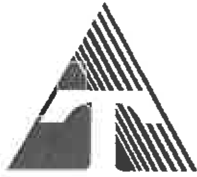


TRUMBULL COUNTY EDUCATIONAL SERVICE CENTER

6000 Youngstown Warren Road • Niles, Ohio 44446 • Phone (330) 505-2800

Michael W. Hanshaw
Superintendent

Kathleen Vilsack
Director, Pupil Services
Susan Shutrump, OTR/L
Supervisor, OT/PT Services

Dear Referring Agent:

Thank you for your interest in Occupational and/or Physical Therapy Services of the Trumbull County Educational Service Center. Due to the nature of these services, it is important that the following information be forwarded to us at the Trumbull County Educational Service Center **before** the child can be seen for an evaluation.

Please note that the items below have been combined for Occupational and Physical Therapy. If they have already been filled out during the present school year, copies can be sent. If both services are being requested, please send separate copies to both the Occupational and Physical Therapy Departments.

1. Signed Parent Consent for Evaluation Form PR-05: ODE Special Education Forms.

   Please be certain that the services which are being requested are identified. This should be done by attaching one of the ODE Evaluation Team Report Planning Forms (PR-06 ETR Form), with OT and/or PT written in to identify the person responsible for the assessment and report under the fine and/or gross motor sections.

2. Medical History TC06-4A to be filled out by the child's parent or guardian.

3. Parent Checklist TC06-4B to be filled out by the child's parent or guardian.

4. Therapy Prescription to Meet the Educational Needs of the Child TC06-4 to be filled out by the child's physician or Parent Consent for Physician Notification TC06-4D to be filled out by the child's parent or guardian. When using the prescription form, please be certain the appropriate discipline is written in the blank at the top of the form and that the physician has written in a diagnosis.

5. Copies of any present or previous summary reports from other disciplines involved with the child, (i.e. Occupational Therapy, Physical Therapy, Psychology, Speech Pathology, etc.) which would be helpful in the evaluation process.

6. Teacher Checklist for Problems Noted in the Classroom TC06-4C to be filled out by the child's teacher.

Upon receipt of the above information, you will be contacted to schedule an appointment for a therapy evaluation.

Thank you for your consideration on this matter.

Sincerely,
Susan Shutrump
OT/PT Supervisor

TC06-4A

TRUMBULL COUNTY EDUCATIONAL SERVICE CENTER
OCCUPATIONAL AND PHYSICAL THERAPY PROGRAM
MEDICAL HISTORY

(to be filled out by parent)

STUDENT NAME: ______________________________ DATE OF BIRTH: ____________________

SCHOOL ATTENDING: _________________________ PROGRAM: _________________________

PARENT'S TELEPHONE NUMBER: ____

PARENT'S NAME AND ADDRESS: ____

____
Street City State Zip

CHILD'S PHYSICIAN'S NAME, ADDRESS, AND PHONE NUMBER:_____________________________

____ (   )   -
Street City State Zip Phone #

Please check any of the following conditions which apply to your child either now or in the past:

___ seizures ___ diabetes ___ asthma
___ allergies ___ orthopedic problems ___ frequent ear infections

Other medical problems. Explain: ____

____

Please explain in detail any of the items checked above: ____________________________________

____

____

Please check any of the following, which are appropriate. My child uses:
____glasses ____ hearing aide ____wheelchair ____bracing ____splints ____prosthesis

___ any other adaptive device. Explain: ____

____

Please list any medications which your child is now taking:_________________________________

____

Please comment on any other information which you feel could be of benefit to the therapist doing the evaluation:

____

____

To the best of my knowledge, the above information is complete and correct. If there is a change in this information, I will notify the school immediately. I understand that this information will be shared with staff of Trumbull County Educational Service Center

______________________________ ______________________
Parent's Signature **Date**

TRUMBULL COUNTY EDUCATIONAL SERVICE CENTER
OCCUPATIONAL AND PHYSICAL THERAPY PROGRAM
PARENT CHECKLIST

(To be completed by parent or legal guardian)

Student's Name: ______________________________ Date: ____________________
Date of Birth: ______________________________

NOTE: Not all of these items may be applicable to your child. Please comment only on the pertinent items.
Answer: **Y** (Yes) **N** (No) **NA** (not applicable)

I. SELF CARE:

A. FEEDING:

Does your child have difficulties in the area of feeding? _______
If yes explain: ____
____
____

B. Dressing Skills:

Does your child have difficulties in the area of dressing? _______
If yes explain: ____
____
____

Can he/she do the following:

_____ buttons _____ belt buckles _____ tie shoes _____ zippers _____ brush teeth
_____ unlace _____ comb hair _____ snaps _____ lace _____ wash hands
_____ put on brace/splint/prosthesis _____ remove brace/splint/prosthesis

C. Toileting:

_____ wears diapers/ pull ups _____ indicates need to use rest room
_____ toilet trained: _____ day _____ night _____ bowel _____ bladder

II. FUNCTIONAL SKILLS:

Does he/she have difficulty in any of the following:

_____ climbing and descending stairs _____ getting in or out of the bathtub
_____ getting on or off the toilet _____ getting down to or up from the floor

Answer: **Y** (Yes) **N** (No) **NA** (not applicable)

III. FINE MOTOR:

__________ Is he/she able to copy shapes
__________ Does he/she appear to use his/her whole hand to grasp a crayon?
__________ Does he/she have a preferred hand? If so, which hand? _____Right ____Left
__________ Does he/she enjoy sitting and coloring?
__________ Can he/she cut with scissors?
__________ Can he/she stack blocks (make a tower)?
__________ Does he/she enjoy puzzles?
__________ Does he/she string beads and turn pages one at a time?

IV. GROSS MOTOR:

__________ Does he/she seem weaker than others his/her age, tire easily?
__________ Does he/she have difficulty hopping, jumping, skipping, or running when compared to others his/her age?
__________ Does he/she appear stiff and awkward in his/her movements
__________ Does he/she seem clumsy, bump into things or fall out of his/her chair?
__________ Does he/she have a tendency to confuse right and left?
__________ Does he/she prefer table top activities to playground participation?
__________ Does he/she ignore one side of his/her body in different tasks?

V. SENSORY PROCESSING

__________ Does he/she seem to withdraw from touch, dislike being cuddled or hugged?
__________ Is he/she apt to touch everything he/she sees, "learning through his/her fingers?"
__________ Does he/she tend to wear a coat when not needed or not allow shirtsleeves to be pulled up?
__________ Is he/she sensitive to any kind of movement (i.e., spinning, swinging)?
__________ Does he/she avoid activities which challenge balance or have observable poor balance
__________ Does he/she excessively crave swinging, bouncing, slides, merry-go-rounds, rocking?
__________ Does he/she have a history of car sickness?
__________ Does he/she fear going on escalators, steps at stores?

VI. BEHAVIOR

__________ Does he/she become easily frustrated?
__________ Is he/she accident prone or impulsive?
__________ Does he/she display a short attention span?

Please describe any major concerns you have regarding the above areas:

____
____
____
____
____

This form must be returned prior to the scheduled school evaluation. It will be shared with the staff of the Trumbull County Educational Service Center. Thank you for your help. If you need assistance, please contact the therapy department at the Trumbull County Educational Service Center.

______________________________ ______________________
Parent's Signature Date

____
District Of Residence

TRUMBULL COUNTY EDUCATIONAL SERVICE CENTER
OCCUPATIONAL AND PHYSICAL THERAPY PROGRAM
PRESCRIPTION TO MEET EDUCATIONAL NEEDS OF THE CHILD

PART I. TO BE COMPLETED BY REFERRAL SOURCE

Student's Name: ______________________________

Address: ______________________________

A(n) ______________________ therapy evaluation has been requested for the above child. Following the evaluation, an individual program is designed for the student to provide treatment as indicated to meet their educational needs.

PART II. TO BE COMPLETED AND SIGNED BY THE PHYSICIAN

The following is to assist us in providing an appropriate program.

(1) Precautions
  a. Seizures Yes ______ No ______
  b. Lower extremity weight bearing allowable: Yes ______ No ______
  c. Other: ______________________________

(2) Surgical procedures (reports of recent surgeries would be appreciated)

____

____

(3) Type of orthotic or prosthetic appliances, if appropriate.

____

(4) Do you have any specific recommendations regarding this student?

____

____

If no, please explain: ______________________________

____

If you would prescribe evaluation and treatment as indicated in PART I., a student diagnosis and your signature are needed below.

Diagnosis: ______________________________

______________________________ ______________________________
Physician's Signature **Date**

Please print or type:

Physician's Name: ______________________________

Street: ______________________________

City, State, Zip: ______________________________ Phone: ______________

TRUMBULL COUNTY EDUCATIONAL SERVICE CENTER
OCCUPATIONAL AND PHYSICAL THERAPY PROGRAM
TEACHER CHECKLIST FOR PROBLEMS NOTED IN THE CLASSROOM

Student's Name:______________________________ Home School:____________________
Date: ______________________________ Program: ____________________
Teacher:______________________________

Please address all areas appropriate for the chronological age of the student referred:

Does the student:	Rarely	Consistently
1. Lose his/her place when reading	______	______
2. Have difficulty copying from the board	______	______
3. Have difficulty drawing basic geometric shapes?	______	______
4. Space poorly between letters or words?	______	______
5. Forget formation of letters?	______	______
6. Have difficulty staying on the line?	______	______
7. Grasp a pencil properly?	______	______
8. Draw lines too tightly, wobbly, faintly, or darkly? Circle appropriate descriptor.	______	______
9. Break pencils?	______	______
10. Have difficulty cutting?	______	______
11. Have difficulty coloring or drawing?	______	______
12. Reverse words/letters when writing?	______	______
13. Draw a human figure in proportion?	______	______
14. Know concepts of left and right?	______	______
15. React to touching (such as hand holding, pat on shoulder, etc.) with extreme reaction , craving touch, rejecting it or both? Circle appropriate description.	______	______
16. Avoid crowded situation such as group, story time, crowded hallways, or the middle of a line?	______	______
17. Have trouble keeping hands to self (pokes or pushes others)?	______	______

TEACHER CHECKLIST FOR PROBLEMS NOTED IN THE CLASSROOM

The following questions should be answered either **Yes** or **No**. Please feel free to comment on any problem areas.

18. Is he/she verbal? ______
19. Does he/she have difficulty-making himself/herself understand? ______
20. Is he/she a slow worker? ______
21. Does he/she appear hyperactive in the classroom? ______
22. Does he/she have difficulty following directions? ______
23. Does he/she appear distractible in the classroom? ______
24. Does he/she have difficulty remembering information? ______
25. Does he/she have problems in organizing his/her work? ______
26. Does he/she appear awkward when participating in playground and/or other gross motor activities at school? ______
27. Does he/she fall frequently? ______
28. Is his/her IQ within normal range? ______
29. Does he/she appear to have established a hand dominance? ______
30. Does he/she generally get tired more easily than the other children? ______
31. Does he/she appear to have poor desk posture? ______

What do you think about his/her behavior in general? ______________________________

____

____

Major Concerns/Comments:____

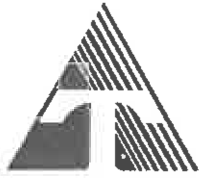
____

____

____

____

Thank you for your help. If we can be of service to you at any time, please call us at the Trumbull County Educational Service Center, (330) 505-2800.



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Michael W. Hanshaw
Superintendent

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Director, Pupil Services
Susan Shutrump, OTR/L
OT/PT Supervisor

PHYSICAL THERAPY PROGRAM TC06-4D

PARENT CONSENT FOR PHYSICIAN NOTIFICATION

Dear Parent/Guardian,

Your child has been referred by your school district for a physical therapy evaluation to be performed by staff of the Trumbull County Educational Service Center. In accordance with the Ohio Physical Therapy Practice Act, it is required that we have a prescription from your child's physician or that we notify them of the evaluation. In order to notify your child's physician, we need their contact information and your signed permission. For this evaluation to occur please provide the following information:

Child's Name:__________________________

Child's Date of Birth:_____________________

Physician's Name:_____________________________________

Address:____

____

Phone Number_______________________________________

Fax Number____

I give my permission to PT staff employed by the Trumbull County Educational Service Center to contact my child's physician following the evaluation.

____

Parent/Guardian Signature

____

Date