PLATTSBURGH CITY SCHOOL DISTRICT
Screening Request

Student Name:_____ DOB:_____

Teacher:_____ Grade:_____

Person Making Referral: _____ Date:_____

OT request_____
OT concerns (check all that apply):

Mixed Hand Dominance _____
Pushes hard/light on pencil _____
Awkward Grasp _____
Trouble Sitting Still _____
Difficulty Dressing/Tying Shoes _____
Poor Visual Attention _____
Poor Eye Contact _____
Difficulty Cutting _____
Sensitive to Touch/Texture _____
Loses Place when Reading _____
Poor Coloring/Writing _____

Other: _____

_____

_____

PT request_____
PT concerns (check all that apply):

Difficulty in Hallways _____
Difficulty with Stairs _____
Trips and falls frequently _____
Slouched posture _____
Awkward Movements _____
Confuses Left and Right _____
Difficult Time in PE Class _____
Appears Weak _____
Tires Easily _____
Difficulty Hopping _____
Avoids/Fears Climbing _____

Other: _____

_____

_____

PARENT CONTACT:

_____ _____
Parent Signature (or documentation of contact) Date

SEE ATTACHED SCREENING FORM FOR RESULTS.

Consultation Done By:_____ Date:_____

Recommendations: _____

_____

_____