

II/A

New York City Department of Education
Office of Related and Contractual Services
Physical Therapy Evaluation

Date of Evaluation: _____ Location: _____

Name of Student: _____ DOB: _____ OSIS#: _____

School/District: _____ Telephone: _____

Name of Evaluator: _____ Telephone: _____

Parent/Guardian: _____ Telephone: _____

Primary Physician: _____ Telephone: _____

Hospital/Clinic: _____ Telephone: _____

Wheelchair Vendor: _____ Telephone: _____

Orthotist: _____ Telephone: _____

Educational History:

Date of Last IEP: _____ Teacher: _____

Program: _____ Paraprofessional Service: _____

Therapists/Mandate: _____

Adaptive Equipment: _____

Reason for referral/evaluation:

Annual Review: _____ Triennial: _____ New Eval: _____ Decertification: _____ Other: _____

Parent/Teacher Interview: (concerns and objectives of parents/teachers, likes & dislikes and strengths & weaknesses of child)

Medical History/Medications/Contraindications/Precautions/Previous Surgeries:

1. **Social History:** (family, # of flights of stairs, w/c accessibility, caregiver, after school activities, involvement with outside agencies)

2. **Range of Motion:** (limitations/contractures; influences on functional tasks)

3. **Muscle Tone/Muscle Strength:** (at rest/with movement; influences on functional tasks)

4. **Posture and Joint Alignment:** (sitting and standing; influences on functional tasks)

5. **Motor Performance:** (transitional movements, transfers, gross motor component of ADL's)

6. **Recreational Skills:** (throwing, catching, kicking balls, running, jumping, hopping as related to school participation)

7. **Balance and Postural Control:** (sitting and standing equilibrium/protective responses, reflex maturation)

8. **Ambulation:** (adult supervision or assistance, distance, endurance, efficiency/timing, equipment, orthoses)

Gait Analysis: (quality of gait)

10. **Stairs:** (adult supervision or assistance, reciprocal pattern, use of external supports, efficiency, timing)

11. **Wheelchair Mobility:** (ability to self-propel, transfers, curb/ramp negotiation)

Power wheelchair _____ Manual wheelchair _____

12. **Task Behavior:** (ability to follow commands, communication, attention span/ cooperation, other behavioral issues, sensory processing -- include specific examples)

PT Assessment Summary

I Present Level of Function: (include strengths and weaknesses as it relates to ability to participate in school)

II _____ **Therapy indicated: Frequency** _____ **Duration** _____ **Group** _____

III Annual Goals: (educationally related)

1.

Short Term Goals:

- a.
- b.
- c.

Annual Goals:

2.

Short Term Goals:

- a.
- b.
- c.

IV Explain how therapy will help this student increase function and/or performance in his/her educational program:

V Recommended Adaptive Equipment:

VI Therapy not indicated: (circle)

- a. Student has adequate functional skills and is maintaining expected levels of function.
- b. Student has reached goals and is functioning at maximum level.
- c. Student's limitations do not interfere with participation in the school environment.
- d. Other _____

Therapist's Signature _____ **Date** _____