Pathways For Learning, Inc
Enhancing Development Through *Sensory* Environments
8045 Providence Road, Suite 200 Charlotte, NC 28277
PN 704.540.5252 * FX 704.540.5755**

Occupational Therapy Referral Checklist
Grades K-5

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Child's Name: ____________________Age:___________Grade:_____School_____________

Gross Motor (Upper Body Strength, muscle tone, trunk stability)

___Slumps in chair
___Holds head up with hand
___Fidgety in chair
___Leans on things when standing
___Tires easily (fatigues before peers, difficulty finishing assignments)

Bilateral Integration (hand dominance, efficient use of two hands together)

___Switches hands during writing
___Switches hands during fine motor tasks
___Difficulty adjusting paper when cutting
___Poor manipulation of dressing fasteners
___Poor stabilization of paper when writing
___Difficulty with bookbag/pencil sharpener/manipulatives/shoes
___Keeps work on one side of desk

Fine Motor (grasp patterns, hand/wrist strength, in-hand manipulation)

___Awkward grasp on pencil/scissors
___Writing pressure too light/too heavy
___Drops things easily
___Flexes wrist when writing/cutting
___Experiences hand fatigue/pain
___Excessive hand perspiration
___Poor isolation on fingers on keyboard
___Writing not fluid

Perceptual Motor/Handwriting/Oculomotor (body perception, visual perception, visual motor integration, eye-hand coordination, visual focus and tracking)

___Poor letter recognition
___Poor letter formation
___Poor letter/word spacing/alignment
___Inaccurate or slow copying/reading (loses place, omits words, add words)
___Difficulty completing reading/writing
___Poorly organized writing
___Cannot think of what to write about
___Poor drawing skills
___Unable to accurately draw a person
___Letter/word reversals (past 1st grade)
___Difficulty coloring within boundaries
___Difficulty staying on lines with cutting
___Confuses right/left (past kindergarten)
___Poor alignment of numbers in math
___Poor memory for written directions
___Poor spelling skills
___Moves head back and forth while reading
___Eye watering/rubbing/squinting
___Poor eye-hand coordination in gym
___Does not recognize or fix own errors well
___Difficulty with mazes and/or dot-to-dots
___Difficulty copying designs with manipulatives or on paper/graphs/dot maps

Sensory Processing (touch, visual processing, auditory processing, movement, body awareness)

___Avoids or has difficulty with eye contact
___Is easily distracted by visual stimulation

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___Seems not to understand what was said
___Appear reluctant to participate in sports and games
___Prefers to touch rather than be touched
___Avoids getting hands messy (art)
___Seems more sensitive to pain than others
___Complains that others hit/push him/her
___Difficulty making friends
___Has strong desire for routine/sameness
___Has strong outbursts of anger/frustration
___Bumps into things frequently
___Falls out of chair
___Seems to deliberately fall or tumble
___Seems overly sensitive to sounds
___Distracted by lots of noise
___Unable to follow 2-3 directions
___Often seems overly active
___Hits or pushes other children
___Oblivious to bruises/heavy falls
___Mouths clothing/objects frequently
___Tends to prefer to play alone
___Intense and easily frustrated
___Lacks carefulness/Impulsive
___Moves in/out of chair while working
___Seems clumsy
___Distracted by background noises

Motor Planning (the ability to plan and execute novel, multi-step tasks)
___Difficulty following multi-step directions
___Difficulty initiating tasks
___Difficulty learning new tasks
___Often tries to imitate others
___Has difficulty maintaining/copying rhythms
___Has difficulty with motor tasks with several steps
___Performance of tasks is slow/plodding
___Poor task completion
___Poor organization skills
___Does poorly on times tests

What is your main area of concern:____
____
____

Please list any medications, medical, vision, or hearing problems:____________________
____
____

Describe performance in gym, art, music:_______________________________________
____
____

Any additional comments/pertinent information:__________________________________
____
____

If possible, please attach work samples (i.e., writing, coloring, cutting)

Name of Person Completing Form:_____________________________________
Relationship to Child:______________________________**Date:**___________________________