**TMCSEA-COLORTMCSEA-COLORTazewell Mason Counties Special Education**

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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**:

**OBJECTIVE:**

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:

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

Independent Living Skills:

*Dressing*:

*Feeding*:

*Hygiene*:

Neuromuscular:

Sensory Processing-

*Concerns*:

*Equipment*:

*Strategies*:

Fine Motor Skills:

Handwriting:

*Hand preference*:

*Pencil Grasp*:

*Prewriting Skills*:

*Method of writing*:

*Posture*:

*Legibility*:

Adaptive Equipment:

**ASSESSMENT:**

**PLAN:** Occupational Therapy services for minutes per week ( visits) and minutes per semester ( visits) supervision to focus on \_\_\_\_\_\_\_.

OR

Occupational Therapy services are not recommended at this time as it relates to \_\_\_\_\_\_ educational programming.

**Classroom/Home Suggestions:**

|  |  |
| --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  , COTA/L | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  , OTR/L |
| Occupational Therapy Assistant | Occupational Therapist |

*Revised 5/16 Z=TM²C*