OGLE COUNTY EDUCATIONAL COOPERATIVE

417 N. COLFAX – P.O. BOX 582
BYRON, IL 61010
PHONE (815) 234-2722 – FAX (815) 234-2938

THERAPY SCREENING FORM

Director approval for evaluation: _____ Date: _____

☐ OCCUPATIONAL THERAPY ☐ PHYSICAL THERAPY

Student: _____ Parent Name(s): _____

Grade: _____ D.O. B. _____ Street: _____

School: _____ City, State, Zip: _____

Teacher: _____ Phone: _____

If appropriate

Current Disability(s): _____ Case Mgr: _____

Concerns, based on: ☐ Classroom observation ☐ Previous Therapy Reports ☐ Parent Input

☐ Fine Motor Development ☐ Perceptual ☐ Gross Motor Skills

☐ Self Help Skills ☐ Mobility ☐ Musculo-skeletal

☐ Sensory ☐ Architectural/Environmental Barriers ☐ Cardio-respiratory

☐ Positioning ☐ Other _____

Explain: _____

Interventions attempted: _____

Completed by: _____ Date: _____

Parent Approval for Screening Signature: Date:

Rev. 08/2009

To be completed by Therapist: _____

EVALUATION RECOMMENDATION Yes No Occupational Therapy Yes No Physical Therapy

Therapist: _____ Date: _____

_____ _____