ______________________ Date of Comprehensive Assessment:______________

Concerns related to student's educational program to be addressed by OT and/or PT: ______________________

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Physical/Motor Problems related to learning: ______________________

____

Intellectual function: ____

Equipment Needs: ____

An OT Eval may be indicated if one or more of the following conditions are checked:

Motor/perceptual skills that interfere with classroom performance or participation:

_____Delayed motor development
_____Appears uncoordinated or clumsy
_____Difficulty with writing, copying, Tracing or cutting

Difficulty with self-help skills:

Feeding

_____Chewing, eating solid foods, drinking
_____Using eating utensils

Dressing

_____Lacks age-appropriate skills
_____Alternative techniques or additional Assistance required

Toileting

_____Not toilet trained/scheduled
_____Requires adaptive equipment

Sensory Processing Difficulties:

____Difficulty taking in sensory information from one's body and environment; and organizing this information to function appropriately in the classroom.

☐ **Occupational Therapy Evaluation**

A PT Eval may be indicated if one or more of the following conditions are checked:

Difficulty with mobility skills that interfere with classroom performance or participation:

_____Use of a wheelchair
_____Requires assistive devices or assistance to walk
_____Walks independently but with difficulty
_____Uses rolling, crawling or scooting for mobility
_____Is not independently mobile

Requires Positioning Assistance:

_____Has or needs adaptive positioning equipment
_____Significant postural problem affecting classroom performance/participation

Physical or Motor deficits are present:

_____Poor motor control
_____Active movement is absent, weak or stiff
_____Joint contractures or changes in muscle tone
_____Significant postural problem affecting classroom performance/participation
_____Lack of age-appropriate balance or coordination skills
_____Difficulty participating in age-appropriate play

☐ **Physical Therapy Evaluation**

Referring Contact Name/Title:______________________ Date:______________

Phone: ______________________ Email: ______________________