

 **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