

IIc/a

NEW YORK CITY BOARD OF EDUCATION
OFFICE OF RELATED AND CONTRACTUAL SERVICES

OCCUPATIONAL THERAPY EVALUATION

Student: _____ CSE#: _____ OSIS#: _____ D.O.B. _____

Therapist: _____ Date of Eval: _____ Agency: _____

School/District: _____ Educational Program: _____

Family Contact: _____ Telephone #: _____

Primary Physician/Hospital: _____ Telephone #: _____

Related Services Currently Receiving: _____

Reason for Referral: _____ Referred By: _____

Tests Administered: _____

MEDICAL HISTORY

MOTOR FUNCTION

Analysis of neuromuscular and gross motor skills as they impact on: classroom and school mobility, posture and endurance, ability to participate in school activities, level of independence / safety.

HAND FUNCTION

Analysis of fine motor and writing / graphomotor skills as they impact on: manipulation of materials, academic performance.

VISUAL FUNCTION

Analysis of ocular motor, visual motor and visual perception as they impact on: task performance, behavior, learning.

SENSORY MOTOR FUNCTION

Analysis of sensory systems as they impact on: task performance, behavior, learning.

ACTIVITIES OF DAILY LIVING

Analysis of daily living skills as they impact on: self-care, school function.

ACADEMIC FUNCTION

Analysis of cognition and perception as they impact on: task performance, behavior, learning.

SOCIAL FUNCTION

Analysis of psychosocial function, communication and task performance / behavior as they impact on: school function, learning, peer relationships.

SUMMARY

Discuss evaluation findings and teacher / parent reports. Include areas of strength / weakness, and provide rationale for school-based occupational therapy recommendations.

THERAPY INDICATED: _____
Frequency _____ Duration _____ Group _____

Indicate areas requiring occupational therapy intervention:

- Motor Function _____
- Hand Function _____
- Sensory Motor Function _____
- Visual Function _____
- Activities of Daily Living _____
- Academic Function _____
- Social Function _____

See attached IEP page 6 for complete annual goals and short term objectives.

ADAPTIVE EQUIPMENT

Current adaptive equipment in use (also indicated on IEP page 5): _____

Equipment recommendations and rationale (general equipment recommendations only; e.g. adaptive seating system, adaptive toilet system): _____

THERAPY NOT INDICATED: _____

- _____ Student's disability does not interfere with the ability to participate in the educational program.
- _____ Student has adequate functional skills and is maintaining expected levels of function.
- _____ Student has reached goals and is functioning at maximum level.
- _____ Other _____

Therapist's Signature _____ Date _____