



LEYDEN AREA SPECIAL EDUCATION COOPERATIVE

10401 GRAND AVE., FRANKLIN PARK, IL 60131

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Director

TEACHER CHECKLIST FOR PHYSICAL THERAPY REFERRAL

Please be aware that an appropriate referral must identify problems related to classroom performance. These problems must adversely affect the student's ability to access their education. When completing this form, please consider age appropriate skills and behaviors. If you have any questions, please call the technical assistance supervisor at 847/455-3143.

General Background Information

Name of Student (L,F,M):	Birthdate	Sex	Grade	AM/PM
Parent/Guardian	Resident District/School		Attending School (Operating School)	
Street Address	City, State, Zip	Home Phone	Work Phone(s)	

Program enrolled in:

- | | |
|---|--|
| <input type="checkbox"/> CCORE | <input type="checkbox"/> Learning Disability |
| <input type="checkbox"/> Early Childhood | <input type="checkbox"/> Emotional Disorder |
| <input type="checkbox"/> Language Learning Program | <input type="checkbox"/> Mentally Impaired |
| <input type="checkbox"/> None (TAS is aware that a 504 plan may be necessary) | <input type="checkbox"/> Autism |
| <input type="checkbox"/> Other _____ | |

Please address cognitive level (if known)

When did this student enter the above program or grade level? _____

Beginning of the school year? _____ Other? _____

When did these problem areas begin to affect the student's ability to access his/her education?

Has a special education evaluation been initiated? Yes (Date Process Began) _____ No

Who initiated this Physical Therapy Referral? _____

By whom and when was the parent informed that a PT Observation/Evaluation is being considered? _____

Adaptive Equipment

This Student Uses (please check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> A regular classroom chair | <input type="checkbox"/> Stander |
| <input type="checkbox"/> Functional bracing for lower extremities, upper extremities and/or spine | <input type="checkbox"/> A Modified Seating System |
| <input type="checkbox"/> Cane | <input type="checkbox"/> Crutches |
| <input type="checkbox"/> Manual wheelchair | <input type="checkbox"/> Walker |
| <input type="checkbox"/> Adaptive toilet seat | <input type="checkbox"/> Electric wheelchair |
| | <input type="checkbox"/> Grab bars for toilet |

Additional Information and Comments:

Seating, Functional Positioning and Changing Positions

Please check all that apply to this student:

- Unable to maintain appropriate sitting posture to complete school tasks
- Unable to safely move on and off all sitting surfaces within educational environment (floor, chair, wheelchair, etc.)
- Unable to maintain stability on the toilet
- Unable to safely board and/or disembark transportation vehicle (e.g. bus, car, etc.)

Additional Information and Comments:

Travel

Please check all that apply to this student:

- Unable to move around classroom environment safely and efficiently
 - Bumps into obstacles (classroom furniture/people) excessively
 - Trips and/or falls excessively
- Unable to move safely and efficiently from one classroom to another as demanded by the student's curriculum
 - Safety is a concern
 - Efficiency is a concern
- Unable to safely move on various flat surfaces (e.g. linoleum, carpet, gravel, pavement, grass, etc.)
- Unable to safely move through the hallways when congested with students and/or obstacles
- Unable to access the elevator independently and safely

Additional Information and Comments:

Student Name:

Birthdate:

Stairs/Ramps

Please check all that apply to this student:

- Unable to negotiate up/down stairs and/or ramps safely as required by the student's curriculum
- Unable to negotiate up/down stairs and/or ramps while holding necessary school supplies

Additional Information and Comments:

Recreational Activity

Please check all that apply to this student:

- Unable to safely engage in gym activities
 - Trips and/or falls excessively
 - Shows poor safety awareness
- Unable to safely access playground equipment
 - Falls off equipment excessively
 - Shows poor safety awareness

Additional Information and Comments:

General Safety

Please check all that apply to this student:

- In the event of an evacuation, unable to exit building to designated area within the time frame required
- Unable to safely reach articles in the student's locker, cubbie, storage area, etc.
- Overall, shows decreased safety, and an increased risk for injury as compared to peers

Additional Information and Comments:

What methods have been attempted to remediate the problems listed? Have they been successful?

Area of Concern	Intervention Attempted	How Long	Results

Student Name:

Birthdate:

Form completed by

Name	Title	Email	Date

Best day and Time to View Noted Concerns: _____

Technical Assistance Supervisor has reviewed this form.

- Completeness
- Accuracy
- Inclusion of Data on Educationally Relevant Interventions, if applicable

If these criteria are met, the TAS should sign below and give completed original to the OT/PT secretary.

Technical Assistance Supervisor's Name	Email	Date

- The Physical Therapist has reviewed the information and is **NOT** recommending further evaluation.
- The Physical Therapist has reviewed the information and is recommending further evaluation.

Physical Therapist's Signature	Email	Date