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**School Based Rehabilitation Occupational Therapy (OT) Screen**

School -Based Rehabilitation Services (SBRS) accepts referrals for students in Junior Kindergarten through secondary school graduation. SBRS occupational therapy provides assessment and direct or consultative treatment at school to students with occupational performance issues.

This screen does NOT need to be completed if an OT assessment has been completed within the past year – please attach assessment report/progress reports to the SBRS Referral Form and submit. If submitting this screen, please upload any previous reports along with the SBRS Referral Form.

**NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DD/MM/YEAR**

**Grade (JK-grade 12):** \_\_\_\_\_\_

**SCHOOL:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Classroom Teacher/SERT/LRT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**School Board:**

RRDSB ❑ KPDSB ❑ KCDSB ❑ TNCDSB ❑ CSDCAB ❑

**Completed by:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name and Designation)

**Date Completed:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DD/MM/YEAR**

**Referral Source:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason for Referral:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical diagnosis if any:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Prior assessment information** (Please attach most recent occupational therapy assessment if completed)

**Prior to referring for an OT assessment, have recommendations from past OT reports been revisited if applicable to the current concern? Please explain.**

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**OT Related Concerns: please describe (recognizing age appropriateness)**

**Fine Motor (such as awkward pencil grasp, poor scissor skills, immature pencil control, hand dominance by age 6)**

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**Gross Motor (such as poor sitting posture, difficulty with bilateral tasks)**

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**Self-Care (such as immature feeding & dressing skills for age, toileting concerns)**

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**Please attach a completed copy of the SBRS referral form to this occupational therapy screen and submit to FIREFLY by e-fax at** **1-866-470-1783.** Referral forms can be found at <http://www.fireflynw.ca/access-to-services>.