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**MIDDLE / HIGH SCHOOL OCCUPATIONAL THERAPY**

**EVALUATION OF FUNCTION AND PARTICIPATION**

**RATING IN COMPARISON TO CLASSMATES**

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| **Student:** | | | **NYC ID:** | | | | | **DOB:** | | | | | **Age:** | | | **Grade:** |
| **District / Borough / School:** | | | **Class Program: Gen Ed \_\_­\_\_ ICT \_\_\_\_ Special Class \_\_\_\_ Class Size / Ratio \_\_\_\_** | | | | | | | | | | | | | |
| **Disability Classification:** | | | **Diagnosis:** | | | | | | | | **Alerts:** | | | | | |
| **Parent / Guardian:** | | | **Telephone #:** | | | | | | | | **Medication:** | | | | | |
| **Primary Physician:** | | | **Telephone #:** | | | | | | | | **Method of Mobility:** | | | | | |
| **Evaluator’s Name:** | | | **Date of Evaluation:** | | | | | | | | **Evaluator: DOE \_\_\_ Agency \_\_\_** | | | | | |
| **Referred by:** | | | **Teacher:** | | | | | | | | **Date of Previous IEP:** | | | | | |
| **Referral Type: Initial \_\_\_\_ (no previous IEP) Add OT to IEP \_\_\_\_ 3 Year Review \_\_\_\_ Requested Review \_\_\_\_** | | | | | | | | | | | | | | | | |
| **Services Receiving:** |  | **Paraprofessional**  **\_\_\_crisis \_\_\_\_ health \_\_\_ mobility** | | |  | **OT** |  | **PT** |  | **Speech** | |  | | **Counseling** |  | **Other** |
| **Existing OT Mandate:** | | | | **Test Accommodations:** | | | | | | | | | | | | |
| **Assistive Devices or Technology / Adaptive Equipment: *(note if in need of repair)*** | | | | | | | | | | | | | | | | |

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| **METHOD OF EVALUATION** | | | | | | | | | | | | | |
|  | **Classroom Observation** |  | **Clinical Observation** |  | **Parent Report** |  | **Teacher Report** |  | **Review of**  **Documents** |  | **COSA**  **Student Interview** |  | **Para Interview** |
|  | **Adolescent**  **Sensory Profile** |  | **VMI** |  | **KELS**  **School AMPS** |  | **SFA**  **GOAL** |  | **THS**  **WOLD** |  | **Vocational**  **Self-Assessment** |  | **Other** |

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| **Section 1: BACKGROUND INFORMATION** |

*Based on OT Teacher Report, Parent Report, and chart review*

***Developmental & Medical History / Relevant Background Information / Reason for Referral***

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| Description here |

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| **Section 2: CLASSROOM FUNCTION & PARTCIPATION** |

**PRIMARY SCHOOL-BASED CONCERNS:** *Based on OT Teacher Report*

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| --- | --- |
| **PRIMARY CONCERN # 1** | Text here |
| **PRIMARY CONCERN # 2** | Text here |
| **PRIMARY CONCERN # 3** | Text here |

**ADDITIONAL CONCERNS:** *Based on OT/PT Parent Checklist and/or observation*

|  |  |
| --- | --- |
| **Parent Concerns** | Text here |
| **Observational Concerns** | Text here |

**LEARNING & PARTICIPATION IN COMPARISON TO PEERS:** *Based on OT Teacher Report*

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| **Grade Level** | **School Activity** | **Above** | **Comparable** | **Below** | **School Activity** | **Above** | **Comparable** | **Below** |
|  | **English Language Arts** |  |  |  | **Electives / Extracurricular** |  |  |  |
|  | **Math** |  |  |  | **Physical Ed. / Sports** |  |  |  |
|  | **Science** |  |  |  | **Attendance** |  |  |  |

**CLASSROOM OBSERVATION**

|  |
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| Text here |

**SOCIAL PARTICIPATION AND EMOTIONAL REGULATION:** *Based on observations in classroom & during evaluation, and/or OT Teacher Report & Parent Report*

***Developing friendships, working cooperatively, managing emotions, advocating for self, demonstrating self-awareness, demonstrating socially appropriate behaviors, using judgement, making responsible choices, expressing needs, etc.***

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| Text here |

**WORK BEHAVIORS:** *Based on observations in classroom & during evaluation and/or OT Teacher Report & Parent Report*

***Following directions, rules, and routines, sustaining effort to complete tasks, attending to lessons and work, solving problems, completing work on time, organizing materials, completing work independently, making decisions, etc.***

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| Text here |

**STUDENT INTERVIEW**

***Student interests, point of view, feelings about school, etc.***

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| Text here |

**STUDENT STRENGTHS**

***Personal, social, functional, etc.***

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| Text here |

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| **Section 3: SKILL ASSESSMENT** |

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| **ACCESS / MOVEMENT** | **SUPPORTS**  **School Function** | **Difficulty noted,**  **DOES NOT significantly impede function** | **Difficulty noted, SIGNIFICANTLY impedes function** |
| **Adjusts position for comfort / maintains posture** |  |  |  |
| **Accesses all areas of building with or w/o equipment** |  |  |  |
| **Moves without fatigue / keeps pace with class** |  |  |  |
| **Navigates safely to destination in school or community** |  |  |  |

**\_\_\_\_\_ No significant difficulties noted**

**\_\_\_\_\_** **Description of difficulties, impact on participation**

|  |
| --- |
| Description here |

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| **LIFE SKILLS** | **SUPPORTS**  **School Function** | **Difficulty noted,**  **DOES NOT significantly impede function** | **Difficulty noted, SIGNIFICANTLY impedes function** |
| **Manages bathroom / hygiene /dressing / meals** |  |  |  |
| **Organizes folders / notebooks / book bag / locker** |  |  |  |
| **Tells time / uses planner / refers to calendar** |  |  |  |
| **Identifies personal information / completes forms** |  |  |  |
| **Makes purchase / counts change / makes budget** |  |  |  |
| **Reads bus or subway map / uses public transportation** |  |  |  |

**\_\_\_\_\_ No significant difficulties noted**

**\_\_\_\_\_** **Description of difficulties, impact on participation**

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| Description here |

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| **MANAGEMENT OF CLASSROOM TOOLS & MATERIALS** | **SUPPORTS**  **School Function** | **Difficulty noted,**  **DOES NOT significantly impede function** | **Difficulty noted, SIGNIFICANTLY impedes function** |
| **Uses pen, ruler, calculator, combo lock, etc.** |  |  |  |
| **Copies / writes independently, legibly, & at pace** |  |  |  |
| **Uses keyboard / computer / tablet** |  |  |  |

**\_\_\_\_\_ No significant difficulties noted**

**\_\_\_\_\_** **Description of difficulties, impact on participation**

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| Description here |

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| **SENSORY SKILLS FOR LEARNING** | **SUPPORTS**  **School Function** | **Difficulty noted,**  **DOES NOT significantly impede function** | **Difficulty noted, SIGNIFICANTLY impedes function** |
| **Auditory: Responds appropriately to environmental sounds** |  |  |  |
| **Visual: Responds appropriately to visuals during instruction** |  |  |  |
| **Tactile: Responds appropriately to touch and various textures** |  |  |  |
| **Proprioception: Adjusts force when handling or moving objects** |  |  |  |
| **Vestibular: Sits without excessive rocking, bouncing, or spinning** |  |  |  |
| **Maintains personal space** |  |  |  |

**\_\_\_\_\_ No significant difficulties noted**

**\_\_\_\_\_** **Description of difficulties, and underlying skills that impact participation**

**If significant difficulty is noted, indicate over-responsiveness or under-responsiveness**

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| Description here |

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| **PRE-VOCATIONAL SKILLS** | **SUPPORTS**  **School Function** | **Difficulty noted,**  **DOES NOT significantly impede function** | **Difficulty noted, SIGNIFICANTLY impedes function** |
| **Follows directions / rules / schedule** |  |  |  |
| **Sustains effort to complete tasks within allotted time** |  |  |  |
| **Submits work on time / works independently** |  |  |  |
| **Identifies / explores realistic post high school goals** |  |  |  |
| **Participates in work or volunteer activities** |  |  |  |

**\_\_\_\_\_ No significant difficulties noted**

**\_\_\_\_\_** **Description of difficulties, impact on participation**

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| Description here |

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| **Section 4: SUMMARY & RECOMMENDATION** |

**CONSIDERATIONS**

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| ***Prior to recommending OT services, the IEP team must determine if the student meets the eligibility requirements for special education. Special education services require identification of a specific disability classification.***  **SCHOOL-BASED OT SERVICES** are designated for eligible students whose difficulties significantly impede participation in school. OT promotes strategies to be implemented by teachers/family for students who are not eligible for services.  **WRITING FUNCTION** is influenced by hand skills, expressive writing abilities, academic skills and work behaviors. Functional writing difficulties for middle school/high school students are best addressed through modifications, accommodations, appropriate instructional technology and/or assistive technology and academic support.  **BEHAVIOR** is most effectively addressed by teachers within the classroom. OT supports students by providing strategies to promote work behaviors and support social-emotional learning, self-regulation and self-management. |

**SUMMARY**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Reason for referral / Brief overview of strengths & weaknesses / Impact on school function*** | | | | |
| Description here | | | | |
| ***Primary Concerns*** | | | |  |
|  | | | **Yes** | **No** |
| **PRIMARY CONCERN # 1** |  | **Is this area best**  **addressed by OT?** |  |  |
| **PRIMARY CONCERN # 2** |  | **Is this area best**  **addressed by OT?** |  |  |
| **PRIMARY CONCERN # 3** |  | **Is this area best**  **addressed by OT?** |  |  |
| **ADDITIONAL CONCERNS** |  | **Is this area best**  **addressed by OT?** |  |  |
| ***Factors contributing to difficulties and Primary Concerns / Rationale for recommendation*** | | | | |
| Description here | | | | |

**RECOMMENDATION:** *Final recommendations to be determined at the IEP meeting*

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|  | **NO** | |
|  |  | **Concerns are best addressed by the primary educational program or other methods** |
|  |  | **Current function is at an appropriate level given the nature of student’s overall learning profile / disability** |
|  | **Concerns do not significantly interfere with function and participation in school** |
|  | **Graduation from OT is recommended as IEP goals have been met / performance can no longer be improved by OT** |

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| --- | --- | --- | --- | --- |
|  | **YES Contingent upon meeting eligibility criteria; final recommendation determined at IEP meeting** | | | |
|  |  | **Initiate OT services** |  |  |
|  |  | **Continue OT at current mandate** |
|  |  | **Continue OT at modified mandate** |

**RECOMMENDED OT MANDATE**:

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| --- | --- | --- | --- | --- | --- |
| **FREQUENCY** | **WEEKLY** | **MONTHLY** | **DURATION**  15 30 45 OTHER | **GROUP SIZE**  MAX = 8 | **LOCATION**  SEPARATE / GENERAL ED / SPECIAL ED |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**SUGGESTIONS TO CONSIDER / STRATEGIES TO PROMOTE FUNCTION**

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|  | **Consultation with Pediatrician** |  | **Community Counseling** |  | **School Counseling** |  | **Additional Academic Supports** |
|  | **Physical Therapy Observation** |  | **Assistive Technology** |  | **Test Modifications** |  | **Speech Therapy Observation** |
| **ADDITIONAL SUGGESTIONS: *Classroom strategies / Community resources / Home programs***  Text here | | | | | | | |

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| **EVALUATOR SIGNATURE** | **DATE** |