

**OCCUPATIONAL THERAPY SCREENER**

*Complete for all clients with OT concerns*

**Client First Name: Client Last Name:**

**Date of Birth** (mm-dd-yyyy**): EMHware #:**

**Informant: Date of Screener** (mm-dd-yyyy)**:**

**School: Address:**

**Previous/current OT services:**  Yes No

**If yes, date of service: Name of OT Service Provider:**

*Please advise the parent/guardian the Occupational Therapist will require previous assessments and if possible to bring previous assessments with them to their first appointment.*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***What are your goals/concerns for your child/youth?***

***Does your child/youth have a diagnosis or specific developmental concern identified by a medical professional? Such as:***

Premature  Seizure Disorder

Cerebral Palsy  Down Syndrome

Spina Bifida  Autism Spectrum Disorder

Head Injury  Fetal Alcohol Spectrum Disorder

Global Development Delay  Vision Impairment

Brain Malformations  Developmental Coordination Disorder

Attention Deficit Hyperactivity Disorder

Other Conditions/genetic disorders/syndromes, specify:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\* If the child/youth has any of the above concerns they are eligible to receive support from FIREFLY

***Does your child have concerns with:***

|  |  |  |  |
| --- | --- | --- | --- |
| ***Feeding*** | | | |
| **Age** | **Even with practice is your child having difficulty with …** |  | **Comments** |
| 0 + years | Latching to a bottle or breast |  |  |
|  | Coordinating suck-swallow-breathe |  |  |
|  | Ongoing choking, gagging, coughing or vomiting during meals |  |  |
| 6 + months | Transitioning to pureed or solid foods |  |  |
| 24 + months | Eating with a spoon |  |  |
|  | Eating at least 20 different foods consistently |  |  |
| 30 + months | Drinking from an open cup |  |  |
| 42 + months | Opening simple containers |  |  |
| 7 + years | Spreading and cutting with a knife |  |  |
| ***Dressing*** | | | |
| **Age** | **Even with practice is your child having difficulty with …** |  | **Comments** |
| 2 + years | Undressing simple clothing (e.g. remove unfastened jacket, hat, mittens, loose shoes, socks) |  |  |
| 4 + years | Fasteners (undoing medium buttons, unzipping, snaps) |  |  |
| 5 + years | Fasteners (zipping up) |  |  |
|  | Dressing independently (with some minimal assistance) |  |  |
| 8 + years | Tying shoes |  |  |
| ***Personal Hygiene*** | | | |
| **Age** | **Even with practice is your child having difficulty with …** |  | **Comments** |
| 4 + years | Bowel accidents |  |  |
| 5 + years | Urinary/bladder accidents |  |  |
|  | Brushing hair with minimal assistance |  |  |
|  | Brushing teeth with minimal assistance |  |  |
|  | Washing & drying hands, face body |  |  |
| 7 + years | Bathing/Showering independently |  |  |
| ***Sleeping*** | | | |
| **Age** | **Is your child having difficulty with …** |  | **Comments** |
| 6 + years | Difficulty falling asleep or waking up during the night |  |  |
| ***Fine Motor Skills*** | | | |
| **Age** | **Even with practice is your child having difficulty with …** |  | **Comments** |
| 6 + months | Bringing hands to mouth |  |  |
| 9 + months | Picking up finger foods with whole hand |  |  |
|  | Transferring objects from had to hand |  |  |
| 12 + months | Putting objects in a large container, picking up small items using a pincer grasp |  |  |
| 18 + months | Holding toy in one hand and manipulates it with another |  |  |
| 3 + years | Building with blocks |  |  |
|  | Copying a circle |  |  |
|  | Stringing 2-4 large beads |  |  |
| 4 + years | Completing a 5-8 piece puzzle |  |  |
|  | Grasping using thumb and first 2 fingers |  |  |
|  | Cutting a big circle |  |  |
| 5 + years | Copying a +, diagonal line or square |  |  |
|  | Drawing a person with 6 body parts |  |  |
|  | Prints own name, but not clearly |  |  |
| 6 + years | Cutting out simple shapes, curves |  |  |
|  | Forming legible letters |  |  |
|  | Uses dominant hand |  |  |
| ***Gross Motor Skills*** | | | |
| **Age** | **Even with practice is your child having difficulty with …** |  | **Comments** |
| 6 + months | Props on forearms while on belly (by 6 months) |  |  |
| 3 + years | Catching a ball against their chest |  |  |
| 4 + years | Using play structures/jungle gyms like their same aged peers |  |  |
|  | Catching a ball in their hands |  |  |
| 5 years | Throwing a ball at a target |  |  |
| **Play** |  |  |  |
| **Age** | **Even with practice is your child having difficulty with …** |  | **Comments** |
| 6 + months | Looking at you for a few seconds |  |  |
|  | Exploring objects |  |  |
|  | Laughing in response to play |  |  |
| 12 + months | Playing peek a boo |  |  |
|  | Clapping their hands |  |  |
| 2 + years | Looking for hidden objects |  |  |
|  | Imitating a pretend play action (e.g. drinking from a cup, sleeping) |  |  |
| 3 + years | Treating dolls/stuffed animals as if they are alive |  |  |
|  | Playing beside other children |  |  |
| 4 + years | Taking turns with other children sometimes |  |  |
|  | Playing with 2-3 children in a group |  |  |
|  | Expressing simple feelings (e.g. sad, mad, happy) |  |  |
| 5 + years | Playing make-believe/imaginary (e.g. house, doctor, dress-up) |  |  |
| **Executive Functioning** |  |  |  |
| **Age** | **Even with practice Is your child having difficulty with…** |  | **Comments** |
| 5 + years | Completing simple routines with the amount of support you would expect for their age? (e.g. getting ready in the morning) |  |  |
| 6+ years | Finishing tasks which is disruptive to their everyday activities or negatively impacting their education? |  |  |
|  | Tasks with multiple steps in the proper sequence, such as getting dress or setting the table? |  |  |
| 8 + years | Managing items in their personal space? (Their bedroom at home, or their desk/coat hook at school) |  |  |
| 12 + years | Organizing their weekly school schedule and manage their assignments in a planner or calendar? |  |  |

Service Pathway for concerns related to the checklist above:

* 1. If the child is not yet attending school or is home schooled they are eligible for FIREFLY services.
  2. If the child has complex needs (e.g. Autism, Cerebral Palsy, Muscular Dystrophy, Down Syndrome, identified on the list above), regardless of their age (0-18) and regardless of their school enrollment they are eligible for FIREFLY services
  3. If the child is attending school and the concerns are related to accessing academic programming the child is eligible for School Based Rehabilitation Services (SBRS). Referrals will be accepted by FIREFLY Centralized Intake. Concerns related to accessing academic programming could include: **fine motor** – poor pencil grip/control, poor scissor skills, **gross motor** – poor sitting posture, difficulty with bilateral tasks, **self-care** – immature feeding and dressing skills for age, toileting concerns