**Tazewell Mason Counties Special Education**

**300 Cedar Street Pekin, IL 61554**

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**OCCUPATIONAL THERAPY ANNUAL REVIEW**

**20\_\_- 20\_\_**

|  |  |
| --- | --- |
| Name:  | Date of Meeting: |
| BD: | Medical Diagnosis: |
| CA: | Medication: |
| Gender: | Doctor: |
| Therapist: | Precautions: |

**BACKGROUND INFORMATION**:

|  |  |
| --- | --- |
| School/District: | Teacher: |
| Grade/ Program:  | Educational Eligibility: Autism, Deaf Blindness, Developmental Delay, Hearing Impaired, Orthopedic Impairment, Specific Learning Disability, Traumatic Brain Injury, Intellectual Disability, Deafness, Emotional Disability, Multiple Disabilities, Other Health Impairment, Speech and Language Impairment, Visual Impairment, 504 |
| Last Full and Individual Evaluation: | Last OT Evaluation:  |
| Related Services: | Current Service Level:  |

Medical Information:

**SUBJECTIVE**: Paraphrased information from the student, family, or teacher. It should reflect the point of view of the child. Also, it is specific to his/her reason for receiving OT services. Include student behavior and/or attendance information that affects therapy and/or treatment.

**OBJECTIVE:** Factual observation, it will be the longest section of the report.

Focus of Interventions: Sensory activities, fine motor strength and coordination activities, handwriting legibility, self-care skills, positioning, gross motor skills, upper extremity range of motion, upper extremity strengthening, trunk strength and stability, visual motor skills, visual perceptual skills, motor planning, bilateral coordination

Goal Performance: OT IEP goals and progress or summary. (See IEP goals update)

\_\_\_\_\_\_\_\_\_\_\_has met \_\_ /\_\_ objectives to improve \_\_\_\_\_\_\_\_ skills. (See Progress Report, Goals and Objectives/Benchmarks)

Independent Living Skills:

*Dressing*:

*Feeding*:

*Hygiene*:

Neuromuscular: Range of Motion, gross motor, fine motor, Vigorimeter, muscle tone, strength measurements, postural balance, bilateral coordination. See attached ROM chart for details.

Sensory Processing-

*Concerns*: Observed or reported sensory processing concerns

*Equipment*: Weighted items, compression items, oral motor, disco seat. Include what has been tried and what has been successful/ unsuccessful.

*Strategies*: Visual supports, movement breaks, heavy work activities.

Fine Motor Skills: Scissor skills, dexterity, in-hand manipulation, manipulation skills, grasp/release patterns.

Handwriting:

*Hand preference*: Right/Left/ Both, Switches.

*Pencil Grasp*: Right/Left, Type of grasp- tripod, quadropod, adaptive tripod

*Prewriting Skills*: Coloring, Shapes.

*Method of writing*: manuscript/cursive/keyboarding

*Posture*: seating, positioning, stabilizing the paper, position of the paper.

*Legibility*: letter or number- formation, directionality, spacing, size, orientation, line placement, legibility percentage, rate, pencil pressure.

Adaptive Equipment: Adaptive equipment and techniques used by student in therapy and equipment recommended by OT for the classroom. Examples- built-up spoon, scoop dish, lap tray, slant board, short pencil, pencil grip, word processor, wheelchair, assistive technology, sensory supports, adapted supports, adapted chair, AAC device.

**ASSESSMENT:** Analysis of Subjective and Objective portions of the report. Summarize the goal performance improvements, maintained skills and deficits. What are student’s weaknesses and strengths and how does this affect performance? How does behavior affect therapy? Include ROM changes. Recommend continue or discontinue of therapy services as they relate to the student’s educational needs.

**PLAN:** Occupational Therapy services for minutes per week ( visits) and minutes per semester ( visits) supervision to focus on…… (Goal areas)

OR

Occupational Therapy services are not recommended at this time as it relates to (insert students name) educational programming.

**Classroom/Home Suggestions:**

|  |  |
| --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Insert your name), COTA/L | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Insert name), OTR/L |
| Occupational Therapy Assistant | Occupational Therapist |

*Revised 5/16 Z=TM²C*