FIREFLY

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 the 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

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

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

Does the 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 the child/youth 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 the child/youth have a Musculoskeletal or Acute Respiratory concern?

☐ Fracture ☐ Sprain/Strain ☐ Osgood-Schlatter disease ☐ Severs

☐ Acute Respiratory Condition ☐ Legg-Perthes Disease ☐ other, please list below:

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

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:

List any equipment the student currently uses at School:

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

☐ Yes, please describe: ☐ No

How does the child mobilise around the school?

☐ Independently ☐ Independent with aids ☐ Supervision required

☐ Dependent with Aids