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School Based Rehabilitation Services
Enabling Participation, Socialization and Learning

OT/PT Additional Information Form

Student's Name:		Date of Birth:	
School Name:		Class/Grade:	
A. Reason for Referral			
Referred By (Name and Position):			
B. Safety & Participation			
Is there a safety plan?	Yes (If yes, please attach)	No	
Is there a safety issue?	Yes (If yes, please describe)	No	
Do the referral concerns affect the child/youth's ability to access the curriculum or attend school?			
Mildly	Moderately	Unable to access any part of the curriculum/Attend school	
C. History & Support			
Does the child/youth have an Individualized Education Plan (IEP)?			
Yes (If yes, please attach)		No	Unknown
Does the child/youth have an Identification, Placement and Review Committee (IPRC) designation?			
Yes (If yes, please attach)		No	Unknown
Does the child/youth have a psychological assessment?			
Yes (If yes, please attach)		No	Unknown
Has the child/youth received school based services previously (formerly SHSS)?			
Yes	No	Unknown	If yes, what strategies have been put into place?
If the child/youth has received OT/PT service before, what has changed?			
Has the school been using any strategies to address concerns?		Yes	No
Are they still working?		Yes	No Please elaborate:
Have you connected with parents and previous teachers to review interventions?		Yes	No
Are there strategies identified in the OSR or with the resource teacher?		Yes	No
What (if any) other resources have been accessed?		Behavioural Team	Children's Mental Health
Ontario Autism Program (OAP),		School Board Resources,	Other (specify)

Student's Name:		Date of Birth:	
D. Information for Therapy Referral			
Please identify any equipment used by the child for mobility at school:			
Areas of Concern:	Gym	Playground	Safety
General Mobility & Accessibility	Equipment Concerns	Other	N/A
Please provide description or examples:			
Please check areas of concern:		Fine Motor/Hand Skills	N/A
Please provide description or examples:			
Printing/Written Output*	N/A	*Please indicate support and/or adaptations for printing/handwriting that have been tried:	
Please provide description or examples:		Printing/Cursive Writing Program 1:1 Support Technology/Software Programs Alternative Pencil Grips or Lined Paper Other (Please describe):	
Sensory**	N/A	**What Sensory resources does your school have?	
Please provide description or examples:		Sensory Room Basic Sensory equipment Other (Please describe):	
		What strategies have you tried? Environmental Adaptations Body Breaks Other (Please describe):	
Self-Care (Toileting, Feeding, Dressing)	N/A		

Student's Name:

Date of Birth:

Other

Please provide description or examples:

Please attach supporting documentation.

Form available at www.quintectc.com and is fillable to allow for more detail.