

Children's Rehabilitation Services Teacher Referral

Name of Child (<i>Last, First</i>)		School
School Contact		Teacher
Grade	Days/Time Attending	

Teacher Checklist – Please check if this child has difficulties in any of the following areas:

Physical Activity	Touch	Language
<input type="checkbox"/> Playing in the playground/gym activities <input type="checkbox"/> Walking <input type="checkbox"/> Jumping <input type="checkbox"/> Hopping/Skipping <input type="checkbox"/> Throwing and catching <input type="checkbox"/> Balance <input type="checkbox"/> Coordination	<input type="checkbox"/> Reacts strongly or adversely when touched <input type="checkbox"/> Standing in classroom lineups <input type="checkbox"/> Touches others frequently <input type="checkbox"/> Stands too close to others <input type="checkbox"/> Reluctant to touch messy or gooey things <input type="checkbox"/> Sensitive to specific clothing/texture	<input type="checkbox"/> Understanding and following instructions <input type="checkbox"/> Using correct grammar <input type="checkbox"/> Organizing and expressing thoughts <input type="checkbox"/> Asking and answering questions <input type="checkbox"/> Reading comprehension <input type="checkbox"/> Phonics
Spatial Concepts	Daily Living Skills	Hearing
<input type="checkbox"/> Concepts of under, over, first, last etc. <input type="checkbox"/> Letter/number reversals <input type="checkbox"/> Copying from the board	<input type="checkbox"/> Toilet training <input type="checkbox"/> Eating <input type="checkbox"/> Tying shoelaces/buttons/zipper/dressing. <input type="checkbox"/> Problem solving	<input type="checkbox"/> Often asks or repeats "What?" <input type="checkbox"/> Speaks very loudly <input type="checkbox"/> Following instructions in noisy situations <input type="checkbox"/> Sensitive to noise
Seated Posture	Safety	Speech
<input type="checkbox"/> Frequently out of chair <input type="checkbox"/> Frequently leans over desktop/rests on elbows <input type="checkbox"/> Falls out of chair <input type="checkbox"/> Stands/kneels on seat	<input type="checkbox"/> In bathroom <input type="checkbox"/> While eating or drinking <input type="checkbox"/> On the playground <input type="checkbox"/> Runs into objects and people <input type="checkbox"/> Falls frequently	<input type="checkbox"/> Is difficult to understand <input type="checkbox"/> Struggles to say a sound even when asked to imitate it <i>(Please indicate specific sounds: _____)</i> <input type="checkbox"/> Stuttering <input type="checkbox"/> Fast rate of speech
Fine Motor	Social Emotional	
<input type="checkbox"/> Printing/writing <input type="checkbox"/> Cutting <input type="checkbox"/> Tremors <input type="checkbox"/> Switches hands when printing/cutting	<input type="checkbox"/> Overactive <input type="checkbox"/> Easily distracted <input type="checkbox"/> Impulsive <input type="checkbox"/> Poor attention <input type="checkbox"/> Aggressive	<input type="checkbox"/> Peer relationships <input type="checkbox"/> Routines/transitions <input type="checkbox"/> Easily frustrated/upset <input type="checkbox"/> Responding to directions <input type="checkbox"/> Anxiety/worry

What are one or two questions that you are hoping to have answered through this referral?

What have you tried already to address these concerns?
