

Occupational Therapy Guidelines and Policies

For Educationally Based OT in Glenn County Schools

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August 2010

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Mission Statement

To provide and implement policies and procedures that will meet the occupational therapy needs of students in a uniform and consistent manner throughout Glenn County in compliance with federal regulations, state laws, and professional standards of practice.

1. Definition of Educational Occupational Therapy

Occupational therapy uses *purposeful, goal directed activities* to enable a student with a disability to benefit from an individualized educational plan (IEP). Specifically, therapy is designed to assist in the development of underlying performance components that are prerequisites for academic learning and vocational training within the child's current educational setting. Depending on the individual, *OT may include improving gross and fine motor skills, postural stability, coordination, motor planning, visual perception skills, sensorimotor processing, organizing and using materials appropriately, adapting environments/ alternative ways of completing activities, and/or self care skill development appropriate to the learning environment.*

FEDERAL DEFINITION

The federal definition of occupational therapy services within the context of special education.

34 CFR 300.34(a)(6) "Occupational Therapy" includes:

- (i) Improving, developing, or restoring functions impaired or lost through illness, injury, or deprivation;
- (ii) Improving ability to perform tasks for independent functioning if functions are impaired or lost; and
- (iii) Preventing, through early intervention, initial or further impairment or loss of function.

STATE DEFINITION

The Government Code, the Education Code, and Title 5 are all generally vague and/or silent with regard to a definition of occupational therapy.

EDUCATION CODE

For the children between the ages of 3 to 22:

56363(a) The term "related services" means transportation, and such developmental corrective, and other supportive services (including physical and occupational therapy...) as may be required to assist an individual with exceptional needs to benefit from special education, and includes the early identification and assessment of disabling conditions in children.

For children under 3 years of age:

56426.7 Medically necessary occupational therapy and physical therapy shall be provided to the infant when warranted by medical diagnosis and contained in the individualized family service plan, as specified under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

CALIFORNIA ADMINISTRATIVE CODE
TITLE 5 (EDUCATION)

3051.6 Occupational Therapy

- (a) When the district, special education local plan area, or county office contracts for the services of a physical therapist or an occupational therapist, the following standards shall apply:
 - (1) Occupational therapy shall provide services based upon the recommendation of the individual education program team. Occupational therapy services for infants are limited by Education Code 56426.6.
 - (2) The district, special education services region, or county office shall assure that the therapist has available safe and appropriate equipment.
- (b) Qualifications of therapist
 - (1) The occupational therapist shall have graduated from an accredited school.
 - (2) (3) An occupational therapist shall be currently registered with the National Board for Certification in Occupational Therapy, (NBCOT) and licensed by the California Board of Occupational Therapy. Continuing education is a requirement of licensure to maintain credentials.

GOVERNMENT CODE (Applies to special education children only -- procedures for non-special education children may differ)

7572. (b) Occupational therapy assessment shall be conducted by qualified medical personnel as specified in regulations developed by the State Department of Health Services in consultation with the State Department of Education.

7575. (a) (1) Notwithstanding any other provisions of law, the State Department of Health Services, or any designated local agency administering the California Children's Services, shall be responsible for the provision of medically necessary occupational therapy as specified by Article 5 (commencing with section 123800) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, by reason of the medical diagnosis and when contained in the child's individualized education program.

(2) Related services or designated instruction and services not deemed to be medically necessary by the State Department of Health Services, that the individualized education program team determines are necessary in order to assist a child to benefit from special education, shall be provided by the Local Education Agency by qualified personnel whose employment standards are covered by the Education Code and implementing regulations..

Note: This document contains only the OT portion of the education code. It has been extrapolated from the full version which also includes physical therapy codes.

2. Occupational Therapy in California Public Schools

A. Eligibility for Educational Occupational Therapy

Public schools are not required to provide a service to a disabled child just because the child will benefit from the service or even if the child requires the service for **other than** educational reasons. According to the CA Ed Code and IDEA 2004, the IEP team is addressing the question, ***“Is OT necessary for the child to benefit from his/her educational instruction?”***

As OT is a related service and as special education instruction frequently can overlap occupational therapy activities in many skill areas, the IEP team needs to thoroughly consider the level of professional expertise needed to address educational goals and to assure that alternate special education resources have been explored before determining that occupational therapy services are required for a student to benefit from their special education program.

Simply having needs in the areas of gross or fine motor skills does not mean that a child needs occupational therapy. Special education teachers can assess and assist children who have special needs in fine or gross motor skills. Most special education children with needs in these areas can and should be served by their teachers.

If the IEP team has exhausted the strategies, activities and resources available within the instructional program, including general education teacher, special education teacher, adapted physical education teacher, etc, and has determined that the student is not likely to benefit from this program’s opportunities without additional professional services from an occupational therapist, a referral for such services should be made.

While “educationally necessary” is difficult to define precisely, determining the need for educationally necessary OT may best be approached by the IEP team addressing a series of questions about the developmental issues involved in the student’s progress toward goals. Answers to the questions below will help the team arrive at the answer to their ultimate question:

Is occupational therapy necessary for the student to benefit from his or her special educational program?

- Does the student have educational goals that involve motor skills or sensory functioning?
- Can these goals be addressed by adaptations or modifications to the classroom environment or curriculum?
- Can these goals be addressed by classroom instructional staff using typical educational strategies with reasonable expectation of success?
- Can these goals be addressed by classroom instructional staff with consultation and guidance or monitoring by an occupational therapist?
- Can classroom instructional staff conduct a program of activities designed by an occupational therapist specifically for this student, with reasonable expectation of success?
- Can activities designed to address educational goals be delivered to the student only by a professional occupational therapist?

There are a few children whose needs are so significant and unique that the child’s special education teacher cannot serve them. These children may need the services of an occupational therapist. Neither state nor federal law sets aside distinct eligibility criteria for occupational therapy services.

In order to receive occupational therapy as a related service, a child must first be eligible for special education. This means that the child must be determined to be an “Individual with Exceptional Needs” as defined by the Education Code and local SELPA guidelines. All the requirements for eligibility must be met. Within this framework, both the American Occupational Therapy Association and federal legislation focus on “improvement of functioning” and not serving goals beyond the capacities of the individual.

The objective of occupational therapy is to have a child participate and function as independently as possible in the in the classroom setting.

Once a child has been found to be eligible for special education, a listing of all his needs which cannot be met by the regular education program must be made. These become his special education needs. Needs in the areas of gross and or fine motor, special physical adaptations or similar areas, which cannot be met by the general or special education teacher, despite previous documented adaptations and modifications within the existing educational program, raise the possibility of OT involvement (consult, monitor, direct service). ***Additional considerations include comparing the student’s functional performance in question with their assessed mental/developmental age, not chronological age.*** For example, ***is there a significant discrepancy in the student’s fine motor, sensory motor, visual motor or oral motor ability compared to their ability level in the areas of cognition, communication, social and self-help skills?***

The ***Occupational Therapy Student Needs Survey*** in Appendix A will assist the SST or IEP team in determining if an OT referral is appropriate.

B. Accessing Educational Occupational Therapy Services

If a student meets the above survey criteria, i.e. the SST or IEP team has completed the ***OT Student Needs Survey*** and deemed a referral is appropriate, a request for an **OT Observation** is made (not a referral via an Assessment Plan).

To schedule an OT Observation, the therapist must first have a signed ***Consent for Observation*** from the parent or guardian along with a completed ***OT Observation Survey*** from the teacher. The OT then has 30 instructional days to perform the observation and hold an SST or IEP to discuss the need for further assessment.

If a formal OT assessment is not warranted, the OT can take this opportunity to share ideas and activities for the classroom and/or parent that may benefit the student. If further assessment is indicated, then an Assessment Plan is signed by the parent or guardian and a 60 day timeline for evaluation begins. An IEP is held after the evaluation is completed to determine the level of Educational Occupational Therapy Services appropriate.

(A flowchart showing the OT referral process as well as all forms needed for an Occupational Therapy Referral are in Appendix A)

In the event a parent presents a medical doctor’s prescription for educational OT, it must be remembered that **an IEP team is the only legal body that determines special education services for a child.** Any relevant input from a medical practitioner would be considered by an IEP team along with other health information but there is no educational requirement or authority to fill a physician’s prescription for OT.

C. Service Delivery Models

In the educational setting, OT services may include **observation, assessment, direct therapy**, and several types of **consultation/ collaboration**. These intervention activities are not mutually exclusive and may occur at the same time. It is important to remember that occupational therapy service delivery is dictated by the current and ongoing needs of the student and should be flexible, using various options across the continuum of service delivery.

Observation -A request is made when the above criteria and Needs Survey indicate an OT observation is appropriate. The OT makes a visit(s) to the school site to observe the student's skills and behaviors in the academic setting. Interviews with teaching staff and parent/guardians are also conducted. This is the first step in determining the need for OT services.

Assessment - Information is gathered by the following: teacher/parent interview, classroom observation, direct, personal contact with the child, structured informal assigned tasks, and/or administration of normed and standardized tests.

Direct therapy employs specific therapeutic techniques, approaches and strategies to remediate or prevent problems that are: 1) identified through the assessment process, 2) adversely affect educational performance, 3) are required to meet educational goals and 4) are based on program objectives developed by the multidisciplinary team.

Direct services may be delivered individually, in a "pull out" or "push in" model or may be done in small groups with other students with similar needs and goals.

Direct services are provided for those students whose needs can not be met by OT collaboration/ consultation with class staff.

Consultation/ Collaboration is the collaboration among therapists, educational staff, parents and/or child to plan and implement modifications and interventions, to meet the child's needs. It can also include monitoring or periodic rechecking of the child's progress.

Consultation services have proven as equally effective as direct services for some students as the interventions are: 1) set in natural environments, 2) embedded in class routines, 3) use functional life skills to increase the efficacy of intervention, and 4) increase the student's motivation to participate and achieve their IEP goals. Consultation services also increase the opportunities for collaboration and skill building among team members along with practice opportunities for the child.

The nature of the consultation should be defined on the comments page of the IEP. All consultation should have a written report delineating what the consultation encompassed and the results.

D. OT's Role in Goal Writing:

The IEP team should be responsible for writing motor goals, self-help goals and attention goals (if appropriate) just as they write academic, language and social/emotional goals. It is important to remember that OT **supports** the classroom educational goals. The OT will generate and write goals for a student receiving **direct** OT services, and should be listed as one of the "person(s) responsible" along with teaching staff, on the Goals page of the IEP. For a student receiving **consultation** OT services, the OT should be a collaborative partner on appropriate IEP goals. OT can be listed as one of the "person(s) responsible" along with teaching staff, on the Goals page of the IEP. OT services at any frequency should be indicated on the "Services" Page of the IEP. It is also important to note that when deciding a service delivery for a student that the IEP determines team configurations but not method of delivery. The IEP should not contain any educational "OT only" goals or services as OT is not a stand-alone service.

3. Educationally Necessary vs. Medically Necessary OT

Medically necessary therapy conducted in the school is not the same as therapy conducted in the clinic. Therapy differs in these two settings in terms of its intent, the role of the therapist, and the type of support available to the therapist.

A child with a disability may have a need for improvement in his functional skills as related to his/her performance in the educational environment. A child may have an educational need as well as a medical need; however, **some medical difficulties may not directly impact educational progress and may not constitute educational need.**

Medically necessary therapy is usually undertaken as an adjunct to medical treatment for acute and chronic conditions to ameliorate an underlying disability. The goal of medically necessary therapy is to improve global functioning through the use of a variety of modalities. ***Educationally necessary therapy is provided in the school to help the child access educational services and benefit from his educational program. In the school, educational goals hold a primary position, while occupational therapy goals are undertaken to support the educational goals.***

The school therapist delivers a wide range of services. These services cover individual therapy, as well as therapy within small groups, and consultation/collaboration with school staff, and with the child's family. Thus, the school therapist is expected to share his/her knowledge and skills with others by demonstrating and monitoring activities that are educationally appropriate. ***OT Services are always collaborative.*** Much time must be given to communicating with other service providers.

The significant ways in which clinical therapy and school therapy differ are summarized below.

MEDICALLY NECESSARY THERAPY	EDUCATIONALLY NECESSARY THERAPY
Assumes an underlying cause with diagnosis based on etiology	Assumes no underlying cause. Focus in on what behavior or functional need is to be accomplished
Evaluation to reveal underlying problem	Evaluation to determine what functional problem needs resolution (targeted behavioral outcome)
Dysfunction is within the student	Dysfunction is a mismatch between student's abilities and what is being demanded or asked.
Therapy goals are primary.	Educational goals are primary
Intervention is directed toward alleviation of a specific medical problem.	Intervention is directed toward facilitating educational progress.
Services tend to be delivered individually in a clinic or hospital setting	Services are collaborative. Much time must be given to communicating with other service providers
Focus is based on developmental milestones and components of movement. The focus is on functional outcomes.	Focus is on functional skills and adaptations that promote the attainment of educational objectives
Few responsibilities are delegated except to parents	More responsibilities are delegated to parents and other educational professionals
Clients come to the clinics to see the therapist	The therapist works in the school setting

4. CCS's Role in Medically Necessary OT Services

FOR SERVICES THAT ARE MEDICALLY NECESSARY:

Children who have medically necessary occupational or physical therapy needs are served by California Children Services (CCS) when they meet the criteria for medical eligibility for the CCS program. This applies from birth-21 years old whether or not they are also eligible for special education.

When a child is suspected of being in need of "medically necessary" therapy, please refer directly to CCS.

Medical eligibility for the CCS program is determined by the CCS Medical Consultant through a review of applicable medical reports from the child's physician(s). Medical eligibility for the CCS medical therapy program is defined in the California Code of Regulations, Title 22, Division 2, Subdivision 7, Section 41832.

CCS medical therapy services are available to all eligible children who require them and are available at no cost to the parents of those children. The frequency of CCS therapy services (monitoring or direct service) is based on physician prescription and is determined by the physician, parent, and therapy team. Services may increase or decrease based on the child's medical condition and progress towards therapy goals. If the parent or legal guardian is not in agreement with the frequency of prescribed occupational or physical therapy he/she may appeal this decision by contacting the CCS administrative office.

CCS therapists may share information and participate in a child's IEP when it is requested and 10 days pre-notification of the IEP is provided. The CCS program is required to inform the school whenever the frequency of a child's occupational or physical therapy changes.

If a child does not meet CCS eligibility requirements and the IEP team determines after an evaluation that the service is required in order for the child to benefit from his/her program of specially designed instruction, special education is responsible for providing this service.

Children who may need occupational therapy for other reasons (e.g. temporary physical disability or where there is no significant/major educational impact) are not the responsibility of the schools. An example of this would be a student who is recovering from a hand fracture and needs rehabilitative occupational therapy.

FOR CHILDREN WHO ARE ALREADY ELIGIBLE FOR SPECIAL EDUCATION:

Even when a child is disabled and needs specifically designed instruction; the child does not automatically receive related services. These services become part of a child's IEP when the IEP team determines that they are needed in order for the child to benefit from special education and when the identified needs are so severe that they cannot be served by his/her regular or special education teacher.

5. Functional Areas Addressed in Educationally Necessary OT

Intervention, as applied in the school, is typically divided into nine functional areas. The services provided in the school setting may differ somewhat from those provided in the clinical setting.

FUNCTIONAL AREA	SERVICES PROVIDED	RELATIONSHIP TO EDUCATION
Self-help	Mobility and transfer skills, feeding, toileting, adaptive equipment	To permit the child to manage personal needs in the classroom and school
Functional Mobility	Equilibrium and balance reactions, transfer skills	To permit the child freedom of movement within the educational setting
Environmental	Recommend modifications of school's or child's equipment	To help the child access the educational environment
Positioning	Positioning with wheelchairs and/or adaptive equipment & handling methods	To maintain the child in the best position for learning and functional use of hands
Neuromuscular and Musculoskeletal Systems	Activities which promote muscle endurance, strength, motor coordination and planning, and integration of developmental reflexes	To enable the child to participate maximally in school activities. To increase speed, accuracy, and strength in manipulative skills in pre-academic and academic tasks.
Sensory Processing	Activities which promote muscle tone and integration of tactile, visual, auditory, proprioceptive, and vestibular input	To process information that will enhance the child's ability to perform learning and motor tasks in school
Adaptive Equipment	Recommend and fabricate devices to facilitate fine motor and self help tasks	Provide the child with alternative means to accomplish functional activities
Fine Motor/Visual Motor	Evaluate and improve functions such as reach, grasp, object manipulation, and dexterity	To facilitate the child's ability to manipulate classroom tools (such as writing implements, puzzles, and art materials)
Communication	In coordination with speech therapists & augmentative communication professionals evaluate & recommend adaptive equipment & communication devices necessary for functional communication	To enable the child to communicate in school, at home and in the community

6. Services of Special Education Teachers vs. Occupational Therapists

In general, OT's concentrate on postural background mechanisms, sensory impairments or motor impairments effecting function. There is, however, some overlap between the things teachers and occupational therapists do in the course of helping children learn and become independent. The following chart may help show who does what.

AREAS OF NEED	WHAT THE TEACHER DOES	WHAT THE OCCUPATIONAL THERAPIST DOES
Fine Motor Function	Teaches, monitors and reinforces normal pencil grasp. Teaches and provides practice opportunities in form reproduction (lines, circles, squares etc.). Teaches letter reproduction, use of lines and spaces. Offers drill and practice opportunities in visual motor and visual perceptual activities. Offers opportunities and assistance to work with motor materials such as puzzles, peg boards, beads, and scissors. Monitors student progress.	Evaluates accommodations and assistive devices necessary for improved grip, grip strengthening activities, postural supports, fatigue minimization, kinesthetic cues. Provides activities which promote muscle endurance, motor planning and integration of developmental reflexes. Monitors student progress.
Self-Help Skills	Encourages independent attitude. Teaches organizational systems for dealing with instructional materials. Teaches and monitors organizational systems for dealing with class work completion. Teaches dressing, toileting, self-feeding specific to individual developmental level, using known adaptations. Develops structure and processes necessary for independence in the cafeteria, restroom, and moving between classes. Defines necessary mobility and transfer skills, and minimizes obstacles in the classroom.	Assists with management of instructional materials by providing exercises to improve visual tracking-scanning, vestibular or tactile issues. Provides adaptations for dressing. Provides postural support/adaptations for toileting. Provides support for utensil usage in feeding, and helps resolve sensory based food resistance. Promotes independence in cafeteria and other school locations by developing adaptations and training the student and staff in their use.
Behavior/ Attention	Addresses issues of oppositional behavior, immature social skills, different learning styles, decreased attention, impulsiveness and self-stimulatory behavior using behavioral/instructional strategies. These strategies include: posted schedules, transition supports, adapted curriculum, social skills training, self-monitoring programs, and systematic reinforcement of functionally equivalent replacement behaviors.	Addresses issues of increased or decreased arousal level based upon vestibular responsiveness, tactile irregularity, or kinesthetic sensation seeking. Addresses issues related to activity shift through work on vestibular/somatosensory regulation and modulation systems. Addresses self-stimulation behavior by assisting to design sensory activities that can be used in the classroom.
Keyboarding	Teaches keyboarding skills.	Provides adaptations, positioning assistance.

7. OT Service Delivery vs. Specific Treatment Approaches

A. Sensory Integration Therapy

The term “sensory integration” is used in California by different people to refer to different types of treatment strategies. Other terms, such as “sensory motor training,” “sensory integrative therapy,” and “sensory processing,” are often used as synonyms. For our purposes, sensory integration is a methodology used by the therapists at their discretion. A teacher (general education, special education, art, music, dance, etc.) may include perceptual motor or sensory motor activities or instruction in his/her curriculum. Specific techniques individualized to a child, which are identified by the OT, can be utilized by the teaching staff with direct supervision and training by the OT.

In general, sensory integration therapy attempts to elicit appropriate behavioral responses to sensory input. It attempts to enhance the brain’s ability to process and integrate sensory and motor information. Sensory integration therapy may result in improvement in the child’s ability to organize sensory information and adapt responses so that they are appropriate to the environment. This technique focuses on ameliorating the underlying problem, rather than on teaching specific skills or utilizing accommodations.

CAN AN IEP TEAM INDICATE SENSORY INTEGRATION THERAPY TREATMENT AS A RELATED SERVICE ON THE IEP OR INDICATE THAT A THERAPIST USE THIS METHODOLOGY? **No, it is not a related service under IDEA 2004; but, rather, a technique or instructional method which may be used.** The decision to use, or not use, sensory integration therapy as a method should be made by the person responsible for the service or instruction specified in the IEP, based on the professional judgment of the service provider and the needs of the child. The local school district is under no obligation to include sensory integration therapy in the IEP since it is a method, not a related service. After the IEP team has identified the child as an individual with exceptional needs and included, for example, therapy in the IEP, the therapist may decide to use whatever method(s) is most effective for carrying out the goals and objectives for that child.

B. Neurodevelopmental Treatment (NDT)

NDT is a treatment approach that can be used by occupational or physical therapists, speech/language therapists, and teachers trained in its use. The aim of NDT is to provide a sense of normal movement, to assist the individual to use movement patterns to improve function. This is done by using techniques to inhibit abnormal patterns and facilitate normal movement. There are many different ways of inhibiting abnormal muscle tone and facilitating normal movement reactions. The goals of NDT are:

- To carefully analyze problems of posture and movement in all possible positions;
- To normalize tone using techniques of inhibition and facilitation in order to allow the child to move more functionally;
- To teach parents and teachers the necessary procedures to ensure consistent management of motor deficits;
- To use equipment to aid in enabling more normal patterns of movement and to help in functional skills; and
- To prevent a cycle of abnormal sensory-motor development including secondary changes such as contractures and deformities from occurring.

CAN AN IEP TEAM INDICATE NDT AS A RELATED SERVICE ON THE IEP OR INDICATE THAT A THERAPIST USE THIS METHODOLOGY? **No, it is not a related service; it is a technique to be used or not as determined by the current therapist.** Typically, an evaluation that determines the need for NDT will result in a referral to a medically based service provider.ⁱⁱ

8. Exit Criteria for OT Services

Any or a combination of the following criteria may justify the dismissal of OT services:

1. A student has accomplished their IEP goals and is performing successfully within the educational environment.
2. Deficits are not interfering with child's ability to function adequately within the school environment. As reported by the teacher, the student is now able to function within average range as compared to other children in the classroom.
3. Strategies can be effectively implemented by current educational team and no longer require the training and expertise of an OT. The child has learned appropriate strategies to compensate for deficits/ Equipment and environmental modifications are in place and are effective.
4. Formal reassessment indicates the child no longer requires the previous level of service and IEP team concurs/ The student continues to make progress in the areas being addressed by the OT that is consistent with developmental progress in other educational areas despite a decrease in OT.
5. Occupational therapy no longer has an impact on or is affecting change on the child's level of function in special education: The child no longer shows potential for progress or change after a variety of intervention strategies and levels of service and delivery have been used by the therapist
6. Therapy is contraindicated because of a change in medical or physical status.
7. Student is unresponsive or unwilling to participate in therapy.

APPENDIX A

Educational Occupational Therapy Guide for Student Referral

Student: _____ DOB: _____ SCHOOL: _____
Teacher: _____ Rm#: _____ Receiving Special Ed: _____

Please indicate the areas below that influence your student's school performance and describe how the student's ability to gain from his educational program is affected. This information is needed for the occupational therapy referral process.

✓ Please check those boxes that apply. Circle student behaviors listed in each area you observe and write any additional comments on back.

- 1 **Balance and motor coordination** appear delayed relative to *cognitive level*, adversely affecting ability to participate in the educational program:
(Frequent falls, significant clumsiness, bumps into things, poor body awareness, difficulty coordinating both sides of body, awkward gait pattern, poor eye-hand coordination).
- 2 **Classroom positions/Postures** are difficult to assume, maintain or tolerate:
(Independent sitting or standing, poor posture, falls out of chair, moving to or from the floor).
- 3 **Fine Motor skills** appear delayed relative to *cognitive level*, limiting ability to reach for, grasp, manipulate or release objects or to use both hands together:
(Difficulty with clothing fasteners, poor scissors use, poor pencil/crayon grasp, difficulty drawing, coloring, cutting, hand does not assist with stabilization, poor quality of writing, switches hands frequently)
- 4 **Visual-perceptual-motor abilities** are delayed not due to vision impairment, developmental readiness or behavior/ emotional disorders: (Difficulty tracing or coloring within lines, copying from the board, forming and spacing letters, poor eye tracking).
- 5 **Oral motor dysfunction** or problems in self-feeding interfere with intake at meals or present a safety hazard: (Scoops poorly, loses food/liquids from mouth, gags, takes excessive time to feed or be fed).
- 6 **Self-dressing skills** related to managing outerwear and clothing at the toilet are delayed: (Difficulty taking off/putting on jacket, backpack, difficulty pulling pants up/down). List others.
- 7 **Adaptive or assistive equipment** to perform educational activities needs to be acquired, fabricated, or adjusted: (pencil grips, desk or chair modifications, positioners, built-up spoons). List others.
- 8 **Sensory-motor processing** deficits may affect attention to task and performance:
(Over-reaction/under-reaction to movement, touch, or noise, difficulty with changes in routine/transitions, impulsive grabbing/hitting, distractible, fidgets constantly/ leaves seat often, craves movement, mouths objects)
- 9 **Functional living skills** require task analysis and modifications to accomplish successful job performance: (decreased strength, coordination, and endurance limit ability to perform living skills or to participate in activities throughout school day).
- 10 **Motor planning abilities** make it difficult to negotiate the school environment and learn new tasks: (difficulty moving within the room or school areas, difficulty imitating movements, understands directions but cannot do task)

SIGNATURE _____ DATE _____ Contact number: _____

OCCUPATIONAL THERAPY OBSERVATION SURVEY

Student: _____ School: _____ Date: _____

Teacher: _____ Rm#: _____ Receiving Special Ed: _____



Please check areas that apply

Fine Motor:

- poor/ non-typical pencil grasp
- positions pencil with non-dominant hand
- switches hands frequently
- poor stabilization of paper
- poor arm posture
- difficulty drawing, coloring, cutting
- avoids crossing midline
- tremors, poor dexterity
- increased/ decreased pressure on writing tool
- poor quality of writing
- writing is slow and laborious
- holds scissors incorrectly

Visual Motor/ Visual Perception:

- poor eye tracking
- poor eye-hand coordination
- colors outside lines
- cuts off corners
- unable to copy simple designs (circle, square)
- forms letters incorrectly
- letter or number reversals
- does not stay on line when writing
- poor spacing between words
- difficulty copying from board
- places paper to one side while writing
- difficulty doing puzzles
- loses place while reading
- holds book close to face
- wears glasses

Gross Motor:

- clumsy, bumps into objects or trips easily
- poor body awareness
- difficulty initiating movement
- difficulty coordinating both sides of body
- poor posture
- awkward gait pattern
- poor balance
- poor coordination, rhythm and/or timing
- does not alternate feet going up stairs
- confuses right and left
- poor ball skills/ eye-hand coordination
- low muscle tone

Assistive Devices: List:

Academic performance _____

Postural Stability:

- sits on leg or knees/ wraps legs around chair
- poor desk posture/ slouches in chair
- falls out of chair
- holds head up with hand at desk
- stands at desk while doing work
- prefers working on floor
- lacks strength and endurance required to participate in activities throughout school day

Behavior:

- marked mood variations
- becomes easily frustrated/ gives up easily
- appears bossy, stubborn, uncooperative
- difficulty interacting with peers
- poor use of unstructured time
- impulsive/ appears ADHD
- accident prone
- distractible (noise, movement)
- difficulty with transitions, changes in routine

Sensory Processing & Organization:

- avoids playground equipment
- prefers sedentary activities
- seems to crave excessive movement
- seeks high risk movement
- fidgets constantly/ leaves seat often
- dislikes noise (covers ears)
- over reacts to unexpected noise
- forgets verbal directions/ needs repeated
- difficulty sequencing directions
- poor direction concepts (ie L/R)
- has trouble keeping hands to self
- hits/ hurts others when playing
- craves tactile sensation
- mouths objects
- high pain tolerance/ under-reactive to injuries
- low pain tolerance/ over-reactive to bumps
- dislikes textures- glue, paint, grass, sand, etc
- dislikes being touched or cuddled/ withdrawals
- reacts emotionally to unexpected touch
- dislikes standing in line close to others
- unable to manage belongings or class materials

Self Help:

- difficulty with zipping, buttoning, dressing
- difficulty with eating, self-feeding
- picky eater
- needs assistance for toileting, hygiene

Glenn County Office of Education
Student Services
676 East Walker / P.O. Box 817
Orland, CA. 95963

**OCCUPATIONAL THERAPY
PERMISSION TO OBSERVE**

Child's Name:

Date of Birth:

Age:

School:

Teacher:

Parent's Name:

Address:

Phone:

Primary Language: Parent:

Child:

I give permission for my child to be observed by Glenn County Office of Education
Student Services **OCCUPATIONAL THERAPIST**
Susan McManus, OTR/L 865-1267 Ext. 3029

Areas of Concern: _____

I understand that the observation will be completed during my child's school day. My
child's days and hours of attendance are _____.

Parent/Guardian's Signature

Date:

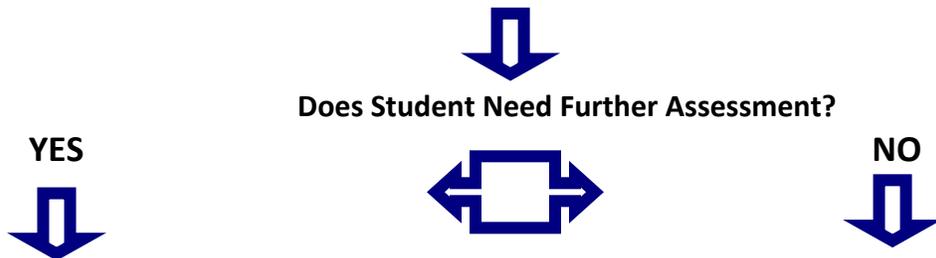
PROTOCOL for OCCUPATIONAL THERAPY REFERRAL

A Request For An OT Observation Can Be Made By:

Program Specialist	Special Education Teacher	General Education Teacher
School Psychologist	School Counselor	D.I.S. Professional Staff
School Nurse	Parent	

Step 1. OT OBSERVATION

1. **OT Observation Parent Consent Form**- must be signed by parent
2. **OT Referral Checklist**- to be completed by Teacher/Parent
3. **30 Day Timeline begins**
4. **Hold IEP or SST to discuss the need for further assessment**



Step 2. OT ASSESSMENT

1. **Signed Assessment Plan**
2. **60 Day Timeline begins**

SST Meeting to discuss findings

1. **Classroom/Parent Activity Suggestions**

Assessment Tools May Include:

- Professional Clinical Observations
- Parent and Teaching Staff Interview
- Standardized Gross Motor and Fine Motor Assessment:
Brunicks-Oseretsky Test of Motor Proficiency
- Standardized Visual Perceptual Assessment:
MFVPT-3
DTVP-2
- Normed Handwriting Assessment:
The Print Tool
- Normed Sensory Processing Assessment:
Sensory Profile Questionnaire
Sensory History Questionnaire



Step 3. IEP/ IFSP

Determination of Educationally Necessary OT Services

End Notes

ⁱ Adapted from: "The Role of the Physical Therapist and the Occupational Therapist in the School Setting," by Judith Hylton, Penny Reed, Sandra Hall, and Nancy Cicirello. TIES: Therapy in Educational Settings. A collaborative project conducted by Crippled Children's Division--University Affiliated Program, the Oregon Health Sciences University and the Oregon Department of Education, Regional Services for Childs with Orthopedic Impairment. Funded by the U.S. Department of Education, Office of Special Education and Rehabilitation Services, grant number G008630055.

Adapted from: "School Administrator's Guide to Physical Therapy and Occupational Therapy in California Public Schools," California Alliance of Pediatric Physical and Occupational Therapists, 40571 Ives Court, Fremont CA 94538.

Adapted from: "Occupational Therapy Guidelines" Contra Costa SELPA, 2520 Stanwell Drive, Suite 270, Concord, Ca. 94520, January 2008

ⁱⁱ Adapted from: Neurodevelopmental Treatment (NDT): Therapeutic Intervention and its Efficacy, by Francine Martin Stern, BS, RPT, and Delia Gorga, Ph.D., OTR, in Infants and Young Children, Aspen Publishers, Inc., 1988.