

**PHYSIOTHERAPY SCREENER**

*Complete for all clients with PT concerns.*

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

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

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

**Is the child currently receiving or have they received PT services in the past:**  Yes  No

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

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

**If this client is an infant, were they born significantly premature? (More than 4 weeks)**

Yes  No  Unknown If “yes” refer for PT Services if parent/guardian agrees.

**# of weeks of gestation:**

**Is the child/youth meeting the developmental milestones for holding up head (4 months), rolling (6 months), sitting (11 months), crawling (12 months) or walking (24 months)?**

Yes  No  Unknown

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

Auto-immune disorder such as Juvenile Rheumatoid Arthritis  Brain Malformations  Cerebral Palsy

Chronic Respiratory issues such as Bronchiectasis  Cystic Fibrosis  Developmental Coordination Disorder

Down Syndrome  Global Development Delay  Head Injury  Muscular Dystrophy Vision Impairment

Scoliosis  Seizure Disorder Spina Bifida Torticollis Plagiocephaly (head shaping)

Genetic Disorders/Syndromes, specify

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

*NOTE: If the child was born premature they may also be eligible for support from other Child Development Programs.*

**Does your child/youth have walking concerns such as?**

Toe-walking (3 yrs. +)  Balance (4 yrs. +)  Coordination (5 yrs. +)  Gait resulting in significant falls (5 yrs. +)

**Does your child have significant or asymmetrical lower extremity concerns? (After 5 years of age)**

In-toeing  Out-toeing  Bow legs  Knock knees

*If the child/youth has concerns related to walking and they are not yet school aged they are eligible for FIREFLY PROP.*

*If the child/youth has concerns related to walking or their lower extremities and they are school aged they are eligible to receive support from the School Based Rehab Services (SBRS).*

**Does your child have a Musculoskeletal or Acute Respiratory concern?**

Fracture  Sprain/Strain  Osgood-Schlatter disease  Severs  Acute Respiratory Condition

Legg-Perthes Disease  other, please list below:

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*If the child/youth has any of the above concerns please redirect to the local hospital or private physiotherapy service.*

**Are there any gross motor concerns at school?**

Yes, continue below  No

**Which School Board? What grade is the child/youth in?**

RRDSB  KPDSB  KCDSB  TNCDSB  CSDCAB

**Are there any safety concerns at school?**

Yes, please describe  No

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**Does the child/youth receive support from an Education Assistant?**

Yes  No

**Describe how the problem is affecting the student’s ability to access the curriculum:**

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**List any equipment the student currently uses at School:**

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**Are there any classroom provisions in place to support the child?**

Yes, please describe:  No

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**How does the child mobilise around the school?**

Independently  Independent with aids  Supervision required  Dependent with Aids