REQUEST FOR EVALUATION
OCCUPATIONAL AND/OR PHYSICAL THERAPY

PURPOSE: The purpose of these services is to provide a comprehensive assessment and/or interdisciplinary evaluation of children with disabilities or those suspected of being disabled.

EVALUATIONS PROVIDED: Occupational Therapy (OT) and Physical Therapy (PT)

REQUEST FOR EVALUATION PROCESS:

For the students within the BHASED Coop:

1. When/if the need for an OT/PT evaluation is suspected, contact Lynette Hubbard, Supervisor OT/PT Services or the OT/PT working in your building to discuss concerns and information needed.

2. Following discussion, the request for evaluation packet is completed using these steps:
   A. Complete all elements of descriptive information on page 1.
   B. Put an X next to the evaluation(s) requested. Note: A current psychological evaluation is not required for submission but attach if previously completed.
   C. Complete the Teacher Summary Report (pages 2-5).
   D. The assigned therapist(s) will assist with the completion of the Release of Information (page 6).
   E. Obtain signatures of the building Principal and the Special Education Coordinator for your district. Please follow up in obtaining these signatures as quickly as possible.

3. Submit the request for evaluation to Lynette Hubbard, Supervisor of OT/PT Services at BHASED.

4. Lynette Hubbard, OT/PT Supervisor, will contact local building personnel notifying them of the receipt of the request for evaluation and to discuss the need for an in-take meeting. At the intake meeting the IEP team will either reject or accept the request for evaluation. If the decision is to accept the request for evaluation, the IEP team will complete the domain grid (ISBE 34-57 B, .2) and request parent signature for evaluation (ISBE 34-57 B, p. 1). If the request for evaluation is rejected, the team will then attempt to determine/implement appropriate accommodations to attempt to assist the student.

5. If the team decides that an OT/PT evaluation is warranted, please return the completed evaluation packet along with ISBE 34-57 B pgs. 1&2. (consent for evaluation form)

6. Once the therapy evaluation has been completed, you will need to schedule a meeting with the IEP team to review evaluation results and determine eligibility. Please contact the therapist to determine a mutually agreeable time for this IEP meeting.

7. A physician's prescription for treatment will be sought by the therapist(s) after the IEP meeting, should services be required. Services will be initiated once the physician's prescription has been received.

For students who transfer into the BHASED Cooperative with OT/PT in their IEP:

1. Upon receipt of IEP information indicating previous OT/PT related service recommendations, contact the building OT, PT or Lynette Hubbard, OT/PT Supervisor at 796-2500.

2. School personnel needs to complete **page 1** of the OT/PT request for evaluation packet, to update caseload information for therapist and provide the therapist with a copy of the therapy records/information from the previous district.

3. **A physician's prescription for treatment will be obtained by the therapist(s) prior to the beginning of any service.**

4. If needed OT or PT will initiate a program amendment to address any concerns/changes.

For students who are transitioning into the BHASED Cooperative from 0-3 services who have been receiving either Occupational or Physical Therapy services at the time of transition:

1. The district should begin the intake process to review and discuss the child's needs, based upon the documentation provided by the 0-3 providers. It would be beneficial to make that information available to the therapist(s) prior to determining whether an OT/PT evaluation should be conducted.

2. Please complete page 1, 2, and the bottom of page 5 of the request for evaluation packet and provide copies of the 0-3 records and submit them to the therapist who is presently working in your building or Lynette Hubbard, OT/PT Supervisor at 796-2500.

3. If the team should decide to move forward with the evaluation(s) the team could:
   a. Choose to initiate the request for evaluation
   b. Choose not to initiate the request for evaluation
   c. Choose to determine placement first, observe the child for a designated period of time and then reconsider the need for request for evaluation.
   This decision should be documented on the domain page grid.

4. Should the district decide to move forward with a therapy request for evaluation, it will be necessary for them to complete the domain grid page and obtain parental permission for evaluation pages (ISBE 34-57 B p. 1, 2) and forward that information, to Lynette Hubbard, OTR/L at BHASED to initiate the evaluation.

5. Once the therapy evaluation has been completed, the IEP team will meet to review evaluation results and determine eligibility. Please contact the therapist to determine a mutually agreeable time for the IEP meeting.

6. A physician's prescription for treatment will be sought by the therapist(s) after the IEP meeting, <u>should services be required</u>. Services will be initiated once the physician's prescription has been received.

REQUEST FOR EVALUATION - OCCUPATIONAL/PHYSICAL THERAPY SERVICES

Student's Full Name: _____Birthdate: _____Sex:_____

District: _____ Building: _____ Grade: _____

Parent/Guardian: _____ Phone: (home) _____(work) _____

Address: _____

Other services receiving: Speech_____ Resource_____ ESL _____ Reading Recovery_____ RTI_____

Classroom Teacher: _____ Disability: _____

Request for evaluation Prepared By: _____Phone:_____

Date: _____ Teacher's Email address: _____

DIRECTIONS: Please indicate the type of evaluation(s) being requested or suspected as necessary. In order for any request for evaluation to be considered, copies of specific documents are being requested and must be attached to this form. The requested documents for each category of evaluation are listed under the appropriate heading and space has been left to check off district receipt.

Request for evaluation WITH INCOMPLETE PAPERWORK WILL BE RETURNED for completion.

___ **OCCUPATIONAL THERAPY - (fine motor skills, visual-perceptual skills, self-help, etc.)**

As of 1/1/94 the State of Illinois no longer requires a physician's request for evaluation for initial evaluation.

___ Current Psychological (If Available)
___ Current IEP
___ Release of Information
___ Teacher Summary Report
___ RTI information

___ **PHYSICAL THERAPY - (gross motor skills, balance, gait, mobility, etc.)**

As of 1/1/94 the State of Illinois no longer requires a physician's request for evaluation for initial evaluation.

___ Current Psychological (If Available)
___ Current IEP (If Available)
___ Release of Information
___ Teacher Summary Report
___ RTI information

TEACHER SUMMARY REPORT
CRITICAL INFORMATION
(Please complete in full)

MEDICAL INFORMATION

Does the student have a diagnosed medical/physical disability? ___ No ___Yes (indicate) _____

_____

Primary physician's name_____

Other medical specialists? ___No ____Yes (Please list all) _____

Allergies: _____

Medications: _____

Do any of the above affect school performance? _____

Does the student use any special/adaptive equipment? (glasses, hearing aid, communication board)
____No ____Yes (indicate)_____

Has the student ever received OT and/or PT services?

1. In the educational setting ____No ____Yes When? _____ Where? _____
2. Outside the educational setting ____No ____Yes When? _____ Where? _____

What is the reason for request of evaluation?

_____

_____

_____

_____

What do you view as this student's preferences/motivations?

_____

_____

_____

INSTRUCTIONS FOR USE: Please consider this student's performance in the following areas in relation to program expectations for participation and in comparison with peers within his/her **educational** setting. Please mark your response and add any description of the student's performance which would help the therapist better understand the student's function within the school program. When describing, indicate **severity and/or frequency** of interference with the student's program. Complete all spaces.

If you mark a section NO continue on to the next section/area. If Yes complete all spaces within the section.

1. **MOBILITY** **Area of concern? _____ No ____ Yes (If yes, describe below)**

a. List any concerns regarding independent mobility: (examples: stairs, using playground equipment, transfers, transitioning between classrooms) _____

_____

_____

b. Are there any safety concerns? (example: frequent falls) _____

_____

_____

c. List any equipment student requires (examples: wheelchair, walkers, braces)_____

_____

_____

d. List any concerns regarding building accessibility (examples: bathroom, stairs)_____

_____

_____

2. **POSITIONING** **Area of concern? ____ No _____Yes (If yes, describe below)**

a. List any concerns about ability to achieve/maintain positions. (examples: sitting at desk, standing, difficulty positioning self and material)_____

_____

_____

b. Does the student demonstrate any atypical/awkward postural habits? (examples: tilts head, leaning, props head on hands or lays on desk.) _____

_____

_____

3. **PHYSICAL PERFORMANCE** **Area of concern? _____ No ____Yes (If yes, describe below)**

a. List any concerns regarding quality of movement (examples: coordination, fatigues easily, unsafe when attempting to use equipment) _____

_____

_____

b. Is the child fearful of movement? (example: avoids playground equipment)_____

_____

_____

c. Has the P.E. teacher expressed concerns/been consulted regarding student participation/performance?

(Please list)_____

_____

_____

4. **FINE MOTOR HAND SKILLS** **Area of concern? ____ No _____ Yes (If yes, describe below)**

Difficulty with grasp/release activities (stringing beads, small objects, holding pencil, etc.)

	No	Yes	
Display safety concerns when using crayons, pencils, scissors, etc.	___	___	_____
a. Demonstrates inadequate pressure and decreased control when coloring/writing. (Circle an option)	___	___	Firm / Light / Adequate
b. Seems to tire easily while writing/coloring.	___	___	_____
c. Does the student utilize any fine motor adaptive devices? (i.e.: loop scissors, pencil grip, adaptive spoon, slant board, paper, etc.)?	___	___	_____

5. **ACTIVITIES FOR DAILY LIVING** **Area of concern? ____ No ____ Yes (If yes, describe below)**

Does this student have difficulty performing any of the following age appropriate self-care skills in the school setting?

	No	Yes	
a. Dressing and Toileting (coat, shoes, boots, mitten, tying)	___	___	_____
b. Fasteners (zipper, button, snaps, shoe tying)	___	___	_____
c. Requires excessive time to complete tasks.	___	___	_____
d. Difficulty with self-cares impacts social acceptance of peers	___	___	_____
e. Personal hygiene	___	___	_____

6. **ORAL MOTOR/RESPIRATION** **Area of concern? ____ No _____ Yes (If yes, describe below)**

Does the student demonstrate difficulty with oral motor skills?

a. Displays difficulty or safety concerns during eating (i.e.: choking, gagging, spitting food, over stuffing mouth) _____

_____

b. Demonstrates atypical breathing (i.e.: mouth, shallow, audible) _____

c. Difficulty producing understandable verbal language _____

_____

d. Demonstrates atypical facial expressions or unnecessary movements of the mouth during activities (i.e.: tongue thrusting, grimacing) _____

_____

e. Demonstrates drooling (if yes when?)_____

f. Pushes food away and/or pushes self away from table during feeding_____

7. **COMMUNICATION** **Area of concern? ____ No _____ Yes (If yes, describe below)**

Does the student demonstrate difficulty with functional communication skills?

	No	Yes	
a. Display expressive language deficits (i.e.: communicate with peers or adults, word retrieval)	___	___	_____
b. Produces meaningful written communication	___	___	_____
c. Does the student have augmentative communication	___	___	_____

8. **ATTENTION** **Area of concern? ____ No _____ Yes (If yes, describe below)**

Does the student have difficulty attending to tasks adequately?

	No	Yes	
a. Seems easily distracted or startled by activity in the environment (extraneous noise, movement, and/or materials)	___	___	_____
b. Seems to be constantly moving in his/her seat	___	___	_____
c. Seems to be overly tired during classroom activities	___	___	_____
d. Uses repetitive and/or atypical movement patterns to accomplish activities	___	___	_____

9. **ORGANIZATION** **Area of concern? ____ No _____ Yes (If yes, describe below)**

Does the student need assistance organizing materials, work space, fine-motor activities adequately?

	No	Yes	
a. Have difficulty following classroom routine	___	___	_____
b. Require extended time or shortened assignments	___	___	_____
c. Need individual cues or assistance to complete a sequence of directions	___	___	_____
d. Seems messy or unorganized while completing writing and or art projects	___	___	_____

10. **ENVIRONMENTAL INTERACTION** **Area of concern? ____ No _____ Yes (If yes, describe below)**

Does the student have difficulty interacting appropriately with peers and/or adults?

	No	Yes	
a. Is easily provoked when			
1. Positioned near others	___	___	_____
2. Touched by others	___	___	_____
3. Exposed to auditory stimuli	___	___	_____
4. Exposed to visual/environmental stimuli	___	___	_____
b. Display decreased eye contact	___	___	_____

11. Does this student have a formal behavior management program? _____ No _____ Yes Please attach

12. What methods/techniques have been utilized to address the above stated needs? Is there any additional significant information to include?

_____

_____

_____

Person(s) completing this form_____Date_____

Signing below indicates you are aware of the request for evaluation.

_____Date_____

Building Principal

_____Date_____

Special Education Coordinator

THERAPY RELEASE OF/REQUEST FOR INFORMATION

Student:_____ District:_____

Parent: _____ Birthdate:_____

City/Zip:_____ Phone:_____

(Please change any incorrect information listed above.)

In order to allow your child to receive therapy and to facilitate communication, your written consent is required. Please fill in the following information in the blanks below.

1. Indicate your child's primary treating physician, from whom a prescription for therapy should be obtained.

2. Indicate any additional physicians and/or non-educational agencies (such as clinics) to be included in your child's treatment planning.

3. Date and sign form.

I give consent to _____ to release written therapy reports and verbal information, and to obtain medical request for evaluation for therapy, records, reports and verbal information, regarding the therapy program of my child, to/from:

Primary Physician: _____
Other physicians/agencies: _____
_____
_____

This release is effective from August 1, 20_____ to August 1, 20_____.

_____ _____
Date Parent/Guardian Signature

_____
Child's Name

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For Office Use

_____
Therapist's Name