SCHOOL BASED ACADEMY

The Capable Classroom

2022-2023

PTS PEDIATRIC THERAPEUTIC SERVICES

PEDIATRIC THERAPEUTIC SERVICES

525 Fayette St.
Conshohocken PA 19428

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PTS' School Based Academy is a multi-session specific training in how to jumpstart a successful career in school-based therapy. It provides practical knowledge a therapist will need, whether a therapist is a brand-new practitioner, coming to the schools from another clinical setting or a returning therapist looking to refresh their skills.

Time Frame:
The School Based Program is run from August to June. There is a scheduled zoom learning series offered in August as well as on-demand webinars. Additionally, there is an optional mentorship throughout the year offered by peers working in the same field of expertise.

School Based Mentorship:

- Sharing experience, insights and feedback that will guide you in the achievement of your learning objectives.
- Understanding your goals and to uncover key learning opportunities that support those goals.
- Providing both with opportunities to share talents, skills, experiences and expertise.
- Focusing on the growth and development, learning experiences and feedback.
- A valuable – but optional – feature of a supportive forum to personal and professional development.

Practical understanding of school-based practice's central issues include:

- Building relationships so teachers, staff, families, and caregivers become your allies for quality student care.
- Managing your caseload and schedule with maximum efficiency.
- Collecting and analyzing data to document students' achievements and your interventions' effectiveness.
- Delivering excellent treatment and care when you're given limited space and resources.
- Writing relevant, measurable, and legally defensible Individualized Education Program (IEP) goals squarely focused on students' progress.

Recommendations for success in the school year

- Mark your calendar for the SBA learning series or set a time aside to review the webinars.
- Schedule zoom or phone meetings that work for you and the mentor.
- Provide a time frame for the meeting so expectations are set in the beginning. (Suggestion of 30 min)
- If reviewing anything, provide a time frame to reply and how feedback would be given. (Oral or written) For example: Can you review this item within the next 5 days and set up a phone call to discuss with you?

School Based Academy Mentor:

PTS' School Based Academy is a multi-session specific training in how to jumpstart a successful career in school-based therapy. It provides practical knowledge a therapist will need, whether a therapist is a brand new practitioner, coming to the schools from another clinical setting or a returning therapist looking to refresh their skills.

Time Frame:
The School Based Program is run from August to June. There is a scheduled zoom learning series offered in August as well as on-demand webinars. Additionally, there is an optional mentorship throughout the year offered by peers working in the same field of expertise.

Mentor Approach:
- Share experience, insights and feedback that will guide the therapist in the achievement of his or her learning objectives.
- Listening plays an important part in the mentoring role – listening to understand the therapist's goals and to uncover key learning opportunities that support those goals.
- Providing both with opportunities to share talents, skills, experiences and expertise.
- Focused on the growth and development, learning experiences and feedback.
- A valuable – but optional – feature of a supportive forum to personal and professional development.

Practical understanding of school-based practice's central issues include:
- Building relationships so teachers, staff, families, and caregivers become your allies for quality student care.
- Managing your caseload and schedule with maximum efficiency.
- Collecting and analyzing data to document students' achievements and your interventions' effectiveness.
- Delivering excellent treatment and care when you're given limited space and resources.
- Writing relevant, measurable, and legally defensible Individualized Education Program (IEP) goals squarely focused on students' progress.

Recommendations:
- Schedule zoom or phone meetings that work for you and the mentee.
- Provide a time frame for the meeting so expectations are set in the beginning. Suggestion of 30 min
- If reviewing anything, provide a time frame for reply and how feedback would be given. (Oral or written) For example: I will review this item within the next 5 days and set up a phone call to review with you.

EDUCATION VS. CLINICAL

EDUCATION VS CLINICAL MODEL

	Education Model	Clinical Model
HOW DOES IT START?	Teacher, parent or other team member can ask the IEP team to consider the need for a therapy screening or evaluation	Referral is initiated by physician based on observed delay or diagnosis or parent is able to independently take the child to a clinic for testing.
WHO DECIDES NEED FOR SERVICES?	• IEP team consensus with recommendation from licensed OT/PT/SLP based on testing and classroom/campus observation • Assessment takes into consideration only needs associated with special education program (except for Speech and Language services which can provide an educational diagnosis and stand alone as a service in an IEP.)	• Testing and clinical observation by licensed OT/PT • Assessment takes all settings into consideration • Frequently driven by doctor's orders
WHAT IS THE PURPOSE OF EVALUATION?	• To contribute knowledge and data to the IEP team for discussion and decisions based on child's educational and academic needs. • Helps to identify areas of strengths and needs • Helps to guide goals • To identify any observable and measurable deficits impacting the child's classroom performance.	• To determine need for services • Helps to identify areas of strengths and needs • Helps to guide goals
WHO DECIDES SCOPE OF SERVICES?	• IEP team–including parents, student (if appropriate), educators, administrators and school based therapists–determine the focus, frequency and duration of therapy • A doctor's orders or outside therapy evaluation does not drive decisions about school therapy services	• Medical team determines location, focus, frequency and duration of therapy. • Insurance coverage, doctor's orders and transportation may be determining factors
HOW CAN SERVICES BE CHANGED?	Changes to related services require an IEP meeting with parents, educators, administrators and the school based therapist present to discuss and come to consensus.	Doctors can alter orders or therapist can change therapy plan, generally discussed with doctor and parents
WHAT IS THE FOCUS OF THERAPY ?	• Therapy addresses access to special education and school environment • Works toward independence and participation • Intervention usually for more chronic problems that interfere with educational process	• Therapy addresses medical conditions and impairments • Works to get full potential realized • Intervention usually for acute problems
WHERE DOES THE THERAPY OCCUR?	• On school grounds, bus, halls, playground, classroom, lunchroom; total school environment • Also work sites and for preschool students some daycare settings	In the clinic, hospital or home
HOW IS THERAPY DELIVERED?	Integrated/inclusive therapy, staff training, program development, collaboration with staff, group intervention, direct one-on-one treatments, consultation	Direct one-on-one treatment to accomplish set goals
WHO PAYS?	No cost to student or family = free and appropriate public education (FAPE)	Fee-for-service payment by family, insurance or governmental assistance.
HOW ARE SERVICES DOCUMENTED?	Related to IEP with accessible, readable language guided by state and local policy reflecting best practice	Dictated by insurance requirements and guidelines ofthe setting; emphasis on medical terminology and billing codes

IEP TEAM MEMBERS

By law, certain individuals must be involved in writing a child's Individualized Education Program.

These are:

The case manager is a licensed teacher or related service provider who is a member of the IEP team and is responsible to coordinate instruction and related services for the student. The case manager will coordinate the delivery of special education services and will be the primary contact for the parent.

Other Team members include:

- Administrator: Principal or IEP coordinator (LEA): a representative of the school system
- at least one of the child's special education teachers or providers
- at least one of the child's regular education teachers (if the student is, or may be, participating in the regular education environment)
- an individual who can interpret the evaluation results
- representatives of any other agencies that may be responsible for paying for or providing transition services (if the student is 16 years or, if appropriate, younger)
- the child's parents or legal guardian’s
- the student, as appropriate
- other individuals who have knowledge or special expertise about the child

Note that an IEP team member may fill more than one of the team positions if properly qualified and designated. For example, the school system representative may also be the person who can interpret the child's evaluation results.

These people must work together as a team to write the child's IEP. A meeting to write the IEP must be held within 30 calendar days of deciding that the child is eligible for special education and related services.

Each team member brings important information to the IEP meeting. Members share their information and work together to write the child's Individualized Education Program. Each person's information adds to the team's understanding of the child and what services the child needs.

Psychologist:

Credentials:

- Psychology License issued by the State of where you are practicing

Responsibilites:

- Provide counseling, instructions and mentoring for those struggling with social, emotional and behavioral problems
- Increase achievement by assessing barriers to learning and determining the best instructional strategies to improve learning
- Promote wellness and resilience by reinforcing communication and social skills, problem solving, anger management, self-regulation, self-determination and optimism
- Enhance understanding and acceptance of diverse cultures and backgrounds
- Identify and address learning and behavior problems that interfere with school success
- Evaluate eligibility for special education services (with a multidisciplinary team)
- Support students' social, emotional and behavioral health
- Teach parenting skills and enhance home-school collaboration
- Make referrals and help coordinate community support services
- Identify and resolve academic barriers to learning
- Design and implement student progress monitoring systems
- Design and implement academic and behavioral interventions
- Support effective individualized instruction
- Create positive classroom environments
- Motivate all students to engage in learning
- Collect and analyze data related to school improvement, student outcomes and accountability requirements
- Implement school-wide prevention programs that help maintain positive school climate conducive to learning
- Promote school policies and practices that ensure the safety of all students by reducing school violence, bullying and harassment
- Respond to crisis by providing leadership, direct services and coordination with needed community services
- Design, implement and garner support for comprehensive mental health programming

Occupational Therapist:

Credentials:

- Occupational License issued by the State of where you are practicing

Responsibilites:

- COTA supervision
- Screen, assess, and evaluate students using appropriate tests and assessment instruments along with clinical observation pertinent to areas of the occupational therapy profession.
- Plan and provide appropriate specialized occupational therapy techniques through individual and/or group sessions designed to meet the educational needs of the
- student consistent with occupational therapy goals contained in Individual Education Plans (IEP).
- Subscribe to an integrated model of service provision, to the greatest extent possible within your program.
- Facilitate group therapy treatment sessions, to the greatest extent that is appropriate within your program.
- Develop and implement program staff training and education.
- Participate in multi-disciplinary meetings to develop Individual Education Plans.
- Evaluate student progress and determine readiness for termination of therapy services.
- Design and construct or modify special equipment to meet individual needs.
- Comply with policies established by federal and state law, State Board of Education rules, and school policy.
- Compile, maintain, and file all reports, records, and other documents required in accordance with federal and state
- law, State Board of Education rules, and school policy to include documentation for the need for equipment and materials.
- Counsel and involve parents in the occupational therapy program of their child.
- Collaborate with classroom teachers to plan and implement classroom based activities.
- Confer with the classroom teachers as requested concerning any educational needs of the students receiving occupational therapy along with making available to teachers instructional ideas that are appropriate for students within the classroom situation.
- Meet the needs of the students program effectively by working in partnership with other disciplines.
- Maintain up-to-date knowledge of research, theories and practices associated with the Occupational Therapy profession.

Physical Therapist

Credentials:

- Valid Physical Therapist License issued by the State where you are practicing

Responsibilites:

- Screen, assess, and evaluate students using appropriate tests and assessment instruments along with clinical observation pertinent to areas of therapy.
- Plan and provide appropriate specialized physical therapy techniques through individual and/or group sessions designed to meet the educational needs of the student consistent with physical therapy goals contained in Individual Education Plans (IEP).
- Subscribe to an integrated model of service provision, to the greatest extent possible within your program.
- Facilitate group therapy treatment sessions, to the greatest extent that is appropriate within your program.
- Develop and implement program staff training and education.
- Participate in multi-disciplinary meetings to develop Individual Education Plans.
- Evaluate student progress and determine readiness for termination of therapy services.
- Collaborate with classroom teachers to plan and implement classroom based activities.
- Confer with the classroom teachers as requested concerning any educational needs of the students receiving physical therapy along with making available to teachers instructional ideas that are appropriate for students within the classroom situation
- Counsel and involve parents in the physical therapy program of their child
- Compile, maintain, and file all reports, records, and other documents required in accordance with federal and state law, State Board of Education rules, and school policy to include documentation for the need for equipment and materials.
- Meet the needs of all students effectively by working in partnership with other disciplines.
- Comply with policies established by federal and state law, State Board of Education rules, and school policy.
- Maintain up-to-date knowledge of research, theories and practices associated with the Physical Therapy profession.

Speech Language Pathologist

Credentials:

- Valid Pennsylvania Level I or II Certificate or Emergency Certificate in the area of Speech and Language Impaired from PDE
- State licensure required for certain contracts

Responsibilites:

- Screen, assess, and evaluate students using appropriate tests and assessment instruments along with clinical observation pertinent to areas of speech and language development.
- Plan and provide appropriate specialized speech and language therapy techniques through individual and/or group sessions designed to meet the educationalneeds of the students consistent with the goals contained within the Individual Education Plans (IEP).
- Subscribe to an integrated model of service provision, to the greatest extent possible within your program.
- Facilitate group therapy treatment sessions, to the greatest extent that is appropriate within your program.
- Develop and implement program staff training and education.
- Coordinate and/or participate in multi-disciplinary meetings to develop Individual Education Plans.
- Evaluate student progress and determine readiness for termination of therapy services.
- Collaborate with classroom teachers to plan and implement classroom based activities to improve receptive and expressive speech and language skills of students.
- Confer with the classroom teachers as requested concerning any educational needs of the students receiving Speech and Language therapy along with making available to teachers instructional ideas that are appropriate for students within the classroom.

Speech Language Pathologist- Case Manager

Speech Therapists can also be case managers. There are 14 Special Education Disability Categories in the Commonwealth of PA. The Special Education section of the school code is known as Chapter 14. Speech and Language disability is one of the 14 categories, and as such, can be a primary or stand-alone service in the schools. When an eligibility determination for a speech and language disorder is made, and it is determined that an IEP with specially designed instruction is required, the speech pathologist is the case manager. Other services can be added as a related service. HOWEVER, those needs must be directly tied to the communication disorder. Your responsibilities as case manager include:

- Distribute IEPs to general education teachers, IEP team members, and be sure to instruct any staff working with student on required accommodations and SDI.
- Re-evaluate students every three years; two years with IEP.
- Progress reports need to be written and entered into online IEP system, hard copy placed in student special service file, and copy mailed to parent
- Communication and coordination of case information across the IEP team
- Track, schedule, conduct IEP, meetings as determined by the IEP team.
    - Annual IEPs MUST be completed prior to the annual due date. IF October 13, 2015 was last annual IEP, then you must complete prior to October 13, 2016.
- Track, schedule, and conduct reevaluation meetings.
    - For speech and language cases, a reevaluation must be held every 3 years to determine continued eligibility. If last eligibility date was September 16, 2013 a reevaluation must be completed prior to September 16, 2016. Note: An IEP must be held within 30 days from the NEW eligibility date.

Speech Language Pathologist-Related Service Provider

As noted, above, with regard to 14 special education disability categories, speech can be a related service to any of the disability categories in which it is determined there is a documented NEED for the expertise of the speech pathologist. Speech services must be determined by a speech pathologist and part of an IEP team decision.

- Contact case managers to introduce yourself and establish communication.
- Clarify goals with case manager for purposes of data collection.
- Progress reports need to be completed and entered into online IEP system, notify case manager of completion so as to be included when sent home.
- You are responsible for knowing due dates for reevaluations and IEPs, so as to be prepared to participate when action is to occur. However, the case manager is to communicate and coordinate with team members about specific dates and times for action and meetings. Be proactive-some case managers are excellent, others could use a boost to remember you.
- NEVER discuss IEP information outside of the IEP team. This can lead to disaster. If, you are in contact with an IEP team member who wants to change some aspect of the IEP, you should alert the case manager immediately, and schedule an IEP meeting.
- You are responsible for ensuring all of your information is correct in the IEP, prior to, and after the IEP is finalized, mistakes happen, but sometimes they aren't mistakes. Double check.

Local educational agency: As defined in ESEA, a public board of education or other public authority legally constituted within a State for either administrative control or direction of, or to perform a service function for, public elementary schools or secondary schools in a city, county, township, school district, or other political subdivision of a State, or for a combination of school districts or counties that is recognized in a State as an administrative agency for its public elementary schools or secondary schools.

Board Certified Behavior Analyst (BCBA)

Credentials:

- Master's in Applied Behavior Analysis
- Supervised experience hours
- Pass the BCBA exam

Responsibilites:

- BCBA's are the team leaders and experts when it comes to behavior management. Their role is to help IEP teams create plans tomanage behaviors that affect a student's learning; they work with the team to provide a comprehensive approach to behavior management that includes evaluation, data collection, interventions and regular progressmonitoring. The BCBA certification requires a graduate level education and specialized training in behavior analysis and modification.

Licensed Behavior Specalist Consultant

Credentials:

- Masters in Special Education, Social Work, Psychology, or related field
- Completion of Behavior Specialist License through PA State Board of Medicine.

Responsibilites:

- The LBSC's are not credentialed by the Behavior Analyst Certification Board but by the State Board ofMedicine. LBSC's are qualified to treat a variety ofmental health disorders that result in problem behaviors that impede one's ability to learn and function adequately in the school setting. LBSC's provide consultation, training, classroom support, and behavioral strategies for regular education teacher, special education teachers, site personnel, and others providing instructional services to students within the school setting.

Register Behavior Technician

Credentials:

- A high school diploma
- At least one year workign with students with developmental disabilites
- The RBT certification of willingness to get one within 60 days of hire

Responsibilites:

- The RBT is a paraprofessional who practices under the close, ongoing supervision of a BCBA, BCaBA, or FL-CBA. The RBT is primarily responsible for the direct implementation of behavior analytic services but does not design intervention or assessment plans. It is the responsibility of the RBT supervisor to determine which tasks an RBT may perform as a function of his or her training, experience, and competence. The BACB certificant supervising the RBT is responsible for the work performed by the RBT on the cases they are overseeing.

Behavior Technician

Credentials:

- A high school diploma
- At least one year working with students with developmental disabilities

Responsibilites:

- A Behavior Technician often works 1:1 with one student all day. A Behavior Technician's role may be similar to that of a Personal Care Assistant or Instructional Assistant with more focus on behavior management and functional communication training. .

Mental Health Specialist

Credentials:

- Psychology License issued by the State of where you are practicing
- PA Department of Education Certificate

Responsibilites:

- Provide counseling, instructions and mentoring for those struggling with social, emotional and behavioral problems
- Increase achievement by assessing barriers to learning and determining the best instructional strategies to improve learning
- Promote wellness and resilience by reinforcing communication and social skills, problem solving, anger management, self-regulation, self-determination and optimism
- Enhance understanding and acceptance of diverse cultures and backgrounds
- Identify and address learning and behavior problems that interfere with school success
- Evaluate eligibility for special education services (with a multidisciplinary team)
- Support students' social, emotional and behavioral health
- Teach parenting skills and enhance home-school collaboration
- Make referrals and help coordinate community support services
- Identify and resolve academic barriers to learning
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- Support effective individualized instruction
- Create positive classroom environments
- Motivate all students to engage in learning
- Collect and analyze data related to school improvement, student outcomes and accountability requirements
- Implement school-wide prevention programs that help maintain positive school climates conducive to learning
- Promote school policies and practices that ensure the safety of all students by reducing school violence, bullying and harassment
- Respond to crisis by providing leadership, direct services and coordination with needed community services
- Design, implement and garner support for comprehensive mental health programming

Social Workers

Credentials:

- A bachelor's degree–ideally in social work, though degrees in psychology and sociology are also relevant–is the minimum requirement for getting a school-based social work position. Many require a Master of Social Work degree (MSW), approved by the Council on Social Work Education (CSWE), and other credentials.
- Specific criteria for becoming a licensed social worker vary by state. Check each state for details about obtaining licensure, as well as any additional certification required for working in schools.

Responsibilites:

- Case manager and counselor, advocate and mediator, identifier and distributor of resources, sometimes even calendar coordinator and truancy officer–school social workers play many roles. But in all they do, they aim to help students function and learn, to succeed both scholastically and socially in school. School-based social workers identify and advocate for students' best interests. Here are some specific shapes that general mission can take:
- Assessing students' biopsychosocial well-being
- The biopsychosocial approach attends to an individual in their fullest context: biological, mental, and relational. This holistic model allows school social workers to treat students and promote their well-being in multidimensional ways.
- Evaluate students' most pressing challenges and identify viable treatment strategies
- Today's students face exceptional social forces threatening their educational success, from the availability of harmful substances to the prevalence of bullying (in person and online). School social workers assess students at risk and, as needed, design and implement treatment to increase their selfdetermination.
- Make home visits
- Observing the student's natural environment firsthand is critical to any accurate evaluation of the student's needs. Domestic conditions and family dynamics shape
- not only how the student behaves and performs at school but also what interventions social workers can implement and what services they will seek to make available. Whether to find out why a student is chronically absent or to open lines of communication with families, home visits are central.
- Provide case management services
- School social workers learn and navigate often complex networks of school and community resources and supports. They refer students and their families to other agencies and collaborate with other professionals to ensure students' physical, mental, emotional, and social needs do not go unmet. They monitor how the service packages they arrange perform, making adjustments as needed.
- Facilitate student and family access to financial and healthcare assistance programs

Acronyms

A

AAC = Alternative Augmentative Communication
ABA = Applied Behavioral Analysis
ADA = Americans with Disabilities Act
ADD/ADHD = Attention Deficit/Attention-Deficit Hyperactivity Disorder
ADLs = Activities of Daily Living
APE = Adaptive Physical Education
ASD = Autism Spectrum Disorders
ASL = American Sign Language
AT = Assistive Technology
AYP = Adequate Yearly Progress

B

BD = Behavioral Disorder
BIP = Behavioral Intervention Plan
BOE = Board of Education

C

CBA = Curriculum Based Assessment
CCSS = Common Core State Standards
CDA = Child Development Associate
CD = Cognitive Delay
CF = Cystic Fibrosis
COTA = Certified Occupational Therapist Assistant
CP = Cerebral Palsy
CST = Child Study Team

D

DB = Deaf-Blind
DD = Developmental Delay
DOE = Department of Education
DOH = Department of Health
DPH = Due Process Hearing Officer
DS = Downs Syndrome
DSM = Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association

E

ECE = Early Childhood Education
EBD = Emotional Disturbance
EHDI = Early Hearing Detection and Intervention Program
EI = Early Intervention
ER=Evaluation Report
ES=Emotional Support
ESD = Extended School Day
ESEA = Elementary and Secondary Education act
ESL = English as a Second Language
ESY or **EYS** = Extended School Year or Extended Year Services

F

FAPE = Free Appropriate Public Education
FAS = Fetal Alcohol Syndrome
FBA = Functional Behavioral Assessment
FERPA = Family Educational Rights and Privacy Act
FM = Focused Monitoring

G

GE = General Education
GT = Gifted & Talented

H

HI = Hearing Impaired
HQT = Highly Qualified Teacher

I

IA = Instructional Assistant
IAES = Interim Alternative Educational Setting
ID= Intellectual Disabilities
IDEA = Individuals with Disabilities Education Act
IEE = Individualized Educational Evaluation
IEP = Individualized Education Program
IFSP = Individualized Family Service Plan
IQ = Intelligence Quotient
IST=Instructional Support Teacher
ITP = Individualized transition Plan

L

LD = Learning Disability
LEA = Local Education Agency
LRE = Least Restrictive Environment

M

MD = Muscular Dystrophy
MD or **MH** = Multiple Disabilities or Multiple Handicapped
MDE= Multiple Disability Evaluation

N

NCLB = No Child Left Behind Act (Elementary & Secondary Education Act)
NEA= National Education Association
NECTAC= National Early Childhood & Technical Assistance Center
NOREP=Notice of Recommendation Educational Placement

O

OCD = Obsessive-Compulsive Disorder
ODD = Oppositional Defiant Disorder
OHI = Other Health Impairment
OI = Orthopedic Impairment
O & M = Orientation and Mobility Services
OT = Occupational Therapy

P

PALS = Peer-Assisted Learning System
PARCC = Partnership for Assessment of Readiness for College & Careers
PART B = Special Education - School - Aged Children
PART C = Special Education - Birth - Two Year's Old
PASS = Plan for Achieving Self-Support
PBS = Positive Behavioral Supports
PD = Physical Disability
PDD = Pervasive Developmental Disorder
PEI = Spanish acronym for the Individualized Education Program (Plan Educativo Individualizado)
PLEP or **PLP** = Present Level of Educational Performance or Present Level of Performance
PP= Paraprofessional
PS = Preschool
PT = Physical Therapy
PTE=Permission to Evaluate
PTR=Permission to Reevaluate

R

RD = Results-Driven accountability
RR=Reevaluation Report
RS = Related Services
RTI = Response to Intervention

S

SA = Self-Assessment
SAS = Supplementary Aids & Services
SAT = Student Assistance Team
SB = Spina Bifida
SE = Special Education
Section 504 = Section 504 of the Rehabilitation Act
SED = Serious Emotional Disturbance
SETT = Students Environments Tasks, Tools
SI = Sensory Integration
SLP = Speech Language Pathologist
SLD = Specific Learning Disability
SLI = Speech/Language Impairment
SSDI = Social Security Disability Income
SSI = Supplemental Security Income

T

TBI = Traumatic Brain Injury
TDD = Telecommunication Devices for the Deaf
TS = Tourette Syndrome
TWWIIA = Ticket to Work and Work Incentives Improvement Act

U

USDOE = United States Department of Education

V

VI = Visual Impairment
Voc Ed = Vocational Education
VR = Vocational Rehabilitation

REFERRAL PROCESS

WHAT IS THE REFERRAL PROCESS?

When does a child need special education and determining eligibility through a referral process?
The child may be eligible for special education if your child:

1) Has an intellectual disability, emotional disturbance, an orthopedic impairment, a hearing impairment, deafness, a speech or language impairment, a visual impairment (including blindness), autism, traumatic brain injury, other health impairment, a specific learning disability, deaf-blindness, or multiple disabilities

2) Needs special education, as determined by an evaluation team. Your child must meet both qualifications in order to be eligible for special education.
In Pennsylvania, all children eligible for special education have the right to a free, appropriate, public education (FAPE). NOTE: Children with disabilities who are not eligible for special education may qualify for accommodations in the general classroom under Section 504 of the Rehabilitation Act of 1973. Chapter 15 regulations apply for these students. Chapter 14 regulations apply to those students who qualify for special education services by meeting the two-part criteria listed above.

Signs of Physical, Sensory, Intellectual, or Emotional Disability

- Some indications that a child may have a disability that meets the first part of the two-part criteria are:
- Consistent problems in getting along with others
- Difficulty communicating
- Lack of interest or ability in age-appropriate activities
- Resistance to change
- Difficulty seeing or hearing that interferes with the ability to communicate • Health problems that affect educational performance, including attention problems
- Difficulty performing tasks that require reading, writing, or mathematics
- Chronic behavior or social problems that affect your child's ability to learn
- The child may need specially-designed instruction to make progress in school. This need for special education is the second part of the two-part criteria to be eligible for special education services.

Screening

A child's school has a screening process in place that identifies students who may need special education.
This process may or may not lead to an initial evaluation for special education and should include:

- A review of the student's records, including attendance and report cards
- A review of the student's vision and hearing

- Assessments at reasonable intervals to determine a student's performance based on grade-appropriate standards in core academic subjects
- A systematic observation of the student's behavior in the classroom or area in which the student is displaying difficulty You may request an initial evaluation at any time, without going through these screening activities.

The Evaluation Process

The evaluation team gathers the information that will be used to determine if a child needs special education and, if so, the types of programs and services needed. The child may be evaluated by a school psychologist. Other evaluations may include tests by a hearing specialist for a child with a hearing problem, or an evaluation from a doctor for a child with 3 a health concern. The evaluation must also include input from a certified professional if certain services, called "related services," may be needed. An example is speech therapy (for speech and language) or occupational therapy (for fine motor and other skills).
A child may be referred for the first (or initial) evaluation in different ways:

- A Parent may ask your school to evaluate your child for special education at any time. This can be done by sending a letter to the principal of your child's school or by asking a school professional employee. It is recommended that you keep a record of your written or verbal request. A Permission to Evaluate- Evaluation Request form should be sent to you within 10 calendar days after the receipt of your request.

OR

- The school may contact you to request permission to have your child evaluated. A parent must consent in writing to their child's evaluation. School officials cannot proceed without the parent's written permission. If permission is not received and the school continues to find that an evaluation is necessary, they may ask for a due process hearing to get approval from an impartial hearing officer to evaluate your child.
- To give permission for the evaluation process to begin, the parent must sign the Permission to Evaluate-Consent form given to you by your local educational agency (LEA).
- The entire evaluation process must be completed within 60 calendar days (not including summer vacation) from the date your permission is received by the LEA.
- If the child is eligible for special education, the ER and a summary must be given to the parent at least 10 school days before a meeting is held to discuss your child's Individualized Education Program (IEP). A parent may not feel the 10 days are necessary and must put in writing to the school that the meeting may be held sooner than 10 days.
- Either way, the parent will be invited to the meeting. The types of tests used in the evaluation process depend upon the educational needs of your child. In most cases, your child may be given several tests to help find strengths and needs. Someone other than your child's general classroom teacher may also observe your child in class.
- Part of the evaluation includes gathering input from parents about their child. Information that they share about their child is very important and must also be included in the evaluation.

Evaluation Will Tell The Parent

The evaluation will include information about the child's skills, strengths, and needs.
All evaluations and 4 reevaluations (which are evaluations done at 2- or 3-year intervals after the initial evaluation) must include a review of the testing and assessments that were conducted, information from the parents, classroom observations, and the observations of teachers and related service personnel.
The evaluation or reevaluation must also tell the parent what additions or changes are needed to help the child meet the goals in your child's educational program described in your child's Individualized Education Program (IEP), and to take part in and progress in the general curriculum (the skills and knowledge taught in a specific LEA).
An evaluation team reviews all materials and writes a report called an Evaluation Report (ER) that states if your child has a disability and if your child needs special education. It makes recommendations about the types of services your child needs. The ER may state that your child is not eligible and does not need special education services. You will receive a copy of the ER and a written notice stating that you have the right to disagree and may request an independent educational evaluation (IEE) or request a due process hearing.
A copy of the ER and a summary of the findings must be given to the parent. If the child is being evaluated for a specific learning disability, parents (as members of the evaluation group) will be given an opportunity to agree or disagree with the results of the ER.
Next to the parent's name, they will indicate whether or not they agree with the report. If they do not agree, they may give the team their opinion in writing, on the parts of the report where they disagree. This is sometimes called a "dissenting opinion," which will become part of the final ER. A copy of the final ER must be given to the parents.

Independent Educational Evaluations (IEE)

They may also get evaluation reports from professionals outside the school system and send them to their child's school. Examples of these professionals may include a psychologist or therapist. The LEA can provide you with information about where an independent evaluation can be obtained. The results of these outside evaluations will be considered in determining if the child has a disability and needs special education. If the parent wish for the LEA to pay for an outside or independent educational evaluation, you first must disagree with the evaluation conducted by the LEA. The LEA then must initiate a special education due process hearing to show that its evaluation is appropriate.

Allowing for Differences in English Language Skills and Ethnic Background
Evaluations and reevaluations must take into account the child's English language skills and ethnic background so that the testing and evaluation will be fair for children of different races and cultures. Tests must be given in the language or form that is most likely to give accurate information, unless it is clearly not feasible to do so. Evaluations must also take into account the child's disability to be sure the results are reliable. For example, a child with a severe visual impairment should not be given a written test with small print.

The Reevaluation Process

A reevaluation is conducted at least every three years. If, however, your child has been diagnosed with an intellectual disability, a reevaluation is required every two years.

A reevaluation is done to determine whether your child still has a disability and needs to continue receiving special education. When additional information is needed to complete a reevaluation, the school must receive your permission to perform the additional evaluation using the Permission to Reevaluate-Consent form.

If the LEA has made what it believes are “reasonable attempts” to receive your permission, but failed to get a response, it may proceed with the reevaluation. Each LEA decides what “reasonable attempts” are.

Such attempts may consist of:

- Telephone calls,
- Registered letters with return receipts required,
- Visits to the home or parents’ place of business.
-

Also, if the school determines that no additional data is needed, they will notify you of this determination. The Parent may agree in writing to your LEA’s recommendation that the three-year reevaluation is not necessary. If the LEA proposes to not conduct the reevaluation, they will issue you an Agreement to Waive Reevaluation form. This is not an option if the child has an intellectual disability.

REFERRAL PROCESS

School District Inital Referral Process Template

Child Identified by Teacher or Parent

Child Study Team Contacted, concerns reviewed and consults with OT, PT or Speech regarding concerns

- Strategies recommned & 4-6 week classroom trial of pre-referral strategies begin.
- Documentation kept using Classroom Data Collection Form

CST and therapist review strategies to determine next steps

- Completed Data Sheets reviewed and summary
- Documentation kept using Classroom Data Collection Form

No Screen Recommended

- Strategies may continue in the classroom
- Summary of strategies reviewed with parent

Screen Request

- If screen recommended; Teacher, Parent and Principal sign off on Data Review form.
- Therapist receives copy of request in office mailbox

Screen Completion

- Therapist completes screen & provides copy to CST & teacher
- Copy of screen report provided to IST and classroom teacher, added to cumulative file.

Follow Up

- Therapist, teacher and/or IST review data together and determine the need for further intervention or evaluation or if the concerns have been resolved.

- If the child does not have a diagnosis (either medical or educational), the process ends here and strategies remain in place in the classroom.
- New strategies may be provided to teacher
- Therapist may provide short term interventions for 6 to 8 weeks

- Proceed to evaluation if child continues to require support and they have a qualifying (medical) diagnosis or going through MDE
- Only SLP's may complete a stand alone evaluation

- If student is going through MDE process, Psychologist will send PTE to the family.

- PTE sent out from Special Ed Office & returned to office
- Copy of signed PTE is given to therapist

- Evaluation complete by therapist and uploaded to Tienet
- Therapist calls parent to review the findings
- Therapist emails copy of the report to the psychologist (MDE), and a copy to office for permanent file

- If student completes MDE process, IEP to be completed by special education teacher following ER

REFERRAL PROCESS

Process for Obtaining Addition Data

IEP team determines that additional data is needed for reeavaluation, or to determine if additional OT and/or PT services are need

- Case Manager or classroom teacher consults with OT regarding needs, reviews referral form
- 4-6 classroom trial of pre-referral strategies begins
- Documentation kept using Classroom Data Collection Forms

Screen Request

- After 4-6 weeks, Case Manager/Learning Support teacher completes Data Review Form
- Team reviews strategies and decides next steps
- Teacher, Parent and Principal sign off on form

Screen is Not Recommended

- Student may continue current strategies
- New strategies may be trialed

Screen Completion

- Therapist receives request and copy of Data Review form
- Therapist completes screen within 30 days of request
- Therapist provides copy of report to case manager and teacher, IEP is revised to add screen

Follow Up

- Therapist follows up with case manager and/or teacher to review strategies and to determine if an evaluation is needed

Evaluation is Not Recommended

- New strategies may be provided to teacher
- Therapist may provide short term interventions for up to 6 weeks

Evaluation is Recommended

- Case Manager will send over screen request form and data collection form to the Special Ed office for approval
- PTE will be sent out by Special Ed Office
- Copy of signed PTE is scanned and emailed to therapist

Evaluation is Recommended

- Evaluation completed by therapist
- Therapist emails copy of report to case manager; parent is called by therapist, and report is sent home
- IEP is revised to include the therapists report & to add goals/service levels IEP revision meeting conducted over the phone or in person with the parent

Copy of the signed NOREP from IEP revision provided to therapist via mailbox & treatment begins.

WHAT IS MTSS?

MTSS stands for Multi-Tiered Support Services and is also referred to as RTII Response to Instruction and Intervention. MTSS is a framework that many schools use to provide targeted support to struggling students. It focuses on the "whole child." MTSS supports academic growth and achievement, but it also supports many other areas. This includes behavior, social and emotional needs, and absenteeism.

The multi-tiered supports are a huge part of MTSS. These tiers of support increase in intensity from one level to the next. For example, some kids receiving small-group interventions may need to "move up" to one-on-one help.

The MTSS model can help general education students receive interventions sooner. It can also help identify sooner which students need special education.

How MTSS Works

MTSS isn't a particular "curriculum." It's a proactive approach that has several key elements:

- Universal screening for all students early in each school year
- Increasing levels of targeted support for those who are struggling
- Integrated plans that address students' academic, behavioral, social and emotional needs
- The use of evidence-based strategies
- A school-wide approach to student support. Teachers, counselors, psychologists and other specialists work as a team when they assess students and plan interventions.
- Professional development so staff can deliver interventions and monitor progress effectively
- Family involvement so parents can understand the interventions and provide support at home
- Frequent monitoring of students' progress so educators can use this data to help decide if more interventions are needed

Some school districts use a system with four tiers of support. But it's more common for districts to use three tiers. Here is a basic outline of how a three-tiered system works:

- **Tier 1:** The Whole Class. All students are taught with methods that research has shown to be effective. All students are screened to see who is and isn't responding to these strategies. Kids may be broken into small groups that address different strengths and areas of need.
- **Tier 2:** Small Group Interventions. Some students receive more targeted support in small groups. The scheduling of these interventions is important. The goal is to keep students from missing any core instruction or other Tier 1 activities that might make it harder to catch up.
- **Tier 3:** Intensive, Individualized Support. A few students who move up to this most intensive level of support continue with Tier 1 activities. Their break-out groups are smaller than in Tier 2. And these sessions last longer and are more narrowly focused.

Examples of MTSS

MTSS is an "umbrella" term. It includes some multi-tier systems of support you may know already:

- Response to Intervention (RTI) focuses on academics. It identifies kids who are struggling. And it provides increasing levels of support to help them catch up. Tier 1 is class-wide instruction and support. Ideally Tier 2 interventions are scheduled so students won't miss any core instruction. The same is true for Tier 3.
- Positive Behavioral Interventions and Supports (PBIS) is a school-wide system. All students are taught how they are expected to behave. And these expectations are described in a positive way. ("Be respectful" instead of "Don't talk back.")

There may be incentives or rewards for good behavior. And a tiered system supports struggling students. The focus overall is not on punishing kids. It's on helping them meet expectations and contribute to a positive learning environment.

MTSS and Special Education

A special education evaluation is usually the next step if students don't make enough progress in Tier 3. But they reach this point with lots of documentation. And data from the MTSS process can be helpful when developing an IEP.

The goal of MTSS is to screen early and to deliver targeted support quickly. It can also help schools tell the difference between kids who have not had good instruction in the past and those who truly need special education.

But parents don't have to wait for their child to go through all phases of MTSS before they request an evaluation for special education. They can ask for an evaluation at any point.

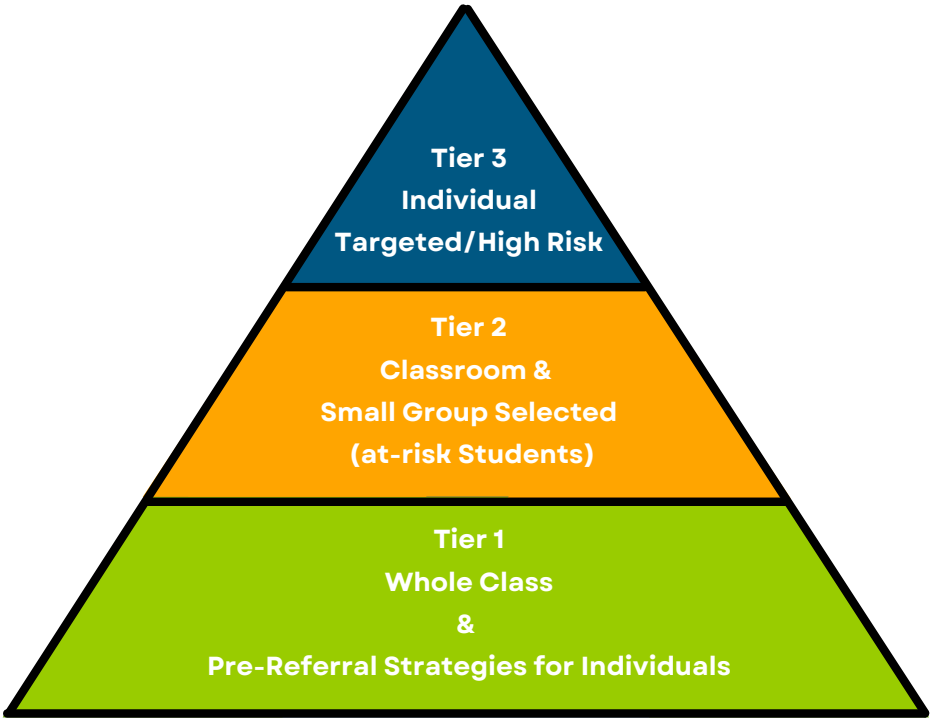
The school can refuse to conduct an evaluation. But it must notify the parent in writing. And the parent could then file a complaint or seek due process. MTSS can't be used to delay or deny evaluations of students suspected of having a disability.

MTSS and ESSA

The Every Student Succeeds Act (ESSA) mentions MTSS by name. It's cited as a way to increase student achievement and teacher effectiveness. ESSA provides states with funding that can be used for professional development to help teachers use MTSS.

You can learn more about systems of supports by getting answers to common questions about RTI. And if you think your child needs more individualized support, learn how to request an evaluation for special education.

MTSS TIERS



A Multi-Tiered System of Support (MTSS) is a data-driven, problem-solving framework to improve outcomes for all students and to help educators provide academic and behavioral strategies for students with various needs. MTSS relies on a continuum of evidence-based practices matched to student needs.

TIER 1

Whole Classroom

- Global Whole Classroom
- Pre-Referral Strategies for a Student
- Global strategies in developmental skills areas.
- Suggested time frame: 30 days
- Implemented by Teacher

TIER 2

Classroom and Small Group (at-risk Students)

- Specific Skills Focused Programs
- Suggested time frame: 6-12 weeks
- Led by therapist or IST/Paraprofessional with therapist as consult

TIER 3

Individual

- Targeted/High Risk
- Suggested Time Frame: 6-12 weeks up to a year
- Formal Screening of Skills & Areas of Need - Discipline specific
- Individualized Short-Term Interventions Plan with Data Collection
- Recommended by Therapist and Incorporated by Whole Team

SPECIAL EDUCATION TIMELINES

Child Find	• Public notice describing special education programs and how to request evaluation	• Annually
Oral Request for Evaluation by Parent	• When an oral request is made to any school professional or administrator, the school entity must provide the Permission to Evaluate- Evaluation Request Form to the parents.	• Within 10 calendar days
Evaluation	• Time to conduct evaluation and complete report after informed consent received from parent • Time prior to IEP meeting for evaluation report to be issued	• 60 calendar days *Exceptions- summer break • At leat 10 school days (can be waived if parent agrees)
Individualized Education Program	• Time following evaluation report to develop IEP • Time from development of IEP to implementation • Review of IEP	• Within 30 calendar days • ASAP or within 10 school days • At least Annually *Note: If the LEA knows or should know that a child has an inappropriate IEP then it must be correct immediatley.
Oral Request for Reevaluation by Parent	• When an oral request is made to any school professional or administrator, the school entity must provide the Permission to Reevaluate- Reevaluation Request Form to the parents.	• Within 10 calendar days
Reevaluation	• All students except those with mental retardation (MR)/an intellectual disability • Students with MR/Intellectual disability	• Must be reevaluated at least once every 3 years (can be waived if parent and LEA agree) • Must be reevaluated at least once every 2 years (canot be waived) • Note: Summer due dates of a Reevaluation Report are not excused from 2- or 3- year required timeline.

MULTIDISCIPLINARY EVALUATION AND ASSESSMENT

IDEA (2004) requires that an evaluation be comprehensive and assess all areas of suspected disability. It is important for the clinician to involve other assessment staff as part of the multidisciplinary evaluation team to address educational and/or behavioral concerns for students who are not meeting the grade-level expectations (IDEA, 2004, Section 34 CFR 300.304).

The standard format is as follows:

- Reasons for referral and/or diagnosis
- Background information, developmental history, health history
- Assessments
  - Standardized assessments or tests
  - Non-standardized assessments or methods
  - Observation in natural setting
  - Activities within natural setting
- Previous evaluation documents
- Behaviors observed during assessment
- Information on progress in academic or curricular areas
- Impact of the disability on academic, functional, and/or social performance
- Information on classroom assessments and statewide assessments
- Information from others (teacher, parent/guardian, aide, other team members)
- Input from the student on his or her disabling condition, thoughts, desires, and wishes
- Impressions
- Summary/conclusions
- Eligibility based on educational, functional, and/or social impact–
  - in order to for a student to be eligible for school-based services:
    - The presence of a disorder or disability
    - Must be accompanied by an adverse effect on academic achievement and functional performance.
    - Are specially designed instruction and/or related services and supports needed to help the student make progress in the general education curriculum The specific definition for eligibility will vary by state and district.
- Recommendations

<u>Other considerations in documentation of evaluation and assessment include:</u>

- Data collection procedures,
- Use of interpreters in test administration,
- Use of translated testing tools,
- Language used during assessment for multilingual students,
- Handling of test protocols,
- Explanation of any nonstandard test administration (i.e., accommodations or modifications)
- Timelines/deadlines for compliance with IEP development and review.

Medical History Questionnaire

To be filled out by Parent

This information is needed so that we can properly evaluate and meet the educational needs of your child. Please fill out this medical questionnaire and return it with the signed Permission to Evaluate form.

Has your child ever experienced any of the following medical conditions?
If yes please describe:

Seizures	☐	Dizziness	☐
Shortness of breath	☐	Neurological Problems	☐
Heart Problems	☐	Surgery	☐
Vision Problems	☐	Skeletal abnormality	☐
Hearing Problems	☐	Muscle Weakness	☐
Digestive Problems	☐	Allergies	☐

List Allergies

Does your child have a specific medical diagnosis?	☐ Yes	☐ No	If Yes, List:
Does your child need access to any special equipment?	☐ Yes	☐ No	If Yes, List:
Should therapists be aware of any special precautions when working with your child?	☐ Yes	☐ No	If Yes, List:
What other medical professionals are involved with your child's care?	☐ Yes	☐ No	If Yes, List:
Is your child taking any medication at this time and for what?	☐ Yes	☐ No	If Yes, List:
May we contact your child's physician if we need any further information?	☐ Yes	☐ No	If Yes, List:
Is there anything else that you can tell us that will help us better evaluate your child?	☐ Yes	☐ No	If Yes, List:

Parent Signature: _____

Date: _____

Doctor's Name: _____

Date: _____

Address: _____

DOCUMENTATION

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DOCUMENTATION

Documentation of service is required whenever professional services are provided to a student. The documentation abides by the time frames, formats and standards established by practice settings, federal and state laws and other regulatory and payer requirements. These requirements apply to electronic or written forms of documentation.

Purpose:

- Provide a clear chronological record of student status, including history and experiences.
- Demonstrate the clinical reasoning and professional judgement.
- Indicate comprehensive, accurate and objective information for justification of skilled services.
- Reflect the nature of services provided, at the individual, group or consult level to meet the needs of the student.

Types of Documentation

Evaluations, IEP, Progress Notes and ESY are reporting in the state required documents in the district IEP system for a student that is being considered for or qualifies for special education.

504's will be created and followed by the school counselor in the specific school district system whether in a word document or IEP system for a student that requires strategies and accommodations.

The Multitiered Support Services (MTSS) or Response to Instruction and Intervention(RTII) will be district specific and created between the district, clinical director and therapist to track the interventions and strategies through a referral process for all students to be supported.

Treatment Plan is created by the therapist that outlines a detailed plan with the treatment approach, methods, and goals to be followed under the specific related services. The plan should also include appropriate discharge recommendations and referrals to other health professionals as needed.

Treatment documentation not only serves as proof of direct and/or indirect services provided but is also critical for monitoring a student's progress and is a great tool to refer to when making decisions about the efficiency of treatment plans.

- Daily Treatment Log
- Monthly Progress Log
- Parent/Staff Contact Log
- Consult Log

Medical Access (MA) Logging is a daily note of treatment submitted to the state for reimbursement of skilled services.The electronic documentation system is specific to the state and district

IEP DOCUMENTATION GUIDE

IEP's are responsible for contributing the following:

- Present Levels
- Strengths, Needs
- Related Services
- Frequencies
- Goals
- Specially designed instruction
- ESY data
- Quartley progress notes

Present Levels of Academic Achievement and Functional Performance
The statement of present levels must contain: Objectively measurable baseline statements in every area of disability-based need, academic and functional, of which you are aware. Every area of need must have a baseline regardless of whether the particular need was identified or recognized in the most recent evaluation report or reevaluation report.

Strengths and needs should be related to performance areas:
OT: Fine motor, gross motor, sensory processing skills, visual motor, visual perceptual, organization, etc., self care as it pertains to school.

PT: Gross motor coordination, strength, endurance, balance, skills, skills pertaining to gym class, recess, and/or navigating the school environment.

SLP: Expressive and receptive language development, articulation,
voice, fluency, social skills

ELIGIBILITY & SERVICE LEVEL DETERMINATION

Direct Treatment:

- Requires a specific IEP goal
- Skill based therapy session
- May be one on one or group
- May be push in or pull out
- Underlying skill deficit
- Establish/teach a specific skill
- New Skill/strategy needed
- Expert rapid response to intervention
- Temporary change in status, for example post-concussion or injury
- Collect data on goal
- Listed as a related service on IEP
- Provide updated data on goal at IEP
- Complete write up in PLEP for annual IEP

Consult under related services:

- To the student, direct contact
- Must be specific amount of time - not “up to” or a range of time
- Should address/monitor SDI related to student or program
- Appropriate for: job site visits, consultation in a specific class, monitoring a sensory program, making recommendations for gym class or adaptive PT
- Requires expertise of therapist for monitoring
- Assess activity demands, performance skills and patterns
- Making changes to the school environment
- Involve the student in problem solving
- Strategies & accommodations that are student specific
- Facilitating participation in Academics & social roles
- Adaptations to specific activities/tasks
- Ensure opportunities for practice & generalization
- Change from remediation to compensation mindset with plateau in skills
- Provide supports in classroom to facilitate performance
- Provide updated info at annual IEP

Consult under supports for school personnel

- To the teacher
- Must also be specific amount of time - not “up to” or a range of time
- Should be actual time that is needed
- Should address SDI from teacher perspective
- Suggestions provided to the teacher regarding adaptions, modifications or strategies
- Modifying physical environment
- Therapist is available as resource to IEP team
- Student discharged from caseload in my PTS Time
- Should be discontinued after one year if team hasn’t identified new issues.

GOALS

A WELL-WRITTEN GOAL OR OBJECTIVE CONSISTS OF THREE COMPONENTS:

1. An operant action, which describes the modes of instruction or assessment, or both, in which a particular response will be observed or measured.
2. A measurable response to that action or set of actions, which clearly and objectively describes how the student will respond to the action
3. A action or criteria for determining whether the response was sufficient to determine the goal or objective mastered. For example, the following measurable annual goal– Given controlled

Basic Goal Template

Action/Accommodation/Strategy → Student Name → Clearly Defined Behavior → Performance Criteria

Given	Given Adapted Paper
Student Name will....	John will complete probes
At or how well (% accuracy, independently, w/ staff support, etc.)	At 80% accuracy
On... (how many times to mastery)	On 4 our of 5 probes
Probed... (frequency of progress monitoring schedule)	Administered 3x a quater

Sample Goal Template

Given direct instruction in.....,student will improve (skill-visual motor, visual perceptual, fine motor, gross motor, balance, coordination, etc.) skill in order to .....with ___% accuracy, over 3 consecutive sessions.

OR

During therapy sessions and classroom activities, student will improve.....skill in order to___ with___% accuracy over 3 consecutive sessions.

Each student really shouldn't have more than 2-3 goals. When adding goals to an IEP, you must add a baseline.

Example:

Given direct instruction in writing, Dylan will improve visual motor skills in order to write 2 sentences with 85% accuracy with sizing and spacing of letters on the baseline, over 3 consecutive sessions.

Baseline: 50% accuracy with sizing and spacing of letters

SPECIALLY DESIGNED INSTRUCTIONS

For every need, there must be:

Describes the type of replacement instruction, adaptations, and modifications the child needs and will receive.

Each item of specially-designed instruction must be:

1. Based on the individual needs of the student, not on "the program" as it exists in a particular building or classroom and not on every passing notion of what might "benefit" the child. Child-specific need is the critical factor for determining the items that are included in this section.
2. Based on "peer-reviewed research, to the extent practicable." Although identifying support for every adaptation and modification in a published, peer-reviewed journal is not "practicable," the selection of reading, written language, math, and social skills programs from publishers and suppliers that can offer research support for their product is both practicable and necessary. Only When research-supported programs are not working after trial, or are demonstrably inappropriate for the individual child, can the IEP team safely include a child-specific approach that does not have research support.

The following rules apply to the drafting of specially-designed instruction and program modifications:

- Rule 1: Be specific as to strategy
- Rule 2: Be generic. regarding brand names of programs (i.e. Zones of regulation, Hand Writing Without Tears).
- Rule 3: Identify either a specific time and duration for each item, a specific condition to which each item applies, or a specific purpose for each item. Although the IDEA used the phrase "frequency and duration" to describe the manner in which items of specially designed instruction must be quantified, not all specially designed instruction lends itself to such numerical quantification. Certainly replacement instruction should always include specific frequency and duration commitments, as should time during which the child will receive scheduled tutoring or support in the special education classroom. Most items of specially designed instruction that describe adaptations and modifications, on the other hand, will need to abandon time commitment language in favor of descriptions of the conditions under which the particular item of specially-designed instruction will be used or the purpose that the item will serve.

SUPPLEMENTARY AIDS AND SERVICES

Definition and Purpose:

"Supplementary aids and services means aids, services, and other supports that are provided in general education
classes, other education-related settings, and in extracurricular and nonacademic settings, to enable children with disabilities to be educated with nondisabled children to the maximum extent appropriate in accordance with §300.114 through §300.116." (34 CFR 300.42)

The purpose of providing supplementary aids and services is to support students with disabilities as active parti-cipants with nondisabled peers, as well as to enable their access to the general curriculum. To that end, supplementary aids and services include modification to the general curriculum and [a child with a disability is not removed from education in age-appropriate regular classrooms solely because of needed modification in the general curriculum]. (34 CFR 300.116 (e))

Full Range of Supplementary Aids and Services

34 CFR 300.114 (ii) states that, "Special classes, separate schooling, or other removal of children with disabilities from the regular educational environment occurs only if the nature or severity of the disability is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily."

Supplementary Aids and Services Should Be:

- Available to all students who need them.
- Designed to provide meaningful educational benefit.
- Provided in a manner that avoids stigmatizing students (Gaskin Settlement Agreement, 2005).

There are an infinite number of possible supplementary aids and services to be considered and implemented by
Individualized Education Program (IEP) teams. Court decisions have required school districts to make a concerted and good faith effort to use supplementary aids and services to address behavioral issues in the general classroom. The provision of positive behavioral interventions, strategies, and supports is designed to foster increased participation of children with disabilities in general education environments or other less restrictive environments, not to serve as a basis for placing children with disabilities in more restrictive settings.

It is important that IEP teams contemplate educational placement in the general education classroom with the
provision of supplementary aids and services as needed.

One framework that may assist IEP teams in considering the full range of supplementary aids and services includes four categories of supplementary aids and services for consideration: Collaborative, Instructional, Physical, and Social-Behavioral (Etscheidt & Bartlett, 1999). The chart that follows provides illustrative examples for each of the categories. The Oberti decision includes reference to four specific supplementary aids and services that local education agencies (LEAs) must consider: modified curriculum, teacher training, effective behavior support, and provision of an aide, if necessary (Oberti v. Board of Education of the Borough of Clementon School District, 995 F.2d 1204 (3rd cir.1993)).

Category	Examples
Collaborative Adults working together to support students	• Scheduled time for coplanning and team meetings • Instructional arrangements that support collaboration (e.g., coteaching, paraprofessional support) • Professional development related to collaboration • Coaching and guided support for team members in the use of assistive technology for an individual student • Scheduled opportunities for parental collaboration • All school personnel collaborate in the development and delivery of SaS
Instructional Development and delivery of instruction that addresses diverse learning needs	• Providing modified curricular goals • Providing alternate ways for students to demonstrate learning • Providing test modification • Providing alternate materials and/or assistive technology (e.g., materials on tape, transcribe text into Braille, large print, alternate computer access) • Providing instruction on functional skills in the context of the typical routines in the general classroom • Changing method of presentation • Using reader services • Providing research-based supplementary materials • Providing instructional adaptations (e.g., preteaching, repeating directions, extra examples and nonexamples)
Physical Adaptations and modifications to the physical environment	• Furniture arrangement in environments • Specific seating arrangements • Individualized desk, chair, etc. • Adaptive equipment • Adjustments to sensory input (e.g., light, sound) • Environmental Aids (e.g., classroom acoustics, heating, ventilation) • Structural Aids (e.g., wheelchair accessibility, trays, grab bars)
Social-Behavioral Supports and services to increase appropriate behavior and reduce disruptive or interfering behavior	• Social skills instruction • Counseling supports • Peer supports (e.g., facilitating friendships) • Individualized behavior support plans • Modification of rules and expectations • Cooperative learning strategies

PROGRESS REPORT PROCEDURE

Purpose:
The purpose of this procedure is to outline the steps necessary for completing progress reports for students within special education. With the IEP on-line system, progress reports can be viewed by parents without the need for reproducing hard copies every quarter for the special education office and parents.

Procedure:

1. At least 14 days prior to progress reports being due, IEP records will be made available to teachers by the special education office. Make sure the records are opened for teachers and therapists to edit the records. On the distribution date for progress reports, a setting will change which will allow parents to see the reports.
2. For families who have requested hard copies of report cards due to no internet access, hard copies of the progress reports must be sent home.
3. Professionals responsible for goals will enter them into the progress section located immediately following the IEP goals within the annual IEP.
4. Graphs which demonstrate goal progress must be entered directly into the progress area using the snipping tool. This will allow the graphs to be viewed by the parent.
5. Typically, a mass email will be sent to all special education parents on the distribution date notifying them that progress reports are ready to be viewed. The distribution date will be the same as the report card date.
6. Progress Report Sign off sheet must be completed and signed and submitted to the special education office. This form now indicates a column for “E” (electronic) or “M” (Mail).
7. The special education office will check IEP records to ensure progress reports have been completed.
8. A paper copy of every progress report will not be required in the special education office every quarter.
9. When annual IEP is completed for a student, a hard copy of the progress report reflecting the previous IEP’s progress reports must be submitted with the annual IEP All progress reports are due to be completed by the REPORT CARD RELEASE DATE AND TIME. Unless otherwise communicated.

Progress Monitoring Guidelines

*All progress monitoring should be given without accommodations as detailed in the IEP goal, and thus graded assessments should be used with caution and only in specific circumstances.

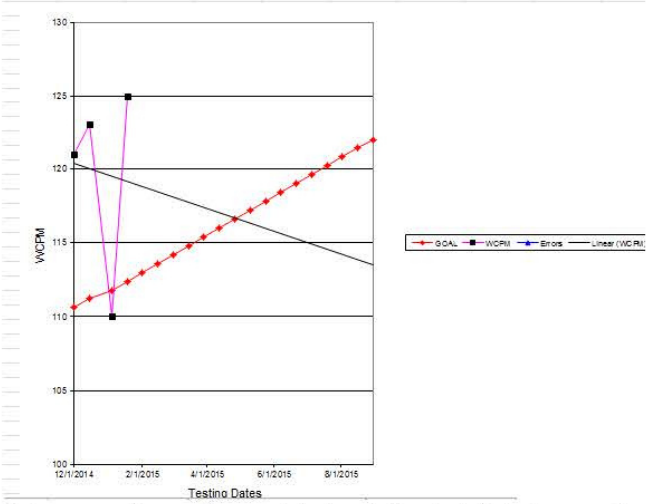
*To determine appropriate level for progress monitoring, teachers must probe down in grade levels until mastery is achieved.

Instructional Area	Measurement tool	Time	Assessment frequency recommended
Reading fluency/Early literacy	AIMSWEB probes	1 minute probe	Elementary: weekly Middle: bi-weekly HS: tri-weekly **Annual IEP**
Reading Comprehension – literal and inferential questions	Read Naturally, Readworks, Focus, other with approval from supervisor	Unlimited	Elementary: weekly Middle: bi-weekly HS: tri-weekly
Math fluency/Early Numeracy	AIMSWEB math probes	Per Aimsweb guidelines	Elementary: weekly Middle: bi-weekly HS: tri-weekly **Annual IEP**
Math applications	AIMSWEB MCAP	Per Aimsweb guidelines	Elementary: weekly Middle: bi-weekly HS: tri-weekly **Annual IEP**
Math Curriculum-Based Skills	Probes created using standards-based problems	Unlimited	Elementary: weekly Middle: bi-weekly HS: tri-weekly
Study skills, if goal on IEP	Study Skills rubric or data collection	N/A	At least 4 times per quarter or per IEP, if goal on IEP
Social Skills, if goal on IEP	Social Skills rubric or other data collection	N/A	1 teacher per week if goal on IEP
Counseling	Observation	N/A	Tri-weekly if goal on IEP
Writing	Probes *Use rubric	Untimed	3 per quarter – all students with writing as a goal. **Annual IEP** for all students.
Spelling	Spelling CBM (Aimsweb)	Per guidelines	At least every other week if IEP goal

*If student's skill level does not allow for use of the assessments as outlined above, substitute assessments may be used with approval from supervisor.

Progress Report – Fidelity Check

Where are your reports in this continuum of examples?

Level	Report on goal: Given a passage on a 5th grade level, Johnny will read 122 wcpm on 3 consecutive biweekly probes.	Take note
Fantastic Example	Johnny is making progress towards his goal. This quarter, he has met or exceeded the aim-line on 3 out of 4 probes as demonstrated by the graph below. His trend line appears to be going down due to the fact that he had an outlier score of 110 when he returned from break.  Johnny will continue his targeted skill intervention of fluency practice 2 times per week since he is making progress.	Graph is used that clearly shows the parent and educator whether Johnny is making progress. The graph is explained. The instruction for the skill is mentioned.
Good Example	Johnny is making progress towards his goal. This quarter, he has met or exceeded the aim-line on 3 out of 4 probes. He scored the following: Date: Score 12/1/14: 121 wcpm 12/14/14: 123 wcpm 1/4/15 (return from break): 110 wcpm 1/18: 125 wcpm	Table with each score listed shows parents and educator how well Johnny is meeting goal.
Poor Example	Johnny scored 121,123,110, and 125	There is not enough information for parents to understand the data presented. Educator does not summarize progress. We cannot prove that data was given bi-weekly.
Non-compliant example	Johnny scored an average of 119.	Data should never be averaged, as it does not give a picture of whether the student is progressing towards the goal. We cannot prove that data was given bi-weekly.

Quarterly Progress Note

Student:	School:
Date of Birth:	Therapist:

LTG 1 LTG 2 LTG 3 LTG 4

	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July
100%											
90%											
80%											
70%											
60%											
50%											
40%											
30%											
20%											
10%											

Long Term Goals:

LTG 1:

LTG 2:

LTG 3:

LTG 4:

Description of Current Interventions and Recommended Changes:

Comments on Student Progress:

EXTENDED SCHOOL YEAR

What is ESY?

Extended School Year (ESY) ser vices are special education and related services that are provided to students with disabilities beyond the 180-day school year. The Individuals with Disabilities Education Act (IDEA), the federal special education law, states that local educational agencies (LEAs) must provide ESY services if a student needs these services to receive a free appropriate public education (FAPE). In some cases, interruptions in the school schedule, such as summer break, may result in some students with disabilities losing basic skill level and taking a much longer time to regain those skills than their peers without disabilities once school is back in session.

ESY services are provided during breaks in the educational schedule to prevent this loss. ESY services are not day care or respite services. ESY services are not a summer recreation program or other programs or services that are not required to ensure the provision of FAPE to a student – even if they provide some educational benefit.

As a teacher, you may be part of an Individualized Education Program (IEP) team that will determine eligibility for ESY services for students with disabilities who receive special education services.

How is ESY Eligibility Determined?

Every student who is eligible for special education has an IEP that describes the programs and services necessary for the student to receive FAPE. One of the issues discussed and decided upon at the IEP team meeting is whether or not the student requires ESY services as part of the student's special education program. ESY must be considered each year for every student with a disability. In addition, the Pennsylvania Department of Education offers guidance regarding students with severe disabilities, such as autism/pervasive developmental disorder, serious emotional disturbance, severe intellectual disabilities, degenerative impairments with mental involvement, and severe multiple disabilities. Students in this group, known as the Armstrong Target Group, must have an IEP team review of ESY eligibility no later than February 28 of each school year, with a Notice of Recommended Educational Placement/Prior Written Notice (NOREP/PWN) issued no later than March 31 of each school year. Students whose disabilities are not in the target group will not be held to the same timelines; however, determinations must be made in a timely manner.

Factors to Guide IEP Team Determination of ESY Eligibility

The IEP team makes its decision about providing ESY services by examining data that have been collected throughout the school year, including before and after scheduled breaks in the school year. The team also reviews input provided by teachers, parents, or other members of the IEP team.

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ESY Service Delivery Models

The IEP team must determine the appropriate service delivery model based on the needs of the individual student. School districts are not required to create new programs merely to provide ESY in an integrated setting if they do not provide services at that time for students without disabilities.

ESY service delivery models may be one-to-one or group instruction. Services may be delivered in the student's home, in the community, or in a school classroom setting. The school district may deliver ESY services in the district of residence, or may contract through another agency to provide ESY services outside the boundaries of the school district. ESY services may include related services, such as speech and language therapy, occupational therapy, and physical therapy, as well as instructional academic goals, based on the student's individual needs and as stipulated in the IEP. ESY services may include:

- "Take home" instructional materials
- Behavioral or other training for parents or program staff
- Itinerant teacher and/or related service provider services
- Consultation
- Tutorials
- Services contracted through community or outside agencies

What if the Parents and the School Disagree on ESY Determination?

If the IEP team, which includes the parents, cannot reach an agreement on the determination of eligibility and/or provision of ESY services, then the school district must issue the NOREP/PWN along with the Procedural Safeguards Notice to the parents explaining the IEP team's decision. If the parents still disagree, then they may respond to the NOREP/PWN with a letter stipulating their concerns, request another IEP team meeting, request free mediation services, or request a due process hearing. Mediation services use a neutral, specially-trained mediator who meets with both sides and helps both parties reach an agreement. A due process hearing is held before an impartial hearing officer who listens to both sides and then makes a decision.

Reliable sources of information could include:

- Progress toward goals on consecutive IEPs
- Progress reports maintained by educators, therapists, and others having direct contact
- with the student before and after interruptions in education
- Reports by parents of negative changes in adaptive behaviors or in other skill areas
- Medical or other agency reports indicating degenerative-type difficulties that become
- exacerbated during breaks in educational services
- Observations and opinions by educators, parents, and others
- Results of tests including criterion-referenced tests, curriculum-based assessments, ecological life skills assessments, and other equivalent measures.
- Progress Monitoring data collected by teachers

There are seven factors that the IEP team must consider to determine if a student is eligible for ESY services. However, no one factor by itself can be used to determine eligibility for ESY services. The child may be eligible by meeting just one of the criteria, but all seven factors must be considered by the IEP team. The seven factors for consideration are:

1. Regression - whether the student reverts to a lower level of functioning as evidenced by a measurable decrease in skills or behaviors that occur as a result of interruption in educational programming
2. Recoupment - whether the student has the capacity to recover the skills or behavior patterns in which regression occurred to a level demonstrated prior to the interruption of educational programming.
3. Regression/Recoupment - whether the student's difficulties with regression and recoupment make it unlikely that the student will maintain the skills and behaviors relevant to the IEP goals
4. Mastery - the extent to which the student has mastered and consolidated an important skill or behavior at the point when educational programming would be interrupted
5. Self-sufficiency and independence - the extent to which a skill or behavior is particularly crucial for the student to meet the IEP goals of self-sufficiency and independence from caretakers
6. Successive interruptions - the extent to which successive interruptions in educational programming result in a student's withdrawal from the learning process
7. Severity of disability - whether the student's disability is severe, such as autism/pervasive developmental disorder, serious emotional disturbance, severe intellectual disabilities, degenerative impairments with mental involvement and severe multiple disabilities

DISMISSAL IN SCHOOLS

Dismissal Versus Continued Eligibility

The goal of public school related services are to remediate or improve a student's disorder or disability such that it does not interfere with or deter academic achievement and functional performance.

The dismissal of students from services is sometimes a difficult, conflicted, and even contentious process. Some parents and/or teachers believe that once a student is determined to be eligible for services, that student should be entitled to those services for the duration of his or her school career. It is often challenging for related service providers to determine if a problem continues to adversely affect academic achievement and functional performance and to communicate aspects of this determination to parents and teachers.

The first step in the dismissal process should occur when the student is first determined to be eligible for services through an IEP. The therapist should make the goals of services clear to parents and teachers. The goals are as follows:

- to determine if the student's disability is adversely affecting academic achievement and functional performance;
- to provide intervention for those disabilities that are adversely affecting academic achievement and functional performance, specifying goals leading to specific criteria for dismissal;
- to dismiss the student from services once the criteria for eligibility are no longer met.

Examples of discharge statements:

·The student's level of educational functioning in the area(s) being addressed has reached age level, grade level and/or level of intellectual potential.
·The student has developed the performance components needed to progress toward the educational goals established in the IEP.
·The areas of concern being addressed in the therapy do not interfere with the student's ability to function or make progress in the educational setting.
·Environmental or curricular adaptations have been established to allow for achievement of educational goals. Adaptations include_____
·The student's needs for remediation and/or compensation in the area(s) being addressed are being fully met by the student's educational or other service providers without the need for continued therapist contact.
·Therapy is not affecting change in the student's level of function or rate of skill acquisition (i.e. the student has plateaued).
·The IEP team has determined that Occupational Therapy services are no longer required.
Resource: https://www.asha.org/SLP/schools/prof-consult/eligibility/

504 WITH RELATED SERVICES

The 504 Plan is a plan developed to ensure that a child who has a disability identified under the law and is attending an elementary or secondary educational institution receives accommodations that will ensure their academic success and access to the learning environment.

Is a medical diagnosis required for a 504 plan?
A student must have a specific medical diagnosis to be considered for Section 504. There is no legal basis under 504 to require a medical diagnosis. However, evaluation processes would typically need to be more thorough and involved if this information does not exist.

Who is eligible for a 504 plan?
To be protected under Section 504, a student must be determined to: (1) have a physical or mental impairment that substantially limits one or more major life activities; or (2) have a record of such an impairment; or (3) be regarded as having such an impairment.

What is the difference between a IEP and 504?
Unlike an IEP, a 504 plan doesn't have to be a written document. A 504 plan generally includes the following: Specific accommodations, supports, or services for the child.

Points about a 504
504's need an initial medical order or statement that meets the evaluation criteria for eligibility. This is not required at the beginning of each year unless accommodations are dependent on updated medical orders.

Therapists
The therapists will provide a word document to the school counselors that will have: The therapist's name and date, with the eval/progress update, frequency and SDI's.

School Counselors
School Counselors are responsible for writing all of the 504 plans – regardless of whether they are medical, OT/PT/speech or otherwise. When a student has a related service such as OT/PT/Speech, etc. that provider should provide input to the counselor, who will include it in the 504 Plan document. That provider should be added as a team member by the counselor and they will be able to see information on these students.

Both Individualized Education Programs (IEPs) and 504 plans can offer formal help for K-12 students who are stuggling in school. They're similar in some ways but very different in others. This chart compares them side-by-side to help you understand the differences.

	IEP	504 Plan
Basic Description	• A blueprint or plan for a child's special education experience at school.	• A blueprint or plan for how the school will provide support and remove barriers for a student with a disability.
What It Does	• Provides individualized special education and related services to meet a child's unique needs. These sercies are provided at no cost to families.	• Provides services and canges to the learning environment to enable students to learn alongside their peers. As with an IEP, a 504 plan is provided at no cost to familes.
What Law Applies	• The Individuals with Disabilites Education Act (IDEA). This is a federal special education law for children with disabilites.	• Section 504 of the Rehabilitation Act of 1973. This is a federal cival rights law to stop discrimination against people with disabilites.
Who is Eligible	• A child has one or more of the 13 disabilites listed in the IDEA. The law lists specific challenges, like learning disabilites, ADHD, autism, and others. • The disability must affect the child's educational performanceand/or ability to learn and benefit from the general education curriculum. The child must need specialized instruction to make progress in school.	• A child has any disability. Section 504 covers a wide range of different struggles in school. The disability must interfere with the child's ability to learn in a general eduation classroom. • Section 504 has a broader definition of a disability than IDEA. (It says a disability must substantially limit one or more basic life activites. This can include learning, reading, communicating, and thinking.) That's why a child who doesn't qualify for an IEP might still be able to get a 504 plan.
Independent Education Evaluation	• Familes can ask the school district to pay for an independent education evaluation (IEE) by an outside expert. The district doesn't have to agree. Familes can always pay for an outside evaluation themselves, but the district may not give it much weight.	• Doesn't allow familes to ask for an IEE. • As with an IEP evaluation, familes can always pay for an outside evaluation themselves.

Who Creates It	• There are strict legal requirements about who participates. An IEP is created by an IEP team that must included
	  ◦ The child's parent or caregiver
	  ◦ At least one of the child's general education teachers
	  ◦ At least one special education teacher, school psychologist, or other specialist who can interpret evaluation results
	  ◦ A district representative with authority over special education services
	• With a few exceptions, the entire team must be present for IEP meetings.
		• The rules about who's on the 504 team are less specific than they are for an IEP.
		• A 504 plan is created by a team of people who are familiar with the child and who understand the evaluation data and special services options. This might include:
		  ◦ The child's parent or caregiver
		  ◦ General and special education teachers
		  ◦ The school principal

What It Does	• The IEP sets learning goals and describes the services the school will provide. It's a written document.
	• Here are some of the most important things the IEP must include:
	  ◦ The child's present levels of academic and functional performance- how the child is currently doing in school.
	  ◦ Annual education goals for the child and how the school will track progress.
	  ◦ The services the child will get-this may include special education, related, supplementary, and extended school year services.
	  ◦ The timing of services- when they start how often the occur, and how long they last.
	  ◦ Any accommodations- changes to the childs learning environment.
	  ◦ Any modifications- changes to what the child is expected to learn or know.
	  ◦ How the child will participate in standardized test
	  ◦ How the child will be included in general education classes and school activities
		• There is no standard 504 plan. Unlike an IEP, a 504 plan doesn't have to be a written document.
		• A 504 plan generally includes the following:
		  ◦ Specific accommodations, support or services for the child
		  ◦ Names of who will provide each service
		  ◦ Name of the person responsible for ensuring the plan is implemented

Notice	• When the school wants to change a child's services or placement, it has to tell families in writing before the change. This is called prior written notice. Notice is also required for any IEP meetings and evaluations.	• The school must notify families about an evaluation or a "significant change" in placement. Notice doesn't have to be in writing, but most schools do so anyway.
Consent	• A parent or caregiver must consent in writing for the school to evaluate a child. They must also consent in writing before the school can provide the services in an IEP.	• A parent or caregiver's consent is required for the school district to evaluate a child.
How Often It's Reviewed and Revised	• The IEP team must review the IEP at least once a year. The child must be reevaluated every three years to determine whether services are still needed.	• The rules vary by state. Generally, a 504 plan is reviewed each year and a reevaluation is done every three years or when needed.
How to Resolve Disputes	• IDEA gives familes serveral ways to resolve disputes (usually in this order): ◦ Mediation ◦ Due process complaint ◦ Resolution session ◦ Civil lawsuit ◦ State complaint ◦ Lawsuit	• Section 504 gives families serveral options for resolving disagreements with the school: ◦ Mediation ◦ Alternative dispute resolution ◦ Impartial hearing ◦ Complaint to the Office of Civil Rights (OCR) ◦ Lawsuit
Funding and Costs	• Students receive these services at no charge • States receive additional funding for students with IEPs.	• Students receive these services at no charge. • States do not receive extra funding for students with 504 plans. But the federal government can take funding away from programs (including schools) that don't meet their legal duty to serve kids with disabilites. • IDEA funds can't be used to serve students with 504 plans.

SERVICE LEVELS AND FREQUENCY

The 504 Plan is a plan developed to ensure that a child who has a disability identified under the law and is attending an elementary or secondary educational institution receives accommodations that will ensure their academic success and access to the learning environment.

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Treatment Plan

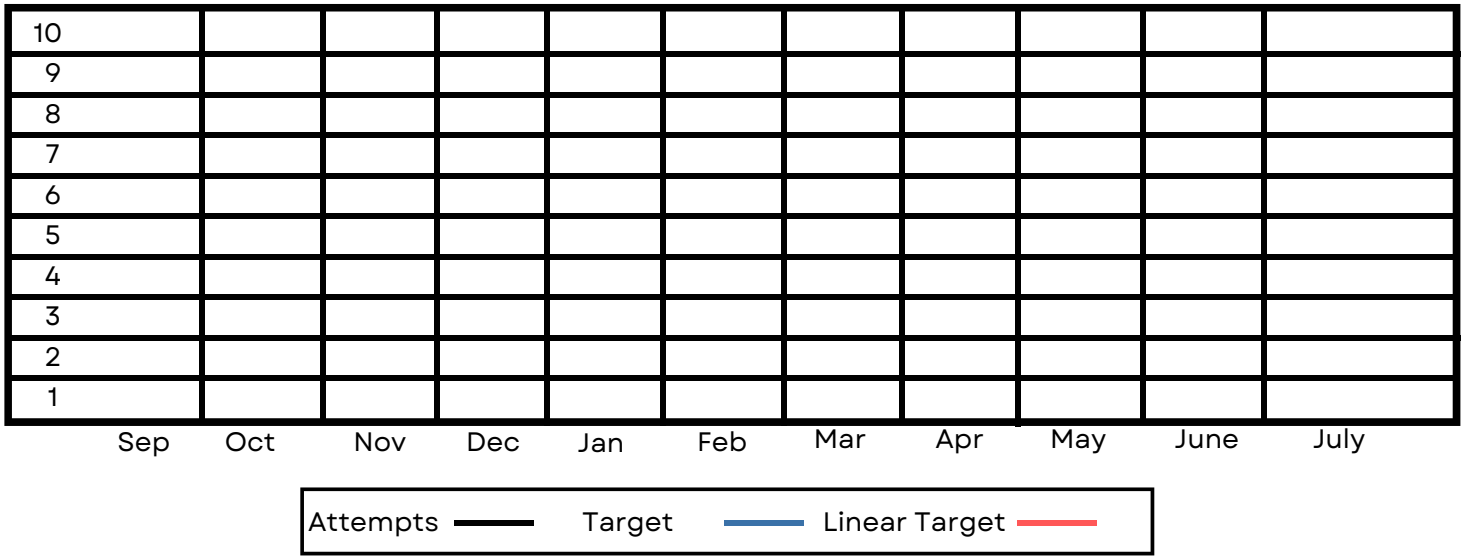
Student:	School:
Date of Birth:	Therapist:

Placement: ◯ Emotional Support ◯ Learning Support ◯ MDS ◯ AS

Treatment via (IEP, 504, MTSS): _____

Level of Service	Frequency
Direct: ◯ Individual ◯ Group Consult: ◯	

GoalTrack™



SDI: _____

_____

_____

Consult Notes: _____

_____

_____

Daily Treatment Log

Student:	School:
Date of Birth:	Therapist:

Date/Type of Service: _____ (minutes) _____ I _____ G

Treatment Provided:

	Fine Motor		Handwriting		Drawing
	Visual Motor		Visual Perception		Functional Skills
	Gross Motor		Motor Planning		Adaptive Equipment
	Range of Motion		Strengthening		Sensory
	ADL's		Positioning		Social Skills
	Typing		Cutting		

Outcome:

Date/Type of Service: _____ (minutes) _____ I _____ G

Treatment Provided:

	Fine Motor		Handwriting		Drawing
	Visual Motor		Visual Perception		Functional Skills
	Gross Motor		Motor Planning		Adaptive Equipment
	Range of Motion		Strengthening		Sensory
	ADL's		Positioning		Social Skills
	Typing		Cutting		

Outcome:

Monthly Progress Log

Student:	School:
Date of Birth:	Therapist:

IEP GOALS	Date: D: I:	Date: D: I:	Date: D: I:	Date: D: I:	END OF MONTH PROGRESS
Daily Comments					

STAFF CONSULT LOG

Student:	School:
Month:	Teacher:

Service Date	Consult Start Time	Consult End Time	Comments

PARENT CONTACT LOG

Student:	
Therapist:	

Name of Parent
Contact Number
Email

Date	Comments

School Bases Access – Medical Access Billing (MA)-Easy Trac

The School-Based ACCESS Program, or SBAP, allows Pennsylvania Local Education Agencies, or LEAs, **to receive federal Medicaid reimbursement for providing IEP health-related services to Medical** Assistance-eligible children as part of their Individualized Education Program (IEP).

PA's ACCESS program The School-Based ACCESS Program is a system that is used by LEAs, including school districts, intermediate units, charter schools, vocational-technical schools and preschool early intervention programs, to obtain funds for health-related services for special education students. Reimbursement is paid through the federal Medicaid program.

SBAP components

- Direct services and special transportation claiming
- Medicaid Administrative Claiming (MAC)
- Random Moment Time Studies (RMTS)
- Annual cost reconciliation and settlement

Allowable health-related services

- Assistive technology devices
- Audiology services
- Hearing-impaired services
- Nursing services
- Nurse practitioner services
- Occupational therapy services
- Orientation, mobility and vision services
- Personal care services
- Physical therapy services
- Physician services
- Psychiatric services
- Psychological services
- Social work services
- Special transportation services
- Speech and language services

Medical ACCESS Billing Reminders

1. Please only document in EasyTrac if your session is **in accordance with the IEP** regarding frequency, duration, and GROUP SIZE. **Note:** when logging, the frequency and duration can be equal to or less than the amount of time for logging in EasyTrac but not more.
2. Please select "Direct" service type for in-person, face to face sessions
3. Please select "Direct: Telemedicine" as service type for virtual sessions that occurred with both audio/visual components.
4. ACCESS did not change, only the delivery of service during the health emergency. Telemedicine was added.
5. Only log for direct services; not for consults.
6. Logs should be entered by the 10th of the month for the previous month. October logs are due November 10th. This allows time to process. A reminder will be sent to you each month.
7. Progress notes need to provide "how" you worked on the activity that you checked in the 'Areas Covered'. Please give details and, it is suggested, that notes should be more than one sentence.
8. Do not copy and paste the same progress notes for every session with your students. Dept. of Human Services/PDE emphasizes this rule.
9. Please be accurate with the dates and times entered of when you provided service to the student. In case of an audit, attendance records for you and the student will be cross checked.
10. The MA Coordinator will contact you if a student on your caseload becomes eligible for ACCESS billing.
11. Please send any new student that is added to your caseload and to the MA coordinator to check for MA eligibility.

Documentation Recommendation

Documentation

Official school records generally fall into three categories (see Moore, 2010a, 2013):

1. Mandatory permanent student records
    - may be required by state law and
    - usually include identifying information about the student, when the student attended schools in the district, and records of subjects taken, grades, immunization, and date of graduation or exit.
2. Mandatory interim student records
    - may be required by state law (see ASHA's State-by-State pages);
    - are held for a stipulated period of time; and
    - include health information, special education information, language training records, progress reports, parental restrictions, parent/guardian and student challenges to records, parent/guardian authorizations/prohibitions for student participation in certain programs, and results of standardized tests.
3. Permitted student records
    - Include counselor/teacher rating scales, standardized tests older than 3 years, routine discipline, behavioral reports, discipline notices, and attendance records.

Please note the following stipulations about types of documentation and their status as records:

- Treatment notes or progress notes and Section 504 (Rehabilitation Act of 1973) accommodation plans are considered school records.
- Lesson plans are not considered school records.
- Notes taken as personal memory aids may be considered "sole possession" notes or may be considered part of the student record, depending on the circumstance.
- Notes to parents/guardians and personal notes are not considered school records unless they are placed in the student's file or shared with others. However, it is best to assume that any e-mail or document that includes a student's personally identifiable information is considered a student record. See Letter to Mr. Otter [PDF] for more information.
- Typically, any information shared with a parent/guardian or other school personnel can be considered part of a student's record.

Location of student records vary by school district in order to restrict access and ensure confidentiality. Most school districts keep files in locked file cabinets with limited access. Often, lists with the names of those who can have access to the student records are posted on the file cabinets. Most special educators keep locked file cabinets in their rooms so that their teacher/specialist file can be kept secured.

State and district procedures vary in terms of how long student records need to be maintained, and it also depends on the type of student record.

- Mandatory student records, such as transcripts, should never be destroyed.
- Special education record retention varies by state and district.
- However, if a student leaves the district due to relocation, then records are sent to the new district; the records must follow the student.
- In terms of teacher/clinician files, check with your local district administration about applicable procedures when a student is no longer on your caseload or at your school.

With regard to retaining documentation, please note the following:

- State Medicaid for school-based reimbursement may require a different length of time for records (documentation) to be kept. Please check with your district Medicaid administrator to confirm the length-of-time requirement.
- Confidential records should be securely disposed of by shredding the documents rather than discarding/ recycling them. Refer to your district's policy on providing public notification before records are destroyed.

Test Protocols

Test protocols are often kept in the clinician's file or in the district's special education file. Consult your district's policies regarding how long and where protocols will be maintained. Once the protocol has been completed, it becomes a student record and cannot be destroyed until the appropriate time, as prescribed by record destruction procedures.

The Family Educational Rights and Privacy Act (FERPA, 1974) neither requires nor prohibits the sharing of test protocols. FERPA also does not define specifically what constitutes the official "student record." Those decisions are left to states and local agencies. However, any document that is considered a part of an official student record is then protected under FERPA.

Fair use under U.S. Copyright Law permits providing a copy of a child's protocol and/or test results to the parent/guardian because that situation does not infringe on proprietary business rights (i.e., one can assume that the parent/guardian is not going to publish or otherwise misuse the protocol; Newport-Mesa Unified School District v. State of California Department of Education, 2005). Check with your state or district regarding their policies.

Frequently Asked Questions About Documentation

- Can parents/guardians insert information into an assessment report?
  - An assessment report is the work of the assessor or assessment team. If the parent/guardian provides evidence of a factual error (e.g., misidentification of the city where the student was born), then the report should be corrected. However, if the parent/guardian disagrees with the report's conclusions or interpretation, the parent/guardian can submit information to be added to the report. School districts have processes and board policies in place for amending student records. Parents/guardians will need to be advised of these procedures if such an issue arises.
- How should reports from other agencies be handled?
  - Reports from other agencies should be considered at an IEP meeting. During the evaluation time period, if an evaluation report is provided from an outside agency, the information should be reviewed and can be incorporated into the school evaluation. The same is true for reports from other providers.
- Should e-mail communications be kept in the student file? Are they part of the "official" record? Is the same true of fax confirmations/text messages/postal receipts?
  - E-mail is considered part of the student record if it is placed in the student's file/record. E-mail, text messages, and other electronic communications can be subpoenaed regardless of whether they are part of the student record. Fax confirmations and postal receipts would be considered appropriate to be included in the student file. All content with personally identifiable information (PII) is considered part of the student record, so if the student's name is mentioned in the e-mail message, then that e-mail message is assumed to be part of FERPA. Be judicious with e-mail, and limit the information that you share regarding students.
- Should telephone conversations be documented? If so, in what form should phone conversations be documented?
  - Yes, phone conversations should be documented. Options for the form include
  - tablets or paper files;
  - computer files; and/or
  - recording files (e.g., generated by a web conferencing program) that can be included in the student's electronic record or transcribed.

<u>Keep these tips in mind:</u>

- For each record, include the time and date (including the year), and identify participants.
-

For recorded conversations, make sure all participants are aware that the conversation is being recorded and provide documented consent. In many states, permission to record a conversation is legally required. If you are unsure about your state's stance, either obtain permission from all parties prior to recording the conversation or research the matter in advance of the call, conversation, or meeting.

- What kind of documentation is needed for students who are home schooled? What about for students who are in private school?
    - Assuming that these students are enrolled in special education, the documentation requirements remain the same. Students who are home schooled or who are enrolled in private school have an individual service plan (rather than an IEP), but the documentation requirements in terms of treatment are the same. States vary in their requirements, so check with your local district on these issues.
- Do I have to include my credentials (e.g., CCC-SLP, CCC-A) in my signature?
    - Educational records are considered a legal document, and the signatures of those who are entering information into this legal document should reflect their role within the organization. The official title of the audiology professional is audiologist, and the official title of the speech-language pathology professional is speech-language pathologist, which may be spelled out or included in the abbreviated credential, CCC-SLP/CCC-A for certified individuals. District rules may also specify the need to include information about licensure or additional credentials. Audiologists or SLPs holding an advanced degree in another discipline, such as psychology or business, should specify their credentials appropriately. See Issues in Ethics: Use of Graduate Doctoral Degrees by Members and Certificate Holders. Members holding specialty certification should also include those credentials.
- Does the SLP/audiologist/OTR supervisor need to co-sign all documentation completed by a student? What about a Clinical Fellow?
    - All student documentation is co-signed by a qualified clinician. Clinicians are responsible for identifying and meeting necessary qualifications. The supervisor must also ensure that the student supervisee documents client records in an accurate and timely manner (ASHA, 2010). See ASHA's Practice Portal Page on Clinical Education and Supervision and Issues in Ethics: Supervision of Student Clinicians.
    - ASHA's requirements for CF supervision do not address record documentation but do require that all CFs follow appropriate state and employer regulations. Review federal and state regulations to determine whether a Clinical Fellow requires a co-signature for documentation. See Issues in Ethics: Responsibilities of Individuals Who Mentor Clinical Fellows in Speech-Language Pathology and Information for Clinical Fellowship (CF) Mentoring SLPs for more information regarding the supervisor's responsibilities.
    - Clinicians may delegate tasks to students or Clinical Fellows only insofar as those tasks are appropriately supervised (see ASHA Code of Ethics, Principle 1, Rule E). Aspects of documentation that require the unique skills, knowledge, and judgment of the clinician should not be delegated (see ASHA Code of Ethics, Principle 1, Rule F).State licensure boards and Department of Education policies may vary in the requirements for documentation completed by students and Clinical Fellows.

- Can the Certified Occupational assistant, audiology assistant or speech-language pathology assistant (SLP-A) assistant who works with me document a student's progress in therapy?
    - No. An audiology assistant or SLP-A may collect data, but the interpreting and reporting of data is the responsibility of the certified or licensed clinician. Clinicians may delegate tasks to support personnel, including audiology assistants or SLP-As, only insofar as those tasks are permitted under state and federal regulations and are appropriately supervised (see ASHA Code of Ethics, Principle 1, Rule E). Aspects of documentation that require the unique skills, knowledge, and judgment of the clinician should not be delegated (see ASHA Code of Ethics, Principle 1, Rule F). See the Speech-Language Pathology Assistant Scope of Practice, ASHA's Practice Portal page on SLP-As, ASHA's Practice Portal page on Audiology Assistants, and ASHA's Code of Ethics. In addition, consult your state's scope and regulations.
    - A Certified Occupational Therapist can document a student’s progress in therapy and write progress notes in the IEP’s.
- Who "owns" the documentation–the clinician who wrote it or the school?
    - All official documents and records are the property of the school entity.
    - What should I do when I am asked to complete documentation for a colleague who has moved on if I was not previously involved in the case that is being documented?
- Ideally, clinicians will complete all documentation prior to leaving a job and will provide sufficient notice before discontinuing services to those they are serving (see ASHA Code of Ethics, Principle I, Rule T). It may be possible for another clinician to review prior notes and treatment logs to put together the necessary information. The clinician should be clearly identified, and the district may note the treating clinician's departure in the record so that it is clear to anyone reviewing the file. If there is not sufficient information to complete the documentation (such as no record of treatment dates), then the district should make note of that in the record. Attempting to recreate records without sufficient information may result in false information and fraudulent billing.
- Are my informal data tallies (e.g., check marks for accurate responses to help me determine progress) considered part of the educational record?
    - The data tallies that are interpreted elsewhere are generally not considered part of the designated record set. Check marks or other informal means of recording data during the treatment session are likely meaningless to anyone other than the treating clinician; however, the interpretation of those data (e.g., "Student was able to complete cloze sentences with 70% accuracy with minimal cues.") is meaningful and is considered part of the record.

Legal and Ethical Issues

The following legal and ethical documents affect documentation in the schools. Professionals should have a strong understanding of all of these issues.

Ethics

ASHA's Code of Ethics, Principle 1, Rule O, states: Individuals shall protect the confidentiality and security of records of professional services provided, research and scholarly activities conducted, and products dispensed. Access to these records shall be allowed only when doing so is necessary to protect the welfare of the person or of the community, is legally authorized, or is otherwise required by law (ASHA, 2016).

ASHA's Code of Ethics, Principle 1, Rule P, states: Individuals shall protect the confidentiality of any professional or personal information about persons served professionally or participants involved in research and scholarly activities and may disclose confidential information only when doing so is necessary to protect the welfare of the person or of the community, is legally authorized, or is otherwise required by law (ASHA, 2016).

ASHA's Code of Ethics, Principle 1, Rule Q, states: Individuals shall maintain timely records and accurately record and bill for services provided and products dispensed and shall not misrepresent services provided, products dispensed, or research and scholarly activities conducted (ASHA, 2016).

The U.S. Department of Education, the state department of education, and districts may impose their own requirements for documentation.

ADA

The Americans with Disabilities Reauthorization Act of 2009 was originally passed as the Americans with Disabilities Act in 1990 and requires "access to buildings, facilities, and transportation, and includes the provision of auxiliary aides and services to individuals with vision or hearing impairments" (Moore & Montgomery, 2008). ADA (1990) deals with accessibility to public domains (including communication access) and "prohibits discrimination on the basis of disability in employment, programs, and services provided by state and local governments, goods and services provided by private companies, and in commercial facilities" (U.S. Department of Justice, 1999, in Moore & Montgomery, 2008). The reauthorization expands the conditions considered to be disabilities under the ADA. The provisions of the ADA are closely aligned to Section 504.

Every Student Succeeds Act (ESSA)

The Every Student Succeeds Act (ESSA), which became law in December 2015, replaced the No Child Left Behind Act (NCLB). The 2002 NCLB instituted provisions of accountability that included establishing subgroups for analyzing adequate yearly progress (AYP) and requiring that teachers be highly qualified. The goal of ESSA is to create a better law focused on the clear goal of fully preparing all students for success in college and careers .ESSA covers various programs, including Title I, Improving Basic Programs Operated by State and Local Educational Agencies; Title II, Preparing, Training, and Recruiting High-Quality Teachers, Principals, and other School Leaders; and Title III, Language Instruction for English Language Learners and Immigrant Students.

For more information, see Every Student Succeeds Act: Key Issues for ASHA Members.

Family Educational Rights and Privacy Act (FERPA)

The Family Educational Rights and Privacy Act (FERPA) (1974) is the federal law that addresses student records, including who can have access to these records. This law ensures that parents/guardians have an opportunity to have the records amended and provides families some control over the disclosure of information from the records. According to FERPA, educational records are defined as records that are (a) directly related to the student and (b) maintained by an educational agency or institution or by a party acting for the agency or institution [20 U.S.C. 1232g(a)(4)(A); Moore, 2010b]. The legislation provides clarification on parental access to student records and limits the transfer of records by requiring consent for record transfers.

Under FERPA, there is a difference between allowing access to records and providing copies. FERPA does not require that copies of documents be provided. Rather, FERPA establishes the right of parents/guardians "to inspect and review the student's education records" (Section 99.7). The law requires that schools establish procedures enabling parents/guardians to review their children's records within a reasonable time after a request is made. FERPA requires that a copy be provided only where a parent/guardian would not otherwise be able to review the student's record (e.g., a parent/guardian is disabled and cannot travel to the school).

Individuals with Disabilities Education Improvement Act of 2004 (IDEA, 2004)

The Individuals with Disabilities Education Improvement Act of 2004 (IDEA, 2004) is the U.S. law that requires the provision of special education and related services for students who are identified as children with a disability (CWD). The determination of eligibility and types of services required is completed following specific procedures for a multidisciplinary assessment and through an IEP process. When students are determined to have a disability under IDEA (2004), they become members of a protected class in the United States; therefore, they secure procedural safeguards, which are realized in the procedural requirements of special education and are outlined in the law (Moore, 2010b). Although IDEA is a federal regulation, each state has created regulations that interpret the law for their particular state. Although state regulations cannot require less than what is required by the federal regulation, it can require more, so it is important to understand your state's regulations for special education.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is the law that pertains to protected health information (PHI). The law was originally enacted in 1996 and was amended in 2003. The 2003 amendments addressed electronic transmission of records and increased restrictions on accessibility to health records. Because school personnel are often seeking information from health care providers or billing Medicaid, periodically there is confusion and there are questions regarding which HIPAA requirements apply in school settings.

In most cases, HIPAA privacy rules do not apply to public schools because the school either is not a HIPAA-covered entity or is a HIPAA-covered entity whose health information is maintained in the education records, which fall under FERPA.

Records shared via electronic transmission fall under FERPA. The clinician must follow FERPA and receive permission from the parents/guardians to send records and bill Medicaid (34 CFR 99.30). At the time, the records are sent to Medicaid, and then that transaction falls under HIPAA.
A private school that is not receiving funding from the U.S. Department of Education and that contracts a therapist to provide services must follow HIPAA. An exception would be when a student in public school is placed in a private school; in this situation, the private school is required to follow FERPA for that student.
The HIPAA privacy rule mandates that a "covered entity" may not use or disclose PHI except as permitted by the rule. A school district is considered the covered entity. In most cases, the PHI is germane to conducting evaluation and development of the IEP and/or Section 504 plan. Again, the intent of both HIPAA and FERPA is confidentiality.

Section 504 of the Rehabilitation Act of 1973

Section 504 of the Rehabilitation Act of 1973 has a broader definition of disability than IDEA of 2004. Section 504 of the Rehabilitation Act of 1973 is a federal civil rights law that prohibits discrimination against individuals with disabilities in programs and activities that receive federal financial assistance. Students who are determined eligible under Section 504 will have a Section 504 accommodation plan. See this chart from the Understood Program at the National Center for Learning Disabilities (NCLD) comparing Section 504 and IDEA.

REFERENCES

- adapted from the North Carolina Department of Public Instruction - https://www.google.com/seach?q=educational+model+vs+medical_model
- Department of Education
- The Understood Team
- Pdesas.org/page?pageId=11
- http://tinyurl.com/esyinpa

OCCUPATIONAL THERAPY

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References

ROLES AND RESPONSIBILITIES

Occupational Therapists and Occupational Therapy Assistants

It is the responsibility of the occupational therapist to determine when to delegate responsibilities to an occupational therapy assistant. It is the responsibility of the occupational therapy assistant who performs the delegated responsibilities, to demonstrate service competency.

The occupational therapist and the occupational therapy assistant demonstrate and document service competency for clinical reasoning and judgment during the service delivery process as well as for the performance of specific techniques, assessments, and intervention methods used.

When delegating aspects of occupational therapy services, the occupational therapist considers the following factors:

- Complexity of the client's condition and needs.
- Knowledge, skill, and competence of the occupational therapy practitioner.
- Nature and complexity of the intervention; and
- Needs and requirements of the practice setting.

Service Competency – determination that 2 people performing the same procedure will have equivalent results

Documentation of Service Competency – It is recommended that the acceptable standard of performance be met on 3 occasions

AOTA COTA VS OTR: STANDARDS OF PRACTICE ROLES

Standard I. Professional Standing and Responsibility	The OTR	The COTA
Delivers OT services that reflect the philosophical base of occupational therapy. Knowledgeable of AOTA standards, policies, and guidelines and state, federal, and other regulatory and reimbursement guidelines. Maintains current licensure and certification; abides by the Occupational Therapy Code of Ethics. Abides by the Standards for Continuing Competence.	X	X
Responsible for all aspects of occupational therapy service delivery.	X	
Responsible for providing safe and effective OT services under the supervision of and in partnership with the occupational therapist.		X
Maintains current knowledge of legislative, political, social, cultural, societal, and reimbursement issues that affect clients.		
Knowledgeable about and applies evidence to practice.		
Respects the client's sociocultural background and provides client-centered and family-centered services.		

Standard II. Screening, Evaluation, and Reevaluation	The OTR	The COTA
Responsible for all aspects of the screening, evaluation, and re-evaluation process.	X	
Accepts and responds to referrals.	X	
Initiates and directs the screening, evaluation, and re-evaluation process and analyzes and interprets the data.	X	
Contributes to the screening, evaluation, and re- evaluation process by implementing delegated assessments and by providing verbal and written reports of observations and client capacities.		X
Uses current assessments and assessment procedures.		
Completes and documents evaluation results.	X	
Contributes to the documentation of evaluation results.		X
Recommends additional consultations or refers clients to appropriate resources.	X	

Standard III. Intervention	The OTR	The COTA
Overall responsibility for the development, documentation, and implementation of the occupational therapy intervention based on the evaluation, client goals, best available evidence, and professional and clinical reasoning.	X	
Collaborates with the client to develop and implement the intervention plan.		
Uses professional and clinical reasoning to select the most appropriate types of interventions.		
Selects, implements, and makes modifications to therapeutic interventions that are consistent with the occupational therapy assistant's demonstrated competency and delegated responsibilities, the intervention plan, and requirements of the practice setting.		X
Modifies the intervention plan and documents changes in the client's needs, goals, and performance.	X	
Contributes to the modification of the intervention plan by exchanging information with and providing documentation to the occupational therapist.		X
Documents the OT services.		

Standard IV. Outcomes	The OTR	The COTA
Selecting, measuring, documenting, and interpreting expected or achieved outcomes.	X	
Documenting changes in the client's performance and capacities and for transitioning the client to other types or intensity of service or discontinuing services.	X	
Prepares and implements a transition or discontinuation plan.	X	
Contributes to the transition or discontinuation plan.		X
Facilitates the transition or discharge process.		
Responsible for evaluating the safety and effectiveness of OT services.	X	
Contributes to evaluating the safety and effectiveness of OT services.		X

OT & COTA SUPERVISION TIPS

- 10% of Direct Time: The supervisor shall have supervisory contact with the occupational therapy assistant at least 10% of the time worked by the assistant in DIRECT patient care.
- Supervisory contact:
  - face-to-face individual contact – on site observation of the COTA therapy session at least once a month.
  - telephone or email communication
  - meetings: group conferences among a supervisor and two or more supervisees
  - review of written reports: daily notes, IEP, screens, progress notes and medical access logs
- Mode, Frequency and Duration: Types of supervisory contact depend on the treatment setting, the occupational therapy assistant's caseload, the condition of patients/clients being treated by the assistant, and the experience and competence of the assistant as determined by the supervisor.
- Monthly Supervision: The supervisor shall ensure that supervisory contact within each calendar month includes a combination of face-to-face, telephone and written communication.
- Documentation: The supervisor shall maintain a supervisory plan and shall document the supervision of each occupational therapy assistant. Documentation shall include evidence of regular supervision and contact between the supervisor and the assistant.
- Appraisal: Levels of supervision should be determined by the occupational therapist before the individual enters into a supervisor/supervisee relationship. The chosen level of supervision should be reevaluated regularly for effectiveness.

DE Code: A written contract at least every six months or more frequently per demand.

The PA Code: a written appraisal at least annually

PTS Billing Guidelines:

COTA:

- Bill directly to the student for: consult, re-eval (for review of a specific student goal, reviewing an IEP with supervisor), or indirect time (team communication/data collection). COTAs do not have a time requirement.
- Supervision is a professional requirement and is not billable time for the COTA.

OT:

- Bill for supervision under Specific School - OTHER- Clinical Supervisor (COTA SUPERVISION)

OR

- Bill directly to the student for: Consultation of a Student or Re-eval
  - (IEP/RR review of a specific student if goal writing, reviewing an IEP, attending an IEP meeting and/or completing a re-evaluation report).
  - Document the nature of the COTA supervision in your log/notes for your own record.
  - There is no time limit for supervision but must be a minimum of 10% of the COTAs DIRECT TIME per month.

GUIDELINES FOR ELIGIBILITY

OT and PT Services in the Educational Setting

The following guidelines are PTS' company recommendations only based upon the suggested criteria currently used by some of the nations' largest school districts. There are no formal eligibility criteria from the AOTA or any other OT professional association to definitively define qualification of students in school based practice.

Legal Basis for Eligibility

Occupational and Physical Therapy are available as "related services" (IDEA Part B) in a child's IEP when the service is "required for a child with a disability to benefit from his or her special education program". The Individualized Education Program (IEP) team is responsible for deciding if the student needs OT/PT services to benefit from their educational program. These services are to provide a child with equal opportunity that would not exist without therapy service and not merely maximization of a child's potential. Legal mandates require the schoolbased therapist to deliver only those services that are necessary to assist students in benefitting from their educational programs. School based therapy must be focused on the IEP goals that therapy is intended to support. Eligibility for therapy services must be based on the student's educational goals and whether the expertise of OT or PT is needed to help the student achieve those goals. While some educational goals may be academic while other goals will focus on student function or the student's participation and success in the school environment, all must be critical to the student's ability to access the curriculum.

No individual team member, including therapists, can independently determine who does or does not need services. The decision to add OT/PT to a student's list of services is determined by the IEP team. Under PA education law the IEP team is not allowed to base OT or PT service options and frequencies on the following factors alone:

- Test scores
- Descriptions or quantifiers of either functional performance or deficits
- Discrepancies between developmental levels and chronological age
- Specific OT, PT, or teacher roles and responsibilities
- Special Education classification categories

Education law mandates that emphasis must be placed on the context of the child's learning and activity. The IEP team cannot consider a child's need for OT or PT in isolation from an educational program. Therefore, the IEP team should not ask, "Does the student need OT or PT in school?" The team should ask, " Does an OT or PT's knowledge and expertise provide a needed component of the student's program that will achieve identified educational outcomes?"

Steps to Inclusion of OT and PT in the IEP

1. To be eligible for special education related service, the evaluation team must establish the existence of a disability and an educational need.
2. Once the child is determined to be eligible for special education services, the IEP team will identify which related services (if any) the child needs in order to benefit from special education services. OT and PT may be added as related services only if they are needed for the student to benefit from the special education services being provided.

A small number of students may qualify for OT or PT services with a Service Agreement under Section 504 of the Rehab Act of 1973 and The Americans with Disabilities Act. These services should be provided only if:

1. The student has a mental or physical impairment (or has a record of an impairment or is regarded as having an impairment)
2. It is substantial, and
3. It limits one or more major life activities (e.g. caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working)

Assessment

Areas to be assessed are based on a top down approach and are dependent on the student's needs. For example, if a screening reveals that a student has sufficient motor skills to be successful in the school environment but is demonstrating behaviors indicative of sensory modulation difficulties, tests that focus on motor skills and visual motor integration will not be warranted. A questionnaire that addresses sensory processing abilities would be more appropriate for this student.

Use of Criteria

Upon completion of an occupational therapy or physical therapy assessment, the therapist and IEP team determine whether an exceptional student demonstrates/exhibits a need for occupational therapy or physical therapy in the school setting in order to benefit from his/her special education program. The therapist should keep in mind specific factors when using the criteria:

- The therapist should use the assessment of functional motor skills, and not the presence of developmental delay, with students who have medical diagnoses, such as spina bifida, muscular dystrophy, and cerebral palsy.
- Poor handwriting skills or lack of athletic skills alone do not constitute an IDEA disability for which a student should be identified as eligible for special education services. Difficulties in these areas must impede the student's ability to benefit from the special education program in order for these problems to justify the need for OT or PT services under an IEP.

Criteria for Physical Therapy in the Education Setting:

- The Child must have a problem with an observable, functional motor skill that is critical to his ability to function in the school environment.
- Mobility must be impaired to the degree that it affects the child's ability to move around the school environment.
- The services of a physical therapist are required to address the above needs

Criteria for Occupational Therapy in the Education Setting:

- Child has difficulty with writing and drawing legibly. This does not mean that the child with sloppy handwriting automatically should receive OT services; if writing is sloppy but still legible, therapy services are not typically warranted. The therapist should discuss strategies for promoting more efficient, neater handwriting with the teacher. Some students will have neat, legible handwriting while in a one-to-one therapy session but will demonstrate lesser quality writing in the classroom. Often, these issues can be best addressed by the teacher, using an incentive program for neat work. Teams should keep in mind that it is very difficult to change grasp and letter formation patterns after 4th grade and recommendations for therapy should be made accordingly. By fifth grade, accommodations for these problems are often better than direct therapy.
- Child has difficulty with manipulative tools such as scissors and it is judged that this difficulty will improve with occupational therapy services.
- Child has diminished ability to attend to tasks and organize work due to sensory processing problems. It is important that the OT assess the child to determine whether or not the attention problem s are due a sensory processing issue a opposed to another type of attention problem that is not likely to respond to OT intervention.
- Child has difficulty perform self-care skills that are necessary in the school setting. OT should only provide services to address these difficulties if they are not being specifically addressed in the child's education program (such as in a life skills curriculum).

Discharge Criteria

The student should be considered for dismissal from Occupational/Physical Therapy when one or more from the following conditions exist:

1. The student's level of educational functioning in the area(s) being addressed has reached age level, grade level and/or level of intellectual potential.
2. The student has developed the performance components needed to progress toward the educational goals established in the IEP.
3. The areas of concern being addressed in the therapy do not interfere with the student's ability to function or make progress in her educational setting.
4. Environmental or curricular adaptations have been established to allow for achievement of educational goals.
5. The student's needs for remediation and/or compensation in the area(s) being addressed are being fully met by the student's educational or other service providers without the need for continued therapist contact.
6. The student's rate of progress in the educational environment in the area(s) being addressed by therapy continues to be steady and commensurate with the student's overall level of progress in other areas despite a decrease in therapy services.
7. Therapy is no longer affecting change in the student's level of function or rate of skill acquisition (i.e. the student has reached a plateau).

CAN OT OR PT STAND ALONE?

It's an important question and one that will come up a lot as you go through your school year. One of our Director's of Pupil Services shared with us an email she sent to her team of psychologists about stand aloneOT evaluations. The information is below. Feel free to use this information during conversations with the teachers, psychologists, and teams you work with!

- OT evals should never be completed in isolation. They should always be part of a Chapter 14 eval or a Chapter 15 eval that is comprehensive. MDEs are preferable and legally defensible.
- Whether a student "qualifies" for OT or would benefit from/respond to OT intervention is not the question when considering 504 eligibility. The question we need to answer as a team is "Is the child exhibiting a performance deficit that is disabling?" or put another way "Does the child have a disability that causes a substantial limitation in school performance?"
- We need to be careful not to rely on parents to produce evidence of a disability (i.e. Dr. note). It is the district's child find obligation to conduct whatever evaluation is necessary to determine a student's needs under Chapter 14 or 15. We also do not presume eligibility based on a Dr. note indicating a disability or script for service. It is ok to ask if there are any DSM diagnoses however but this should not delay a needed action under our child find obligation.
- The threshold for determining "substantial limitation" is somewhat low. Nevertheless, it must be discussed by the team.
- Eligibility determinations must also consider whether the needed skill is available within the grade-level curriculum.

*A student can have OT or PT in a 504 (but typically the services are consult for accommodations and not a direct service). However, most districts are no longer providing "OT only" 504 plans.

*Counselors and Psychologists - remember that it is an essential step that all students undergo the 504 Evaluation process prior to drafting a 504. This is a procedural requirement. The 504 evaluation process may involve collection of data, team input, and observation. It does not have to involve a psychologist but the team should strongly consider the need for psych involvement & Chapter 14 eligibility when the CST nature of concern is related to ADHD like behaviors or OT-like needs.

*A 504 plan should not be developed strictly as a means to provide OT and/or PT services.

MTSS 1:
WHOLE CLASSROOM CONSULTATION

Dear Teachers:

We are very excited to bring you new programming for the upcoming school year. Starting in September, Occupational Therapy will be implementing initiatives already underway at the building. The goals for these new initiatives is to support classroom teachers with fine motor and handwriting strategies and boost fine motor/handwriting skills in the primary grades. The OT MTSS program will include the follow Tier 1 intervention:

The Primary - Whole Classroom “Push –In” Consultation: Teachers will have access to this support during the first quarter of the school year. Once the MTSS Classroom Needs Assessment form is completed and returned to the OT, the therapist will schedule a time or multiple times to integrate into the classroom and consult on the identified classroom needs. The teacher and therapist will have 60 minutes that can be divided and utilized as needed by the classroom. Whole class strategies, tools, and tips will be provided by the therapist during these times.

Tip Time: Teachers will have support of the OT and PT during an office hours’ type setting completed before or after school. The OT and PT listen, strategize and problem solve with any school staff in attendance. This is a great time for paraprofessionals and encore teachers to ask specific questions directly related to a student. The OT and PT coordinate a time and place where the office hours will occur and send out an email to all school personnel.

Warm Regards,
Jennifer Cancro, OTR/L
Director of Clinical Services
Pediatric Therapeutic Services

The Primary Boost and Tip Time

Occupational Therapy Consultation & Training Classroom Needs Assessment

Date of Request:	Grade:
Teacher:	Number of Students in Classroom:
	Email:

I am requesting the following:

- ◯ Primary Boost Classroom Observation & Consultation with Teacher
- ◯ "Tip Time" (before school or after school) with any School Personnel

Topics Requested for Consultation:

- ◯ Handwriting – Manuscript
- ◯ Handwriting – Cursive
- ◯ Desk/Materials Organization
- ◯ Sensory Strategies
- ◯ Pencil Grasp
- ◯ Scissors Grasp
- ◯ Need for Adapted Paper
- ◯ Ergonomics
- ◯ Creating Fine Motor Stations in the classroom
- ◯ Other: _____

I have already trialed the following strategies in my classroom:

- ◯ Pencil Grips
- ◯ Use of a 3" binder as a slant board
- ◯ Use of computer
- ◯ Use of multi-sensory approach to letter writing (shaving cream, drawing letters in sand)
- ◯ Modifications made to worksheets/paper (such as highlighting or bolding lines)
- ◯ Fine motor station in classroom: fine motor box filled activities such as with play-dough, scissors and various materials with resistance to cut – cardboard, felt, straws, push-pull manipulatives such as legos, lacing cards, pushing pennies into a small can
- ◯ Other: _____

Sensory

- ◯ Movement breaks such as student running "errands" for teacher (i.e. carrying library books, pushing the lunch cart, erasing board)
- ◯ Visual timer or timer to provide organization
- ◯ Movement to prepare for seated work tasks (i.e. runners stretch, stretching neck, side bends, etc.)
- ◯ Quiet hand fidgets (such as pipe cleaner or pom pom during independent work time or group listening time)
- ◯ Gum or oral motor tools
- ◯ Other: _____

The best day and time to observe in my classroom is:_____

*Please return form to the OT mailbox by_____

School District

Multi-Tiered System of Supports

PTS PEDIATRIC THERAPEUTIC SERVICES

OT Classroom Observation Request Form for MTSS (Multi-Tiered System of Supports)

Student Name:	Date of Birth:
School:	Current Teacher/Grade:
Case Manager:	Date:

Teacher/Team Concerns:

Fine Motor/Self Care Skills

- ☐ Holding Pencil Appropriately
- ☐ Tool Use (scissors, ruler)
- ☐ Dressing (Zippers, buttons)
- ☐ Manipulating small objects
- ☐ Completing art projects
- ☐ Other:

Sensory/Attention/Behavior

- ☐ Listening Skills
- ☐ Following Directions
- ☐ Attention Span
- ☐ Organizational Skills
- ☐ Personal Hygiene
- ☐ Sitting still during class

Visual Motor /Perceptual Skills

- ☐ Copying from board
- ☐ Forming letters
- ☐ Letter recognition
- ☐ Need for Assistive Technology
- ☐ Drawing
- ☐ Reversing Letters
- ☐ Illegible writing
- ☐ Writing on or between lines
- ☐ Need for Prevocational/ Vocational Skills
- ☐ Other:

Therapist Findings:

The therapist completed an observation on _____. The following recommendations are being made:

☐ No further intervention is recommended at this time

☐ Participation in MTSS is recommended to address the following areas:

____Fine Motor ____Self Care ____Sensory ____Visual Motor/Perception

**Please complete the MTSS Intervention Plan*

☐ A screening is recommended to further assess _____

*Please obtain parent permission and parent signature to proceed with screening

_____ _____

Occupational Therapist **Date**

Parent Permission for Screen

☐ **I give permission to proceed with OT screening.** ☐ **I do not give permission to proceed with OT screening**

_____ _____

Parent signature Date

_____ _____ _____

Parent name (Printed) Daytime Phone Number E-mail

School District

PTS PEDIATRIC THERAPEUTIC SERVICES

Multi-Tiered System of Supports (MTSS) Plan& Tracking Form

Plan Participants:

Student:	Grade:
Classroom Teacher:	Physical Therapist:
MTSS:	Speech/Language Therapist:
Parents:	Occupational Therapist:

Reason for Referral: _____

Identified Area of Support: _____

Duration of Plan: _____

MTSS Goal:	Strategies:	Person(s) Responsible:

Method of Documentation: _____

Follow up Date: _____

Summary/Recommendations:: _____

_____

_____

MTSS Goal:	Baseline:	Progress:	Continue/Discontinue

Action: _____

_____

_____

_____ _____

Implementing Therapist Date

PTS

MTSS 1 Student CLASSROOM DATA FORM FOR OCCUPATIONAL THERAPY STRATEGIES

Student Name:_____ **School:**_____ **Grade:**_____ **Teacher:**_____

Date Strategies Initiated: _____

Below, please find a form of common recommendations and strategies. Upon the completion of the 2 week trial period, I will consult with you to see how they have worked in your classroom. Please feel free to contact me with any questions!

Referral Period Data *Progress Code: N = No Improvement, I = Improving, R = Resolved*			
Strategies	**Week 1**	**Week 2**	**Notes**
Pencil grasp			
☐ Have child hold a pom pom or sponge in their last two fingers while they write	☐ ☐ ☐ N I R	☐ ☐ ☐ N I R	
☐ If holding too close or far from the point, put a small rubber band at the right spot	☐ ☐ ☐ N I R	☐ ☐ ☐ N I R	
☐ Pencil Grip/wishbone pencil/ visual prompt _____	☐ ☐ ☐ N I R	☐ ☐ ☐ N I R	
☐ Use 2" pencil and broken crayons	☐ ☐ ☐ N I R	☐ ☐ ☐ N I R	
☐ Use slant board / 3-inch 3-ring binder turned 90° for all writing/coloring tasks	☐ ☐ ☐ N I R	☐ ☐ ☐ N I R	
Letter formation			
☐ Daily alphabet writing w/visual cues – *supervised & stressing* TOP DOWN	☐ ☐ ☐ N I R	☐ ☐ ☐ N I R	
☐ Review letter patterns w/similar formations (e.g. "Magic c" & "Diver")	☐ ☐ ☐ N I R	☐ ☐ ☐ N I R	
☐ Create tactile letters for tracing (puff paint, sandpaper, etc.)	☐ ☐ ☐ N I R	☐ ☐ ☐ N I R	
Spacing / alignment / legibility			
☐ Use a popsicle stick, "spaceman" or finger to measure off space between words	☐ ☐ ☐ N I R	☐ ☐ ☐ N I R	
☐ Put a small underline between words; use graph paper: 1 letter/square; blank between words	☐ ☐ ☐ N I R	☐ ☐ ☐ N I R	
☐ Use paper with dotted mid-line; highlight lower half of line for "small letter" placement/ visual cue	☐ ☐ ☐ N I R	☐ ☐ ☐ N I R	
☐ Spaghetti & meatball spacing (spaghetti between letters/ meatballs between words)	☐ ☐ ☐ N I R	☐ ☐ ☐ N I R	
☐ Use visual cue/checklist/rubric for self-monitoring legibility/spacing/alignment	☐ ☐ ☐ N I R	☐ ☐ ☐ N I R	
Cutting / coloring			
☐ Highlight or create raised boundaries (white glue or puff paint)	☐ ☐ ☐ N I R	☐ ☐ ☐ N I R	
☐ Practice cutting cardstock, index cards or craft foam as they're easier to manage	☐ ☐ ☐ N I R	☐ ☐ ☐ N I R	
☐ Ensure cutting is the correct direction *(R = counter clockwise; L = clockwise)*	☐ ☐ ☐ N I R	☐ ☐ ☐ N I R	
Reversals			
☐ Provide right/left cue at the top of their desk (e.g. green dot in top left corner of desk)	☐ ☐ ☐ N I R	☐ ☐ ☐ N I R	
☐ Provide a letter strip at the top of their desk and/or visuals for specific reversals	☐ ☐ ☐ N I R	☐ ☐ ☐ N I R	

Positioning – (for fine motor/ handwriting)			
☐ 90-90-90 seating: chair height so hips, knees & ankles at 90˚	☐ ☐ ☐ N I R	☐ ☐ ☐ N I R	
☐ Desk height should be such that the desktop is within..... at elbow to 2" above	☐ ☐ ☐ N I R	☐ ☐ ☐ N I R	
☐ Paper tilted at a 45˚angle to left for a right hander / 45˚angle to right for a left hander	☐ ☐ ☐ N I R	☐ ☐ ☐ N I R	
☐ Use tape line on desk/arrow on bottom corner of page (points to belly button) for paper placement	☐ ☐ ☐ N I R	☐ ☐ ☐ N I R	
Sensory – Alerting/ wake-up			
☐ Jumping jacks, Dance, Cross-crawl (R elbow to L knee/alternate), chair airplane (arms out = wings, touch floor w/R fingers/L fingers), chair push-ups)	☐ ☐ ☐ N I R	☐ ☐ ☐ N I R	
Sensory – Calming			
☐ Quiet time, lights out/use natural light, balloon breaths or Take 5, quiet hand fidgets such as a pipe cleaner	☐ ☐ ☐ N I R	☐ ☐ ☐ N I R	
Sensory – Organizing			
☐ Heavy work; errands/jobs with weighted items (e.g. carrying books, erasing board, stacking chairs), isometric hand press, push-ups, yoga	☐ ☐ ☐ N I R	☐ ☐ ☐ N I R	
☐ Attach thera-band/bike tube to the chair or desk legs	☐ ☐ ☐ N I R	☐ ☐ ☐ N I R	
☐ *Oral* – provide chewy object, gum or sport water bottle with a straw	☐ ☐ ☐ N I R	☐ ☐ ☐ N I R	
Sensory – Visual			
☐ Provide visual cues for looking and listening, clear irrelevant desktop items, use "office walls," enlarge print to create more whitespace on page	☐ ☐ ☐ N I R	☐ ☐ ☐ N I R	
Sensory – Tactile			
☐ Provide fidgets, Velcro on desk (student's choice of rough or smooth), etc.	☐ ☐ ☐ N I R	☐ ☐ ☐ N I R	
Sensory – Auditory			
☐ Provide quiet space for working, headphones at work time/noisy environments (lunch, assemblies), instrumental background music	☐ ☐ ☐ N I R	☐ ☐ ☐ N I R	
Other – please specifiy			
	☐ ☐ ☐ N I R	☐ ☐ ☐ N I R	
	☐ ☐ ☐ N I R	☐ ☐ ☐ N I R	

Follow Up Date: _____ Upon completion of interventions and data collection for the 2 week period, please send Screening Request form and this data collection sheet to the IST for review. Upon approval of the OT screening, the forms will be forwarded to the therapist for the Screening. Copies should be kept in the Guidance Counselor's file, Therapist file, and in the main student file in the Special Education Office.

_____ **Concerns Resolved, no further action needed**

_____**OT Screening requested (Please identify student's diagnosis if applicable):** _____

Request for Occupational Therapy Screening

Student:	Case Manager:
Date of Birth:	Teacher:
Gender:	School:
Date:	Grade:

I am concerned with this student's:

Fine Motor Skills

- ☐ Holding a pencil appropriately
- ☐ Tool Use (scissors, ruler)
- ☐ Dressing (zippers, buttons)
- ☐ Manipulating small objects
- ☐ Completing art projects
- ☐ Other: _____

Attention/Behavior

- ☐ Listening Skills
- ☐ Following Directions
- ☐ Personal Hygiene
- ☐ Making Friends
- ☐ Sitting still during class
- ☐ Attention Span
- ☐ Organizational Skills
- ☐ Problem Solving
- ☐ Self Esteem
- ☐ Working in groups with other students

Visual Motor Skills

- ☐ Copying from board
- ☐ Letter recognition
- ☐ Illegible writing
- ☐ Drawing
- ☐ Need for Prevocational/ Vocational Skills
- ☐ Forming letters
- ☐ Need for Assistive Technology
- ☐ Reversing Letters
- ☐ Writing on or between Lines

Significant History, Diagnosis or Precautions:
Prior to this request, what strategies, if any, have been utilized to address these concerns:
Please attach student work samples and note any additional concerns:

This child already receives: ☐ Special Ed ☐ Speech ☐ Psych ☐ PT

Signature of Therapist Receiving Screen Request: Date:

Request for Occupational Therapy Screening- Additonal Data

Student:	Case Manager:
Date of Birth:	Teacher:
Gender:	School:
Date:	Grade:
Parents:	Room:
Phone Number:	Date of last IEP:
Address:	

Referred by:	Have parents been notified of your concerns? ☐ YES ☐ NO
Please Return this Form to:	

I am concerned with this student's:

Fine Motor Skills

- ☐ Holding a pencil appropriately
- ☐ Tool Use (scissors, ruler)
- ☐ Dressing (zippers, buttons)
- ☐ Manipulating small objects
- ☐ Completing art projects
- ☐ Other:_____

Attention/Behavior

- ☐ Listening Skills
- ☐ Following Directions
- ☐ Personal Hygiene
- ☐ Making Friends
- ☐ Sitting still during class
- ☐ Attention Span
- ☐ Organizational Skills
- ☐ Problem Solving
- ☐ Self Esteem
- ☐ Working in groups with other students

Visual Motor Skills

- ☐ Copying from board
- ☐ Letter recognition
- ☐ Illegible writing
- ☐ Drawing
- ☐ Need for Prevocational/ Vocational Skills
- ☐ Forming letters
- ☐ Need for Assistive Technology
- ☐ Reversing Letters
- ☐ Writing on or between Lines

Significant History, Diagnosis or Precautions:	**If handwriting is a concern, please attach writing samples.**
Prior to this request, what strategies have been utilized to address these concerns:	☐ Request for screening. (Initial step in referral process to determine need for evaluation. Informal observation and consultation.) Parent permission required
Please list grades and standard scores that support the need for possible therapy in the educational setting:	

IST Approval: _____ School Principal: _____

Request for Occupational Therapy Screening: Secondary School Referral

Student:	Case Manager:
Date of Birth:	Teacher:
Gender:	School:
Date:	Grade:

I am concerned with this student's:

Fine Motor Skills

- ☐ Forming Letters
- ☐ Manipulating small objects
- ☐ Manipulating Combination Lock
- ☐ Tool Use (scissors, ruler)
- ☐ Completing art projects
- ☐ Reversing Letters
- ☐ Dressing (zippers, buttons)
- ☐ Letter Recognition
- ☐ Other: _____

Attention/Behavior

- ☐ Following "Whole Class Instruction"
- ☐ Following Directions
- ☐ Personal Hygiene
- ☐ Initiating/Using compensatory strategies previously taught
- ☐ Attention Span
- ☐ Organizing Classroom Materials
- ☐ Organizing Personal Belongings
- ☐ Planning of Long Term Projects

Visual Motor Skills

- ☐ Copying from board
- ☐ Finding Place on a page or a book
- ☐ Illegible writing
- ☐ Drawing/Difficulty copying diagrams
- ☐ Other
- ☐ Efficient Note-taking Strategies
- ☐ Work is disorganized
- ☐ Efficient Use of Computer
- ☐ Writing on or between Lines

Significant History, Diagnosis or Precautions:
Prior to this request, what strategies, if any, have been utilized to address these concerns:
Please attach student work samples and note any additional concerns:

This child already receives: ☐ Special Ed ☐ Speech ☐ Psych ☐ PT

Signature of Therapist Receiving Screen Request:	Date:

Occupational Therapy Screening

Date:
Student's Name:
D.O.B.:
Grade:
Teacher:

Positioning and Work Space Observations

Child's Placement in Classroom

- ☐ Near the source of instruction
- ☐ Front and center
- ☐ Front of classroom
- ☐ Middle of classroom
- ☐ Back of classroom
- ☐ Near the door
- Near the window

Comments

Desk Height

- ☐ Appropriate
- ☐ Too High
- ☐ Too Low

Comments

Chair Height

- ☐ Appropriate
- ☐ Too Big
- ☐ Too Small

Comments

Positioning and Work Space Observations Cont.

Seated posture (Upper Body)

- [ ] Upright
- [ ] Slumped with rounded back
- [ ] Bottom sliding forward on chair
- [ ] Propped head on hands
- [ ] Head lying on arm
- [ ] Leaned chest against desk

Comments

Seated Posture (Lower Body)

- [ ] Feet planted firmly on floor
- [ ] Legs wrapped around chair legs
- [ ] Dangled Legs
- [ ] Swinging or kicking legs
- [ ] Right leg underneath bottom
- [ ] Left leg underneath bottom

Comments

Accommodations/Support

- [ ] Has personal schedule
- [ ] Has cues on desk for looking & listening
- [ ] Uses a “buddy” for task completion

Comments

Fine Motor/Self Care Skills Observations

Dominant Hand

- [ ] Right
- [ ] Left

Comments

Scissors Grasp

- [ ] Right
- [ ] Left

Comments

Fine Motor/Self Care Skills Observations Cont.

Scissors Grasp

- [ ] Neutral Wrist Position - Thumb Up
- [ ] Pronated Wrist - Thumb Down

Comments

Cutting Skills

- [ ] Able to cut a straight line
- [ ] Able to cut a curved line
- [ ] Able to cut angular shapes
- [ ] Able to cut curved shapes
- [ ] Stabilizes paper with non dominant hand
- [ ] Able to turn paper while cutting
- [ ] Needs assistance (explain in comments section)

Comments

Self-Care Skills

- [ ] Able to button/unbutton
- [ ] Able to zip coat independently
- [ ] Needs assistance with engaging zipper
- [ ] Able to tie shoes
- [ ] Able open drink/snack/lunch containers
- [ ] Able to use utensils

Comments

Handwriting Skills and Observations

Hand use for Pencil Grasp

- [ ] Left
- [ ] Right

Comments

Handwriting Skills and Observations Cont.

Grasp Pattern

- [ ] Fisted
- [ ] Pronated
- [ ] 5 finger
- [ ] Thumb wrap
- [ ] Tripod
- [ ] Quadripod

Comments

Open web space

- [ ] Yes
- [ ] No

Comments

Pencil Grip Used

- [ ] None
- [ ] Claw
- [ ] Pencil grip
- [ ] Crossover grip
- [ ] Grotto Grip
- [ ] Triangular

Comments

Slant Board Used

- [ ] Yes
- [ ] No

Comments

Stabilizes Paper with Non Dominant Hand

- [ ] Yes
- [ ] No

Comments

Letter Start Point

- [ ] Top
- [ ] Bottom

Comments

Handwriting Skills and Observations Cont.

Letter Formation

- [ ] Counterclockwise - optimal
- [ ] Clockwise
- [ ] Left to Right - optimal
- [ ] Right to Left
- [ ] Letter Reversals noted: b, d, p, q, z
- [ ] Other:

Comments

Pencil Pressure

- [ ] Hard
- [ ] Soft
- [ ] Appropriate

Comments

Letter Size

- [ ] Large
- [ ] Appropriate
- [ ] Small

Comments

Spacing

- [ ] Tight between letters
- [ ] Tight between words
- [ ] Excessive between letters
- [ ] Excessive between words

Comments

Copying Near Point

- [ ] Independent
- [ ] Needs cueing and/or assistance

Comments

Copying Far Point

- [ ] Independent
- [ ] Needs cueing and/or assistance

Comments

Attention, Behavior & Sensory Processing Observations

Attention/Regulation

- [ ] Able to focus and complete tasks
- [ ] Fidgety and restless
- [ ] Frequently gets out of chair
- [ ] Appears to be “driven by a motor”
- [ ] Appears to daydream; internally distracted
- [ ] Slow to start
- [ ] Chews on clothing, pencils, items
- [ ] Difficulty with transitions

Comments

Sensory Processing

- [ ] Appears under-responsive
- [ ] Appears sensitive and/or over-responsive
- [ ] Tactile
- [ ] Movement/Vestibular
- [ ] Proprioception
- [ ] Auditory
- [ ] Visual
- [ ] Oral

Comments

Sensory Seeking

- [ ] Tactile
- [ ] Movement/Vestibular
- [ ] Proprioception
- [ ] Auditory
- [ ] Visual
- [ ] Oral-Motor

Comments

Sensory Avoiding

- [ ] Tactile
- [ ] Movement/Vestibular
- [ ] Proprioception
- [ ] Auditory
- [ ] Visual
- [ ] Oral-Motor

Comments

Attention, Behavior & Sensory Processing Observations Cont.

Motor Planning/Task Completion

- [ ] Able to initiate following directions
- [ ] Needs repeated instructions to get started
- [ ] Needs prompting for sequencing multiple steps
- [ ] Able to follow _____ steps
- [ ] Needs verbal prompting
- [ ] Needs visual prompting
- [ ] Needs physical prompting

Comments

Organization

- [ ] No needs
- [ ] Difficulty completing morning routine
- [ ] Difficulty managing papers
- [ ] Difficulty managing assignments
- [ ] Difficulty finding items in desk
- [ ] Difficulty packing up backpack
- [ ] Difficulty completing afternoon routine

Comments

Accommodations/ Support

Currently has:

- [ ] None
- [ ] Move ‘n Sit cushion
- [ ] Thera-band wrapped around desk/chair legs
- [ ] Hand/finger fidgets
- [ ] Gum/oral motor fidgets
- [ ] Schedule
- [ ] Warnings for transition
- [ ] Visual timer

Comments

Occupational Therapy Screen Recommendations

Date:

Dear ,

Thank you for the opportunity to observe . He/she was observed during . I've attached a form of priority needs as well as recommendations and strategies. I've also attached a 6 week data collection form to chart the trial of these strategies. Upon the completion of the 6 week trial period, I will consult with you to see how the strategies and recommendations have worked out. I have highlighted recommendations and strategies I feel would be best to incorporate into the daily class times to address the above stated needs. Please feel free to contact me with any questions!

Sincerely,

Days available at school:

Times available for consultation:

Phone:

Email:

Copy of the screen report given to:

- ☐ Teacher
- ☐ IST
- ☐ Special Education Office for student records
- ☐ Cumulative folder in school's main office

Occupational Therapy Screen Recommendations

Date:
Student's Name:
Teacher Name:
Therapist Name:
Follow up consultation to be scheduled for 6 weeks. Date:

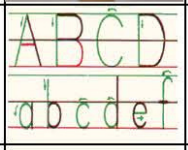
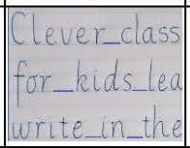
Needs	Recommendations	Equipment or Materials Needed
Fine Motor/ Visual Perceptual/ Visual Motor		
Handwriting		
Self-Care		
Attention/ Regulation/ Sensory		

PTS PEDIATRIC THERAPEUTIC SERVICES

Fine Motor

CLASSROOM DATA COLLECTION FORMS FOR STRATEGIES FROM THE CHILD STUDY TEAM

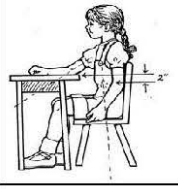
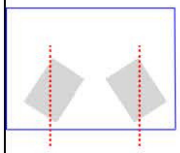
Student Name: _____ Grade: _____ Teacher: _____

		Referral Period Data *Progress Code: 1- Making minimal progress, 2-Making progress with strategies, 3-Making progress without strategies*						
Fine Motor/Handwriting	**Example**	**Week 1**	**Week 2**	**Week 3**	**Week 4**	**Week 5**	**Week 6**	**Notes**
• Pompom or sponge in last two fingers		1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	
• Small rubber band or binder clip at correct pencil grip position		1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	
• Popsicle stick or finger for spacing between words		1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	
• Letter strip on students' desks		1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	
• Other: _____ _____		1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	
Visual Perception/Handwriting	**Example**	**Week 1**	**Week 2**	**Week 3**	**Week 4**	**Week 5**	**Week 6**	**Notes**
• Right/Left cue at top of desks		1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	
• Small underline between words to fill space		1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	
• Other: _____ _____		1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	

PTS PEDIATRIC THERAPEUTIC SERVICES

Positioning
CLASSROOM DATA COLLECTION FORMS FOR STRATEGIES FROM THE CHILD STUDY TEAM

Student Name: _____ Grade: _____ Teacher: _____

		Referral Period Data *Progress Code: 1- Making minimal progress, 2-Making progress with strategies, 3-Making progress without strategies*						
Posture/Positioning for Handwriting	**Example**	**Week 1**	**Week 2**	**Week 3**	**Week 4**	**Week 5**	**Week 6**	**Notes**
• Raise/Lower desk and/or chair (90°-90°-90°)		1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	
• Paper at 45° to the left for right-handed Paper at 45° to the right for left-handed		1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	
• Vertical writing positions via white board, 3" ring binder, lying on floor, etc.		1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	
• Other: _____ _____		1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	

PTS PEDIATRIC THERAPEUTIC SERVICES

Sensory
CLASSROOM DATA COLLECTION FORMS FOR STRATEGIES FROM THE CHILD STUDY TEAM

Student Name: _____ Grade: _____ Teacher: _____

		Referral Period Data *Progress Code: 1- Making minimal progress, 2-Making progress with strategies, 3-Making progress without strategies*						
Sensory Strategies for Calming and Alerting	**Example**	**Week 1**	**Week 2**	**Week 3**	**Week 4**	**Week 5**	**Week 6**	**Notes**
• Alerting: Jumping jacks Marching in place Crossing midline (right elbow to left knee) Brain Breaks on Youtube		1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	
• Calming: Wall/Table push-ups Hand fidgets (pipe cleaner, paper clip, Velcro dots on pencil/under chair or desk)		1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	
• Calming: Deep breathing Relaxation music (Youtube) Yoga poses		1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	
• Calming/Alerting (organizing, errands 2-3 times/day) Carry heavy books or bins Push lunch cart Erase board		1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	
• Calming/Alerting (modified work station) Bean bag Caribbean Corner Visual cues on desk (looking, listening) Lowering/turning off lights		1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	

PTS PEDIATRIC THERAPEUTIC SERVICES

CLASSROOM DATA COLLECTION FORMS FOR STRATEGIES FROM THE CHILD STUDY TEAM

Student Name: _____ Grade: _____ Teacher: _____

Thank you for the opportunity to discuss your student today. Please view the list of priority needs as well as recommendations and strategies. Upon the completion of the 6 week trial period, the CST will consult with you to see how the strategies and recommendations have worked in your classroom. Please feel free to contact the team with any questions.

_____

_____

_____

_____

_____

_____

_____

_____

_____

Upon completion of this form, please send this data collection sheet to in the Child Study Team.

Follow Up Date: _____

- ☐ Concerns Resolved, no further action needed
- ☐ Concerns Continue, OT Screening needed: _____

Signature of Director of Student Services: _____

PTS PEDIATRIC THERAPEUTIC SERVICES

Using the OT *Practice Framework* to Choose Effective and Efficient Assessments for School-Based Occupational Therapy

(adapted from AOTA)

Assessing Occupation: Assessments That Measure Engagement in Meaningful Activity						
Measure	**Purpose**	**Constructs**	**Age**	**Time to Administer**	**Format/Type of Administration**	**Format and Scores**
Canadian Occupational Performance Measure (COPM)	Identify occupational performance problems, define priorities, and guide goal setting	Measures clients' perceived occupational performance in three areas: self-care, productivity, and leisure	Any age, with or without disabilities	15–30 minutes	Semi-structured, interviewed by therapist	Standardized scores norm-referenced
Miller Function and Participation Scales (M-FUN)	Assess a child's performance related to school participation, with a focus on motor skill performance	Measures mild to moderate delays in visual, fine, and gross motor skills	2.6–7.11 years	20–30 minutes per subset, 45–60 min for entire assessment	Workbook/task format, administered by therapist	Standard scores, percentile ranks age equivalents, and progress scores
Hawaii Early Learning Profile (Help)	Family centered, curriculum-based assessment tool created to evaluate young children	Focuses on six areas of development that include: fine motor, gross motor, social, self-help, expressive language, and cognitive skills; children are evaluated against their own prior achievement	0-3years, 3-6 years	15 to 20 minutes	Observation in natural environment/multiple settings	There are no standardized scores, however, skills and behaviors that are assessed in this assessment have normative data for age groups
Roll Evaluation of Activities of Life (REAL)	A standardized assessment of a child's ability to care for him/herself	Comprised of two domains: activities of daily living (ADL's) and instrumental activities of daily living (IADL's)	2.0-18.11 years	15-20 minutes	The ADL domain consists of 78 statements that address six skill areas. The IADL domain consists of 58 statements that address six skill areas.	Manually scored; reports standard scores, percentile ranks, and standard error of measure
Developmental Assessment for Individuals with Severe Disabilities (DASH-3)	Criterion referenced measure of specific skill levels in children and adults who have physical, intellectual, or sensory disabilities, including those with autism spectrum disorders	Five scales that look at relevant skills in a developmental sequence for the following areas: Sensory Motor, Language, Social Emotional, ADL, Academic	6 months-Adulthood	2-3 hours	Individually administered behavior rating, through direct observation, interview, or informant report	Criterion referenced measure; Developmental age scores for each scale and subscale, plus an overall developmental age
Pediatric Evaluation of Disability Inventory (PEDI)	Assesses functional skill level of independence, and the extent of modifications required in a child's environment	Evaluates capability and performance of functional activities in the domains of self-care, mobility, and social function	6 months–7 years; useful for older children whose functional abilities are lower than those of seven-year-olds without disabilities	45–60 minutes for administration and scoring	Questionnaire format, administered by parent report/interview, clinical judgment, or combination of the two	Standard and scaled performance scores
Pediatric Evaluation of Disability Inventory Computer Adaptive Test (PEDI-CAT)	The PEDI has been revised as a computer adaptive test (CAT).	The PEDI-CAT measures abilities in three functional domains: Daily Activities, Mobility and Social/Cognitive.	Birth to 20 years	10-20 minutes	Software utilizes IRT statistical models to estimate a child's abilities from a minimal number of the most relevant items or from a set number of items within each domain	Normative standard scores (provided as age percentiles and T scores) and Scaled Scores; available for 21 age groups (intervals of one year)

Assessing Performance Skills and Patterns: Assessments That Measure Participation						
Measure	**Purpose**	**Constructs**	**Age**	**Time to Administer**	**Format/Type of Administration**	**Format and Scores**
Children's Assessment of Participation and Enjoyment (CAPE)	Examines participation in everyday activities outside of school classes	Five dimensions of participation including diversity of activity, frequency, enjoyment, and context	Children with and without disabilities, 6–21 year	30–45 minutes	Questionnaire, self-report, or interview	Mean intensity and subjective enjoyment
Child Occupational Self-Assessment (COSA)	Captures children and youths' perception regarding sense of occupational competence and importance of everyday activities	How competent does a child feel engaging in and completing activities?	8–13 years (must have self-reflection and planning skills	25 minutes	Self-report, structured interview	Importance rating scale, priorities for change
Goal-Oriented Assessment of Lifeskills (GOAL)	Assesses functional motor skills required for daily living skills	Measures 7 tasks requiring fine or gross motor skills: utensils, locks, paper box, note- book, carry tray, ball play, manage clothing	7–17 years, with or without disabilities	45–60 minutes	Series of seven occupation-based activities	Standard scores, with option to document progress over time
Participation and Environment Measure—Children and Youth (PEM-CY)	Assess participation in the home, at school, and in the community as well as environmental factors of participation	Home, school, and community	5–17 years, with or without disabilities.	25–40 minutes	Parent report questionnaire	Rating scale of participation frequency, involvement and desire for change, and environmental support
Preferences for Activities of Children (PAC)	Recreational, active physical, social, skill based, and self-improvement	Measures activity preference	6–21 years, with or without disabilities	15–20 minutes	Self-report or interview	Preferences for involvement in meaningful activities
School Function Assessment (SFA)	Assessment of functional capabilities and performance of functional activities that support participation in academic and related social aspects of an education program	Participation, task supports, activity performance	5–12 years	60–90 minutes.	Judgment based questionnaire, inter-view, or observation	Raw scores, criterion scores 0–100 for full grade functioning

Assessing Client Factors: Measures That Assess Body Function, Structure, and Personal Factors						
Measure	**Purpose**	**Constructs Evaluated**	**Age**	**Time to Administer**	**Format/ Administrations**	**Scores**
Bruininks-Oseretsky Test of Motor Proficiency (BOT-2)	Comprehensive assessment of gross and fine motor skills	Fine motor precision, fine motor integration, manual dexterity, bilateral coordination, balance, running speed and agility, up- per limb coordination, and strength	4–21.11 years	Complete form, 45–60 minutes *short form is avail- able, 15–20 minutes	Series of motor tasks that require a skilled professional to guide child through assessment and score during performance	Age-based standard scores, percentile ranks, age equivalents, and descriptive categories
Beery-Buktenica Developmental Test of Visual-Motor Integration | Sixth Edition (VMI)	Identify difficulties in visual motor integration. Supplemental versions assess visual perception and motor coordination	Visual motor integration, visual perception, and motor coordination	2–99.11 years	10–15 minutes; supplemental Visual Perception and Motor Coordination tests: 5 minutes each	Child completes a series of tasks in a test booklet. Professional guides child with scripted instructions and manually scores results; Short and Full Format tests can be administered individually or to groups	Standard scores, percentiles, age equivalents
Developmental Test of Visual Perception (DTVP-3)	Identify the presence and degree of visual perception and visual-motor difficulties in children	Measures 7 tasks requiring fine or gross motor skills: utensils, locks, paper box, notebook, carry tray, ball play, manage clothing	4–12 years	30 minutes	Child completes a series of tasks in a test booklet. Skilled professional guides child with instructions and manually scores results	Composite scores for motor reduced visual perception, visual motor integration, and general visual perception
Motor-Free Visual Perception Test – 4th Edition (MVPT-4)	Allows you to assess visual–perceptual ability without requiring a motor response from the examinee	Visual perception	4-80+ years	20-25 minutes	The examinee matches line drawings using a multiple-choice response format; individually administered	Raw scores, standard scores, and percentile ranks; Perceptual Quotient and a Perceptual Age Score
Test of Visual Perceptual Skills (TVPS-4)	Assesses visual-perceptual strengths and weaknesses	Visual Perception	5-21 years	25 minutes	Administered individually; response format suitable for all children, including those with disabilities	Scaled scores, percentile ranks, and age equivalents for each subtest and for overall performance
Gross Motor Function Measure (GMFM)	Evaluates changes in gross motor function in children with cerebral palsy (GMFM-66). GMFM-88 evaluates gross motor function in children with Down syndrome	Examples of motor skills evaluated include rolling, walking, jumping	5 months–16 years	45–60 minutes	Observation plus score sheet	4-point scoring system

Manual Ability Classification System (MACS)	Classifies how children with cerebral palsy use their hands when handling objects in daily activities	Classifies what children do with both hands together	Children with cerebral palsy, 4–18 years	n/a, score made in accordance with observation and interviews	Observations of child and interview of parents, teachers, or child used to deter- mine a child's ability	Numerical classification based on a 5-item scale based on manual ability
Peabody Developmental Motor Scales, 2nd edition (PDMS-2)	Assesses motor skill development	Six domains: grasping, visual- motor integration, reflexes, stationary, locomotion, object manipulation	Birth–5 years	45–60 minutes	Child participates in series of tasks administered by evaluator	Standard scores, percentiles for total motor, fine motor, and gross motor quotients
Evaluation Tool of Children's Handwriting (ETCH)	The ETCH is a criterion-referenced tool designed to evaluate manuscript and cursive handwriting skills of children in Grades 1 through 6	Legibility and speed of handwriting tasks similar to those required of students in the classroom	Grades 1-6	15-20 minutes	Includes alphabet and numerical writing, near-point and far-point copying, dictation, and sentence generation	Scoring targets legibility of individual tasks and total tasks and speed. A scoring standard for legible letters and words has been established
Schoodles	Fine Motor assessment that uses school tasks and developmental age levels to determine educational need.	Task areas include classroom skills such as handwriting, coloring, cutting, and puzzle building, and supporting skills such as core strength, upper extremity strength, motor planning, eye-hand coordination, and coordination of fine and gross motor skills	3 years and older	30-45 minutes	Components of the assessment are chosen based on the student need identified by the student's teachers	A criterion-referenced tool for age level placement for each skill; Can be used as a stand-alone tool to determine the need for intervention or as a companion to standardized testing.
Handwriting Without Tears Print Tool	Non standardized assessment tool used to evaluate and remediate capital letters, lowercase letters, and numbers	Evaluates handwriting components: memory, orientation, placement, size, start, sequence, and word spacing	Grades K-5	15-30 min	The evaluation form shows which letters and numbers and components are causing difficulty. Based on this information, remediation is targeted	Provides simplified scoring process for spacing and printing; online scoring tool available
Test of Handwriting Skills-Revised (THS-R)	Assess neurosensory integration skills involved in print and cursive writing	Manuscript and cursive writing	6 through 18:11 years	25 minutes	Student performs 8 handwriting tasks; individual or group administration	Overall standard score, and scaled subtest scores and percentile scores
DeCOSTE Writing Protocol	An informal diagnostic tool that helps educators identify factors affecting an individual student's ability to write.	Often used for dysgraphia and other writing issues	Grades K-12	Less than 30 min	To gather data, students complete 4 similar tasks using handwriting and keyboarding	A formative assessment (Non standardized)
WOLD Sentence Copy Test	The WOLD is a timed test designed to evaluate speed and accuracy when copying a sentence.	Provides a sample of the child's handwriting	Grades K-3	5 minutes	1:1 administration; child asked to copy sentence provided; observations re: posture, grip, etc is also noted	Calculate the percentage complete in order to extrapolate their time to a grade/age score; norms for each age group are given in seconds

Sensory Profile 2	Identifies how sensory processing may affect a child's participation at home, school, and community	Caregiver and teacher reports on child's response to sensory events throughout the day using the appropriate form *Versions available depending on the child's age and setting (Infant/Toddler, Adolescent/Adult, School Companion)	Birth–14.11 years	5–20 minutes	Standardized questionnaire completed by caregiver or teacher	Each form produces a sensory system score, behavior score, and sensory pattern score. The school companion version produces a school factor score
Sensory Processing Measure (SPM)	Provides a complete picture of children's sensory processing difficulties at school and at home	Scores praxis and social participation as well as visual, auditory, tactile, proprioceptive, and vestibular functioning	2–5 years preschool version, 5–12 years standard version	15–20 minutes per form	Parent or teacher completes a rating scale	Norm-referenced standard scores with descriptions and clinical information provided
Developmental Assessment of Young Children | Second Edition (DAYC-2)	Test used to identify children with possible delays in five different domains	Each of the five domains (Cognition, Communication, Social-Emotional Development, Physical Development, and Adaptive Behavior) reflects an area mandated for assessment and intervention for young children in IDEA	0-5 years	10–20 minutes for each domain	Information obtained through interview, observation, or direct assessment. The domains can be assessed independently or for overall general development if all five domains are tested	Standard scores, percentile ranks, and age equivalents are provided for each domain, and for overall general development if all five domains are tested
Behavior Rating Inventory of Executive Function 2 (BRIEF-2)	Assesses executive function and self-regulation in children and teens	Measures executive function in home and school environments	5 to 18 years	10 minutes; 5 minutes for screening version	Individually administered rating scale completed by parent, teacher, or self-report	Behavioral Regulation Index, Emotional Regulation Index, and Cognitive Regulation Index combine to form a Global Executive Composite

Assessing Context and Environment: Measures That Assess the Influence of Environment

Measure	Purpose	Constructs Evaluated	Age	Time to Administer	Who	Scores
Pediatric Volitional Questionnaire	Play-based assessment of a child's motivational strengths	Motivational strengths, weakness es, environmental support, hindrances, and activities of interest	2–7 years, with or without disabilities	10–30 minutes	Observational assessment tool	Scored on a continuum of volitional development
School Setting Interview	Investigates student environment fit for students with physical disabilities	How do environmental factors influence student's activity and participation?	10 years and older, physical disabilities or motor dysfunction	40 minutes	Patient-reported outcome based on 16 interview questions	4-step rating scale indicting need for environmental adjustment

Green - Assessment can be completed virtually

Blue - Assessments in PTS' Lending Library

Orange - Assessments can be completed both virtually and in PTS' Lending Library

Occupational Therapy Evaluation

Student:	School/District:
DOB/Age:	Grade:
Parents/Guardian:	Teacher:
Home Phone:	Therapist:
Address:	Date of Evaluation:

I. Reason for Referral

Student was referred for an Occupational Therapy evaluation due to:

II. History

III. Evaluation Data Results

Motor Skills Related to Student's School Performance

Visual Skills Related to Student's School Performance

Hand Skills Related to Student's School Performance

Attention and Organizational Skills Related to Student's School Performance

IV. Summary of Findings

V. Educational Strengths and Learning Needs

Strengths:

Needs:

VI. Suggested Recommendations

VII. Suggested Annual Goals:

Annual Goal:

Short Term Objectives:

VIII. Suggested Specially Designed Instruction:

Occupational Therapy Evaluation Reference Guide

- Observational Data Tables are meant to help collect observational data and not to be placed into the Evaluation Report.
- Standardized Evaluations are listed as Resources and not intended to be used unless clinically necessary.

Student:	Grade:
Chronological Age:	Evaluation Date:
Date of Birth:	School:

Background/Medical/Social Information:

Review Student, Contextual, and Environmental Factors

1. Past and Current Medical Information (Including Allergies)

Seizures	Shortness of Breath	Heart Problems	Vision Problems	Hearing Problems	Allergies
Digestive Problems	Dizziness	Muscle Weakness	Neurological Problems	Skeletal Abnormality	Surgery

2. Early Intervention
3. Social History
4. Communication Needs
5. Mobility Needs
6. Current Outside Services
7. Special Precautions

Parent Interview

1. What are the functional difficulties the child is having?
2. Potential factors contributing to these difficulties
3. Student's Strengths and Interests

Reason for Referral/Educational Diagnosis/Functional Concerns of Teacher/Therapists

1. What are the functional difficulties child is having?
2. Potential factors contributing to these difficulties

Accommodations

1. Any accommodations currently being used?
2. What has been attempted so far?
3. Have these been successful?

MOTOR SKILLS Related to Student's School Performance

Postural Stability/ Muscle Tone: The ability of the body to use core body muscles to assume and maintain postures during the completion of classroom activities, such as sitting on the floor during circle time or sitting upright in a chair to complete seatwork. It provides the foundation for controlled movements needed for writing, fine, and gross motor skills.

Gross Motor/Coordination/Balance/Strength and Endurance: The ability to safely maneuver throughout the school environment.

Clinclial Observation

Positioning and Work Space Observations	Skills Observed	Comments
Child's placement in classroom	• Near the source of instruction • Front and center • Front of classroom • Middle of classroom • Back of classroom • Near the door • Near the window	
Desk Height	• Appropriate • Too High • Too Low	
Chair Height	• Appropriate • Too big • Too small	
Seated posture (Upper Body)	• Upright • Slumped with rounded back • Bottom sliding forward on chair • Propped head on hands • Head lying on arm • Leaned chest against desk	
Seated Posture (Lower Body)	• Feet planted firmly on floor • Legs wrapped around chair legs • Dangled Legs • Swinging or kicking legs • Right leg underneath bottom • Left leg underneath bottom	
Alternate seating	• Posture at circle time/ Pretzel sit • Lay prone propped on elbows	
Accommodations/ Support	• Has personal schedule • Has cues on desk for looking & listening • Uses a "buddy" for task completion • Alternate seating adaptations • Not Applicable	

Gross Motor	Skills Observed	Comments
Gross Motor/ -Balance	• sit, stand, run, and tiptoe. • ambulated throughout the testing environment. • walked backwards and ran forward for at least ten feet without falling. • safely negotiated stairs, alternating feet. • walked forward in a heel to toe manner on a line • hopped forward on one foot for at least four hops. • jumped over objects up to six inches in height, landing with both feet together. • smoothly galloped. • climbs and slides on playground equipment while keeping up with peers. • holds onto a swing to be pushed. • threw a ball overhand with relative accuracy and trapped a ball against his chest to catch it. • imitated seven out of seven bilateral arm postures upon visual demonstration.	
Coordination	• Coordinating both sides of the body • Sequencing motor tasks • Crossing Midline of body • Left/Right Discrimination • Reciprocal stair climbing • Maneuver environment/classroom (busy or quiet) • Imitate Motions for Music and motion • Carry lunch tray to table and sit down	
Strength& Endurance	• Fatigue during movement • Maintain pace with peers • Access and use appropriate playground equipment • Get on and off bus without assistance • Carry belongings such as books,/binders/backpack • Open/close chair • Open/close door	
Safety	• Necessary adaptations needed:	

STANDARDIZED ASSESSMENTS

Developmental Assessment of Young Children (DAYC) – (0-5.11Y):
The Developmental Assessment of Young Children-Second Edition (DAYC-2) Physical Development Domain Gross Motor and Adaptive Development Domain subtests were utilized to assess a student's development via direct assessment as well as structured interview with his parents reporting skill set. DAYC-2 Purpose- Norm-based assessment used to identify possible developmental delays in children from birth through 5 years, 11 months old.

Physical Development Domain Gross Motor: Standard Score _____ - and % percentile
Adaptive Development Domain: Standard Score- _____ and % percentile
Summary of MOTOR SKILLS related to student's school performance:

HAND SKILLS Related to Student's School Performance

Fine Motor: The ability to use small movements of the fingers to complete manipulative tasks with the hands. This includes the ability to complete routine classroom tasks, including the use of writing tools for coloring and drawing, using classroom materials and manipulatives, and using the small muscles of the hand to assist with daily needs.

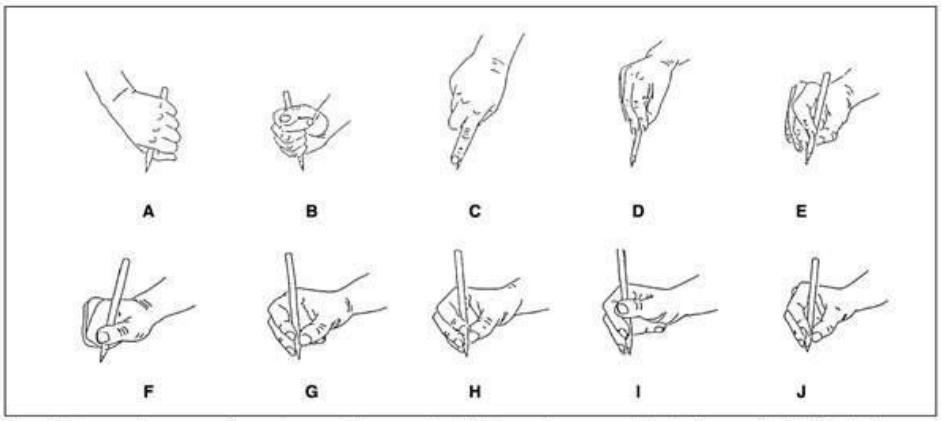
Clinclial Observation

Fine Motor/Self Care Skills Observations	Skills Observed	Comments
Dominant Hand	• Right • Left	
Scissors Grasp	• Right • Left	
Scissors Grasp	• Neutral Wrist Position - Thumb Up • Pronated Wrist - Thumb Down	
Cutting Skills	• Able to cut a straight line • Able to cut a curved line • Able to cut angular shapes • Able to cut curved shapes • Stabilizes paper with non dominant hand • Able to turn paper while cutting • Needs assistance (explain in • comments section) • Not observed at this time	
Self Care Skills	**Clothing management:** • Able to button/unbutton • Able to zip coat independently • Able to Don/Doff Jacket • Needs assistance with engaging zipper • Able to tie shoes **Feeding Management** • Able open drink/snack/lunch containers • Able to drink from a cup • Able to use utensils • Spillage **Hygiene** • Hand washing • Toileting • Tooth brushing **School Materials** • Back Pack Management • Opening packages • Morning routine (use of cubbie/coat closet) • Departure Routine • Not observed at this time	

Fine Motor/Self Care Skills Observations	Skills Observed	Comments
Fine Motor Manipulation/Dexterity Functional Tasks	• Handedness • In-hand manipulation • Turn pages of a book • Glue • Fold paper • Difficulty with small manipulatives • Ability to access assistive devices for communication (switch access, finger isolation for choice selection on key boards and touch screens) • IPAD or CHROME BOOK	
Hand use for Pencil Grasp	• Right • Left	
Grasp Pattern	• Dynamic Tripod: open web space with thumb stable, fingers move during tool use, wrist extended up, grasp distal with opposition of thumb, index and middle finger • Dynamic Quadripod: common alternate grasp using four fingers around the tool shaft, provides much more stability, grasp is distal with opposition of thumb, index, middle and ring fingers, open web space • Static tripod: May have less open web space and reduced finger opposition, hand moves instead of fingers during writing • Static Quadripod: closed web space, uses 4 fingers on tool, hand moves instead of fingers • Immature pronated grasp: wrist pronated, thumb down, tool held with fingers, no web space, arm moves as a unit • Power grasp: fisted neutral hand, wrist flexed, arm moves as a unit • Poor grasp due to low muscle tone: Web space collapse, thumb appears unstable, joints in hand may be hyperextended, hand may appear still to help hold the position • Lateral pinch grasp: no web space, no thumb opposition • Fisted Hand Grasp:	
Open web space	• Yes • No	
Pencil Grip Used	• None • Claw • Pencil grip • Crossover grip • Grotto Grip • Triangular	
Slant board Used	• Yes • No	

Fine Motor/Self Care Skills Observations	Skills Observed	Comments
Stabilizes Paper with Non Dominant Hand	• Yes • No	
Coloring	• Scribbled • Minimal regard to lined boundaries • Attempted to remain within lined boundaries <5 deviations • Able to remain in lines given bolded boundaries • Not Applicable • Teacher reports concern (explain)	
Drawing	4 Stage Process: • Scribbling stage • Combine stage (Construction of basic diagrams and geometric figures/Gains understanding of how to create figures (stick figures) • Aggregate stage (combine 3 or more figures) • Pictorial stage (more refined and complex drawings include depth) Drawing development • Sequential coloring • Channeling activities • Tracing activities • Copying activities	
Copy	• With Model • Without model	
Letter Start Point	• Top • Bottom	
Letter Formation	• Counterclockwise - optimal • Clockwise • Left to Right - optimal • Right to Left • Letter Reversals noted: b, d, p, q, z • Other:	
Pencil Pressure	• Hard • Soft • Appropriate	
Letter Size	• Large • Appropriate • Small	
Spacing	• Tight between letters • Tight between words • Excessive between letters • Excessive between words	

Fine Motor/Self Care Skills Observations	Skills Observed	Comments
Letter Alignment	• Letters and words anchored on the line • Letters and/or words "float" above the line • Letters and/or words placed on top of or below the lines • Letters or words gradually float up or down as student works across the page	
Transition to Left Side of the Page	• Appropriately transitions to next line and returns to the left margin • Student inconsistently returns all the way to left margin • Student drifts toward the middle of the page when transitioning lines	
Copying Near Point	• Independent • Needs cueing and/or assistance • Not observed	
Copying Far Point	• Independent • Needs cueing and/or assistance • Not observed	
Cursive Handwriting	• Student currently receives cursive instruction in the classroom • Student does not receive cursive instruction in the classroom • Not Applicable	
Cursive Handwriting	• Student able to form lower case letters from memory • Student able to copy cursive letters from a near point/far point model • Student is able to connect letters without difficulty • Not Applicable	
Quality of Handwriting	• Beginner • Developing • Very good • Excellent • Handwriting Samples Observed	



A = radial cross palmar grasp; B = palmar supinate grasp; C = digital pronate grasp, only index finger extended; D = brush grasp, E = grasp with extended fingers; F = cross thumb grasp; G = static tripod grasp; H = four fingers grasp; I = lateral tripod grasp; J = dynamic tripod grasp.

STANDARDIZED ASSESSMENTS:
School Functional Assessment (K-6 grade): A criterion Referenced evaluation of a student's performance of functional tasks and activities

Assessment Results:

Developmental Assessment for Individuals with Severe Disabilities (DASH-3) (6 months-adulthood): A criterion Referenced measure of specific skills in individuals with severe/multiple disabilities

Assessment Results:

The Roll Evaluation of Activities of Life (REAL) (2-18.11 years): A standardized screening instrument used to help assess independence in ADL's and IADL's

Assessment Results:

Bruininks-Oseretsky Test of Motor Proficiency 2nd Edition (BOT-2) (4-21 years): The purpose of this test is to assess gross and fine motor skills. Tasks administered look at fine manual control, or activities that require precise control of finger and hand movements such as drawing, cutting and folding of paper.

The Manual Coordination composite section uses goal directed activities that involve reaching, grasping, and two handed coordination with small objects within a given time limit as well as activities designed to measure visual tracking with coordinated arm and hand movements, such as catching and dribbling and throwing.

Subtest 1-Fine Motor Precision: This untimed subtest assesses the ability to complete tasks that require precise control of finger and hand movements, such as coloring in a small area, controlling a pencil, folding paper on a line, and cutting on a line.
Subtest 2-Fine Motor Integration: This subtest requires the student to copy drawings of various geometric shapes that increase in complexity.
Subtest 3-Manual Dexterity: This timed subtest requires hand speed and dexterity to manipulate small objects with one hand and both hands.

	Raw Score	**Age Equivalence**	**Percentile**	**Standard/Scale Score (11-14 is Average)**	**Description**
Fine Motor Precision					
Fine/Visual Motor Integration					
Fine Manual Control					
Manual Dexterity					

The Peabody Developmental Motor Scale-2 (PDMS-2) (0-5 years):
Administered to assess a student's fine motor development. This test includes subtests that assess the ability to grasp and manipulate items, reproduce block designs, complete simple puzzles, cut, color, and copy designs. PDMS-2 Purpose: Norm and criterion referenced assessment used to measure the fine motor age levels of children between 0 and 6 years of age. There are two subtests in the PDMS-2 that compose the fine motor part of this assessment. GRASPING and VISUAL-MOTOR INTEGRATION. The GRASPING subtest measures a child's ability to utilize his hands for activities. The VISUALMOTOR INTEGRATION subtest measures a child's ability to use his visual perceptual skills in order to complete activities requiring hand-eye coordination such as block building and form copying.

	Raw Score	**Age Equivalence**	**Percentile**	**Standard/Scale Score (11-14 is Average)**	**Description**
Grasping Subtest				(Avg: 8-12)	
Visual Motor Subtest				(Avg: 8-12)	
Fine Motor Quotient				(Avg: 90-110)	

Assessment Results:

Schoodles (3-8 years): A qualitative assessment of skills that contribute to fine motor work. Skills are assessed according to age levels of attainment and quality of performance, and it can be individualized for each student's identified challenges. Skills are broken down into Classroom Skills and Supporting Skills, those skills needed to support fine motor outcomes. Classroom skills included are design copy, handwriting, coloring, cutting, and puzzle construction. Supporting skills included are manual muscle testing, proprioception, gross motor coordination, eye-hand coordination, finger coordination, crossing midline, motor planning, bilateral coordination, trunk strength, and vision skills.

Assessment Results:

Evaluation Tool of Children's Handwriting (ETCH) (Grade 1-6): To evaluate a child's handwriting skills; mainly assessing legibility and speed on tasks similar to those required within the classroom. This assessment examines both whole word legibility and individual letter legibility, as well as numbers. Components of writing process contributing to illegibility are identified.

Subtests	Word Legibility %	Letter Legibility %
Upper Case		
Lower-Case Letters		
Upper case		
Numeral Writing		
Near Point Copy		
Far Point Copy		
Letter Dictation		
Sentence Composition		
Total ETCH Legibility	Letter %:	Numeral %:

The Print Tool (Grade K-5): Includes student and school information, a review of school papers, and careful observation of the child's physical approach and fine motor skills. It evaluates capitals, numbers, lowercase letters, and seven specific handwriting components: memory, orientation, placement, size, start, sequence, and word spacing.

Assessment Results:

Wold Sentence Copy Test (Grade K-3): The Wold Sentence Copy Test is a timed test designed to evaluate the child's speed and accuracy when copying a sentence from the top of a page to the lines on the rest of the page. Observations made during the test include writing speed, copying accuracy, posture, number of fixations, letter and word spacing, letter formation, frustration level, attention and fine motor fatigue. This is comparable to the child copying from a blackboard to a book; a task required every day in the classroom but without the extremes of eye movements. The test also provides a sample of the child's handwriting.

Writing Speed

GRADE	Mean Copy Rate	Child's Copy Rate

DeCoste: Written Handwriting Productivity Profile: Comparing handwriting to keyboarding (K-12 grade): This profile gathers data on handwriting and keyboarding in 4 similar tasks and makes it useful when making decisions about a student's written productivity.

1. Handwriting Assessment

	LPM	**WPM**
Alphabet:		
Sentence copying:		
Dictated sentence:		
Independently composed sentence:		
Handwriting observations:		

2. Keyboarding Assessment

	LPM	**WPM**
Alphabet:		
Sentence copying:		
Dictated sentence:		
Independently composed sentence:		
Handwriting observations:		

Assessment Results:
Summary of HAND SKILLS related to student's school performance:

Visual Skills Related to Student's School Performance

Visual Skills- The ability to coordinate eye movements to follow a ball, watch the teacher in circle time, keep eyes on tasks, maintain eye contact with peers and staff, and looking where someone else is pointing.
Visual Motor/Eye –Hand Coordination- The ability to combine movements of the hands with guidance from the eyes for coloring, cutting, letter/number formation, ball catching, and choice selection on touch screen devices.
Visual Perception- The ability to understand spaces and shapes such as puzzles, nesting cups, letter formation, and matching.

Clinclial Observation

Functional Vision Assessment	Skills Observed	Comments
General Observation Control and coordination or a "teaming" of eye movements. The tests performed should be for the use of both eyes and with separation of eye and head movement	• Note Head and Body position • Visual Behaviors (eye poking, finger flicking, staring) • Gaze • Groping for objects held in relation to face when patient looking at object • Eye Preference/ Field Preference • Color Perception • Complaints/ Tolerance • Visual Attention	
External Appearance of Eyes	• Red, swelling, tearing • Ptosis, eyelid/eye opening • Blinking • Nystagmus at rest • Pupil size • Any asymmetries	
Pupil Response	• Dilate /Constrict • No change	
Visual Pursuits: Range of Motion	• Horizontal R L B • Vertical R L B • Diagonal R L B • Circular R L B	
Saccades	• Smoothly movement of their eyes from one object to another 16" in front of the face and 6" apart	
Convergence Divergence	16-18' from eyes • Eyes converge/diverge smoothly • Difficulties with Converge R L • Difficulties Divergence R L	
Peripheral Fields	• Right: Top Bottom Lateral • Left: Top Bottom Lateral • Norms: • Top 65* Bottom 95* Lateral 95*	

Functional Vision Assessment	Skills Observed	Comments
Acuity	• Near: L: R: Both eyes: • Far: L: R: Both eyes:	
Depth Perception	• Difficulties at certain distance • Difficulties at certain quadrants	

Visual Perception Area	Task Observed Definition	Areas within Academic Setting	Comments
Visual Discrimination	• The ability to find similarities or differences between items.	Spelling, reading, comprehension, writing, compare or contrast activities	
Visual Memory	• The ability to recall a visual image.	Organization, critical thinking, comprehension, long term memory	
Visual Sequential Memory	• The ability to observe, recognize, remember, and reproduce a sequence of symbols.	Spelling, following directions, writing, attention span, sight words, remembering steps of a demonstrated task, copying accurately	
Visual Figure Ground	• The ability to perceive a form visually, and then find this form hidden in a conglomerated background.	Attention, organization, reading, locating necessary information in a visually stimulating environment	
Visual Form Constancy	• The ability to see a form and being able to find that form, even though it may be a different size, reversed, rotated or hidden.	Letter recognition, sight words, reading, writing, orientation of letters	
Visual Spatial Relationships	• The ability to perceive the position of two or more objects in relation to themselves or each other.	Reading, writing, letter recognition, problem solving in conceptual skills required for a higher level of math and science	
Visual Closure	• The ability to visually “close” and perceive a figure in the absence of part of the form.	Drawing, reading, comprehension, conceptual thinking, planning	

STANDARDIZED ASSESSMENTS:

Test of Visual Perceptual Skills- 4 (TVPM-4) (5-21yrs): Overview- standardized tool used to determine visual perceptual strengths and weakness in the following seven areas: Visual discrimination, Visual Memory, Spatial Relationship, Form Constancy, Sequential Memory, Visual-Figure Ground, Visual Closure It has additional lower- level items to address needs of younger or more impaired students.

Miller Function and Participation Scales (M-FUN) (2-7:11 years): The Miller's Function and Participation Scales is a standardized tool designed to assess young children's performance abilities as well as participation in their daily life within their school and home environment. It consists of a Home Observations Checklist completed by the primary caregiver, a School Observations Checklist completed by the Classroom Teacher, a Test Observations Checklist completed by the test administrator and a motor assessment. The motor assessment looks at Fine Motor, Visual Motor, and/or Gross Motor skills.

Performance	Raw Score	Description
Fine Motor		
Visual Motor		
Participation Scores		
Home Observations		
Classroom Observations		
Test Observations		

Motor Free Test of Vision Perception (MVPT)-4 (4-80 years): This test assesses different areas of visual perception including visual memory, the ability to distinguish same/different, directionality, locating hidden designs, and visually perceiving a complete picture when only fragments are presented.

	Raw Score	Percentile	Standard Score	Description
MVPT				

Assessment Results:

Developmental Test of Vision Perception (DTVP-3) (4-12.11 years): The DTVP-3 includes 8 subtests that measure different components of visual perceptual and visual-motor abilities

	Raw Score	Percentile	Quotient Index	Description
General Visual Perception				
Motor-Reduced Visual Perception				
Visual Motor Integration				

Assessment Results:

Beery-Buktenica Developmental Test of Visual Motor Integration (VMI)-6 (0-100 years): The primary purpose of the VMI is to help identify significant difficulties that some children have in integrating, or coordinating, their visual perceptual and motor abilities. It includes two supplemental tests: motor coordination and visual perception.

The VMI involves accurately copying geometric designs which increase in complexity.

	Raw Score	Percentile	Standard Score	Description
Beery VMI				

Test of Visual Motor Coordination : This battery helps to assess a child's motor coordination as it assesses the student's ability to control finger and hand movements to see if a student can draw within a targeted area.

	Raw Score	Percentile	Standard Score	Description
Beery VMI				

Test of Visual Perception: This battery helps to assess a student's visual perception, or how he/she makes sense of what he/she sees.

	Raw Score	Percentile	Standard Score	Description
Beery VMI				

Assessment Results:
Summary of VISUAL SKILLS related to student's school performance:

Sensory Skills Related to Student's School Performance

Sensory assessments: help to gather information on a child's sensory processing patterns and their possible impact on classroom performance. Targeted sensory interventions may then be recommended to help promote improved participation within the classroom and school environment.

Motor Planning: The ability to figure out new or unpracticed movements fairly easily, such as playing on playground equipment or participating in motor activities, as well as the ability to play with an object in multiple ways.

Clinclial Observation

Sensory Processing Observations	Skills Observed	Comments
Sensory Processing Identifies, Responds, Selects, Associates, Organizes, and Remembers Sensory events	Tactile: Over-Responsive • Difficulty standing in line or sitting beside other students • Dislikes games in playground or gym • Avoids 'messy' play activities • May react aggressively to unexpected touch, especially light touch • Dislikes certain clothing, fabrics	Tactile: Under-Responsive • Doesn't seem to notice when someone touches him or her • Leaves clothes twisted on body • Touches other students or objects frequently • Uses too much pressure when writing
	Visual: Over Responsive • Discomfort with bright light/ fluorescent lighting Prefers dark environments, or prefers the lights turned off in the classroom • Difficulty making eye contact • Easily distracted by visual stimuli in the room; i.e., movement, decorations, toys, windows, doorways etc. • Loses place when copying from a book or the board, or when reading	Visual: Under Responsive • Misses objects in competing backgrounds • Finds it difficult to name or match colors, shapes and sizes Likes bright, reflective or spinning objects or lights • Difficulty writing e.g. spaces between words, letter formation, letter size etc. • Poor ball skills - catching or throwing
	Auditory Over Responsive • Easily distracted by background noise • Seems to ignore instructions or is slow to follow instructions • Difficulty participating in group work • Dislikes noisy settings Responds negatively to unexpected noise • Distracted by noises others do not notice	Auditory Under-Responsive • Appears to not hear what you say (e.g. when you call students name) • Makes noises (e.g. humming) to keep focused on task • Difficulty remembering or understanding what has been said (e.g. when given instructions for a task) • Speaking loud or having outburst
	Olfactory- Over- responsive • Complains of smells which others do not find unpleasant • Refuses to eat lunch in the cafeteria	• Olfactory- Under Responsive • A strong preference for certain smells • Doesn't seem to notice orders • Smells objects or people

	Skills Observed	Comments
Behavioral/ Learning/ Social	Vestibular Over Responsive • Refuses to participate in gym and playground games • Only engages in sedentary activities • Distracted and/or fearful when feet are off the ground	Vestibular- Under Responsive • Fidgets, rocks or swings in chair • Frequently leaves chair to walk/run around in classroom • Engages in fast and impulsive movements • Loses attention when seated for prolonged periods
	Proprioceptive • Bites/chews on objects • Hyper-extends joints e.g. bending back fingers, locking knee joints • Holds objects with excessive pressure e.g. writes heavily on page • Enjoys rough and tumble play but can be excessively rough with others • Prefers to run, jump or stamp heavily when he/she should be walking • Likes to sit with knees tucked under himself/herself • Walks on tiptoes • Crashes and falls on purpose • Bumps into classmates, furniture or walls	
	• Craves predictability • Engages in repetitive play • Doesn't understand concept of personal space • Has difficulty joining group activities • Has difficulty with transitions between activities • Difficulty initiating and completing tasks • Struggles with sequencing activities • Poor organization, loses things frequently • Easily overwhelmed or frustrated • Frequently tunes out or withdraws • Frequently acts out or tantrums	

STANDARDIZED ASSESSMENTS:

Sensory Profile 2 (0-14.11 years): This test provides information about sensory processing including auditory, visual, movement, oral, and touch processing.

Quadrant	**Raw Score**	**Percentile**	**Classification**
Seeking/Seeker			
Avoiding/Avoider			
Sensitivity/Sensor			
Registration/Bystander			
Sensory Section	**Raw Score**	**Percentile**	**Classification**
Auditory Processing			
Visual Processing			
Touch Processing			
Movement Processing			
Body Position Processing			
Oral Sensory Processing			
Behavioral Section	**Raw Score**	**Percentile**	**Classification**
Conduct Associated with Sensory Processing			
Social Emotional Processing associated with Sensory Processing			
Attention responses associated with Sensory Processing			

Sensory Processing Measure (SPM) (5-12 years): This test provides information about sensory processing in the following areas: social participation, vision, hearing, touch, taste and smell, body awareness, balance and motion, planning and ideas, and school environments.

	HOME	**SCHOOL**	**Description Summary**
Social Participation	T-	T-	
Visual	T-	T-	
Hearing	T-	T-	
Touch	T-	T-	
Taste and Smell			
Body Awareness	T-	T-	
Balance and Motion	T-	T-	
Planning and Ideas	T-	T-	
TOTAL	T-	T-	

Assessment Results:

Sensory Profile School Companion: Provides school-based clinicians the ability to evaluate a child's sensory processing skills and how these skills affect the child's classroom behavior and performance.

Section Summary		Raw Score Totals	Range
A	Auditory	/ 50	
B	Visual	/ 55	
C	Movement	/ 70	
D	Touch	/ 60	
E	Behavior	/ 75	

Quadrant Summary		Raw Score Totals	Range
1	Registration	/ 85	
2	Seeking	/ 60	
3	Sensitivity	/ 80	
4	Avoiding	/ 85	

School Factor Summary		Raw Score Totals	Range
1	School Factor 1	/ 105	
2	School Factor 2	/ 65	
3	School Factor 3	/ 85	
4	School Factor 4	/ 55	

Assessment Results:

Summary of Sensory Skills related to student's school performance:

Executive Function Skills Related to Student's School Performance

Executive Function Skills:	Skills Observed	Comments
Task Initiation Planning Time Management	Task Initiation • Able to initiate following directions • Slow to start Planning • Knows where to start • Needs repeated instructions to get started • Needs prompting for sequencing multiple steps • Able to follow steps • Needs verbal prompting • Needs visual prompting • Needs physical prompting Time Management • Demonstrates awareness of time • Completes in allotted time	
Organizing	• No needs • Difficulty completing morning routine • Difficulty managing papers • Difficulty managing assignments • Difficulty finding items in desk • Difficulty packing up backpack • Difficulty completing afternoon routine • Track and organize materials	
Working Memory Metacognitive	Working Memory • Remembers past experience, draws on and applies to problem solve • Remembers instruction for classroom tasks Metacognitive • Student can report how they are doing	
Goal Directed Flexibility Attention	Goal Directed • Able to focus and complete tasks Flexibility • Difficulty with Transition • Can revise plan with obstacles Sustained Attention • Can complete a task without direction	

Executive Function Skills:	Skills Observed	Comments
Self Regulation Response Inhibition	• Thinks of consequences before acting first/think later • Fidgety and restless • Frequently gets out of chair • Appears to be “driven by a motor” • Appears to daydream; internally distracted • Chews on clothing, pencils, items • Self-Stimulation Behaviors • Bumping into other children or into objects in environment • Identify body parts • Can they walk in line • Do they have to lean on wall or touch objects when walking down hall • Do they maintain age-appropriate space when requested from peers and staff	
Motor Planning	What stage of Motor Planning is the child having difficulty with? • Ideation: ability to be creative , coming up with an idea or play scheme • Initiation: setting up the play scheme (helping to set up an obstacle course, or sequencing pictures on picture schedule) • Execution: the actual motor component	
Accommodations/ Support	Currently has: • None • Move ‘n Sit cushion • Thera-band wrapped around desk/chair legs • Hand/finger fidgets • Gum/oral motor fidgets • Schedule • Warnings for transition • Visual timer	

Summary of Executive Function Skills related to student's school performance:

Summary of Findings

What was found to be significant? What does the testing represent?

Relate standard scores to function in the school setting.

RECOMMENDATIONS: A review of this evaluation report will be discussed with the IEP team in conjunction with other assessments/evaluations, data, and team observations to determine eligibility of services.

Suggested recommendations for service may include RELATED SERVICES FREQUENCY, whether it's individual, group or consult for this type of service delivery.

If the student does not need continued therapy services, please mention that no school-based occupational therapy needs have been identified at this time.

Per the direction of the district, you may be asked to provide suggestions in the following areas on the evaluation report:

Suggested Educational Strengths and Learning Needs
Strengths: List OT specific strengths
Needs: List OT specific needs as they pertain to student's ability to access their educational environment for every need, there must be an SDI or Goal

Suggested Goals:

- Measurable Annual Goal: Student's name, a behavior that the child is to exhibit, a description of the condition under which the child it to perform that behavior (situation, setting or type of material used) and the criteria by which mastery of that behavior will be measured and determined to measure the goal.
- Baseline performance: enter student's current level of function from present levels, for this goal
- Describe HOW the student's progress toward meeting this goal will be measured: Functional skill probes, rubric, checklist, writing samples, etc.
- Describe WHEN periodic reports on progress will be provided to parents: report card

Suggested Specially Designed Instruction (SDI):
Describe the type pf replacement instruction, adaptation and modifications the child needs and will receive. Each item of specifically designed instruction must be:

- Based on individual needs of the student.
- Be specific as to strategy
- Be generic regarding brand manes of programs
- And identify either a specific time and duration of each item, a specific condition to each item or a specific purpose for the item.
- Be reasonable, clear and practical suggested strategies.

Therapist Name, Title DATE

Sample Occupational Therapy IEP Input

Patrick has been receiving OT services for 60 sessions per IEP year to address fine motor, gross motor, and visual motor skills for building the skills and strengths needed for his success in the classroom. At the beginning of the school year, Patrick was independently writing “Pat” in all upper case letters. OT then introduced Patrick to writing his full name with an upper case ‘P’ and the rest of the letters in lower case (“Patrick”). After the winter break, Patrick was scoring 9/12 on the rubrics scale for copying his full first name from a visual sample. For a period of time from mid-January through February Patrick was not consistently copying his full first name, even with direct visual cues from written sample and verbal cues. OT has consulted with Patrick’s teacher regarding this inconsistency. It’s been determined that Patrick’s inconsistent performance in copying his name can be due to any of the following (or a combination at any given time period): attention and focus or his level of distractibility, how many classroom demands he is processing at the moment, and fatigue. As of 3/13/15, Patrick has demonstrated more accuracy and carry-over for copying his name from a written sample then in the previous weeks, yet it is inconsistent. Why do you think he demonstrated greater accuracy? Did you change the room, change the paper, does he appear more focused? Identify the reason why you think he improved for a few times. The lower case ‘a’ is written reversed, and the ‘r’ looks like a ‘v’, and the other letters are not fully connected. Patrick is continuing to learn how to correctly form all the letters, and as that improves, he will become proficient at copying and writing his name. Multi-sensory and multi-media approaches identify these approaches here – wet, dry, try for HWT or the wooden sticks, or shaving cream? have been used for teaching Patrick the correct letter formation. These techniques will continue to be used for teaching Patrick letter formation.

In the area of scissor skills, Patrick independently holds the scissors his left hand in the correct thumb up, neutral wrist position. He can independently turn the paper with his opposite hand (right) while cutting. Is it fluent movement or does he need to improve bilateral coordination to have his two hands work together for cutting curved lines and shapes? Patrick demonstrates improved performance when cutting on a bold or highlighted line. During the 1:1 OT setting Patrick remains focused while cutting, with 3 or less deviation. However, in the classroom setting Patrick is distracted by his surroundings and demonstrates higher level of distractibility as well during cutting activities and therefore has more deviations from the lines. The cutting goal changed from cutting geometric shapes in OT and the classroom, to cutting shapes and curves in the classroom with 3 or less deviations.

OT continues to work with Patrick on zippering skills. Patrick demonstrates good bimanual hand skills to line up the zipper, but needs assistance to fully engage the pin into the box. Once the zipper is fully engaged, Patrick can independently manipulate the zipper. Patrick’s goal was to achieve a 20 on the rubrics scale. At end of marking period 2 Patrick achieved a 10/20 on the rubrics scale for zippering. Currently Patrick is scoring a 13/20 on the rubrics. For improving independence and bimanual hand coordination, the goal for zippering is to achieve a 22 on the rubric. At this time Patrick needs continued weekly OT services. Services will address the fine motor, and visual motor skills needed for his success in the classroom. OT will consult with the teacher and team members, 10 times per IEP year.

Therapist, COTA

PTS Occupational Therapy Goal Bank

BASIC GOAL TEMPLATE:

Condition*****Student Name-*****Clearly defined behavior*****Performance Criteria

Given	Given a grade appropriate picture
At or how well (% accuracy, independently, w/support staff etc.)	John will cut a picture
At or how well (% accuracy, independently, w/support staff etc.)	With correct placement of his paper and smooth edges within 1/8-inch of line
On. (how many times to mastery)...	On first trial
Probed..(frequency of progress monitoring schedule)	As monitored monthly for 3 consecutive probes

FINE MOTOR/VISUAL MOTOR/PERCEPTUAL SKILLS:

Cutting:

1. _____ will snip with scissors in 4 out of 5 trials with _____ assist and _____% verbal cues to promote separation of sides of hands and hand eye coordination for optimal participation/ success in school setting.

2. _____ will cut across a piece of paper in 4 out of 5 trials with _____ assist and _____% verbal cues to promote separation of sides of hands and hand eye coordination for optimal participation/ success in school setting.

3. _____ will cut out a circle in 4 out of 5 trials with _____ assist and _____% verbal cues to promote separation of sides of hands and hand eye coordination for optimal participation/ success in school setting.

4. _____ will cut out simple shapes with smooth edges in 4 out of 5 trials with _____ assist and _____% verbal cues to promote separation of sides of hands and hand eye coordination for optimal participation/ success in school setting.

5. _____ will cut simple shapes within a ½" of the line in 4 out of 5 trials with _____ assist and _____% verbal cues to promote separation of sides of hands and hand eye coordination for optimal participation/ success in school setting.

6. In OT and the classroom, will improve visual motor skills by cutting a 6-inch line within 1/4- inch of the line on first trial as monitored monthly for 3 consecutive months. (Baseline: cuts curved lines within 1/3-inch of line with cues to cut carefully)

7. Given cutting task, will improve visual motor skills by cutting out a picture rotating the paper in a counterclockwise direction cutting within 1/4-inch of the line wit no jagged edges present on first trial as monitored monthly for 3 consecutive probes. (Baseline: cuts in a clockwise direction; jagged edges on end product.

8. In OT and classroom, will improve visual motor skills by cutting a grade appropriate picture with correct placement of his paper and smooth edges within 1/8-inch of line on first trial as monitored monthly for 3 consecutive probes. (Baseline: positions paper on left side of scissors, jagged edges on end product.

Blocks:

1. _____will stack _____ blocks in 4 out of 5 trials with _____ assist and ____% verbal cues for increased precision and accuracy of distal finger skills for optimal participation/ success in school setting.
2. _____will copy block designs with visual and verbal cues with _____ blocks in 4 out of 5 trials with _____ assist and ____% verbal cues for increased precision and accuracy of distal finger skills for optimal participation/ success in school setting.

Puzzles:

1. _____ will complete a variety of insert puzzles independently in 4 out of 5 trials with _____ assist and ____% verbal cues for increased visuomotor and spatial relationship skills.
2. _____ will complete simple puzzles independently in 4 out of 5 trials with _____ assist and ____% verbal cues for increased visuomotor and spatial relationship skills.
3. _____ will place shapes into form board in 4 out of 5 trials with _____ assist and ____% verbal cues for increased visuomotor and spatial relationship skills.
4. _____ will insert circular, square, and triangular shapes in 4 out of 5 trials with _____ assist and ____% verbal cues for increased visuomotor and spatial relationship skills.
5. _____ will complete interlocking puzzles in 4 out of 5 trials with _____ assist and ____% verbal cues for increased visuomotor and spatial relationship skills.

Drawing:

1. _____will imitate vertical and horizontal strokes in 4 out of 5 trials with _____ assist and ____% verbal cues for increased graphomotor skills while maintaining a tripod grasp without thumb wrap and with an open web space.
2. _____ will copy a _____(circle, triangle, square, cross) in 4 out of 5 trials with _____ assist and ____% verbal cues for increased graphomotor skills while maintaining an open web space.
3. _____ will copy closed circle _____ times with _____ assist and ____% verbal cues for increased graphomotor skills while maintaining a tripod grasp.
4. _____ will imitate vertical and horizontal strokes in 4 out of 5 trials with _____ assist and ____% verbal cues for increased graphomotor skills while maintaining a lack of thumb wrap.
5. _____will imitate vertical and horizontal strokes in 4 out of 5 trials with _____ assist and ____% verbal cues for increased graphomotor skills while maintaining a dominant writing hand.

Copy Design

1. In OT, ___ will improve visual perceptual skills by copying 6-10 cube designs from a model with 100% accuracy on first trial as monitored monthly for 3 consecutive probes. (Baseline: unable to accurately copy 6-cube pyramid and step design)
2. ___ will improve visual perceptual skills by completing an 8-piece puzzle independently on first trial as monitored monthly for 3 consecutive probes. (Baseline: moderate assistance to complete 8-piece puzzle, minimal assistance for 6-piece puzzle)

COLORING

1. Given coloring task, will improve fine motor and visual motor skills by coloring a 2-inch round space using finger movements and coloring within 1/4-inch of the boundary on first trial as monitored monthly for 3 consecutive months. (Baseline: uses wrist movements, vertical strokes and colors within 1/2-inch of the border.

TRACING

1. Given task in the classroom, will improve bilateral hand skills by tracing a grade appropriate stencil with less then 2 slips on first trail as monitored monthly for 3 consecutive probes. (Baseline: 2-4 slips on basic stencil)

HANDWRITING

Letters

1. During classroom and therapy handwriting activities, _____will improve visual motor skills by writing the lower case letters with a distinct height difference between short and tall letters, place the letters “g, j, p,q and y” below the writing line, place letters within one-sixteenth inch of the baseline and leave ade- quate space (1/2 inch) between words., with 80% accuracy over 3 consecutive data points.
2. In OT and classroom, will improve visual perceptual and visual motor skills by writing all upper and lower case letters from memory with correct formation of 26/26 letters within 1/8-inch of the line on first trial as monitored monthly for 3 consecutive probes. (Baseline: correct formation of 80%of upper and lower case letters, 50% of letter within 1/8-inch of line on classroom writing samples.

Sentences

3. Given writing task, will improve visual motor skills by writing a 3-sentence paragraph with 90% of letters on the line, 90% letter closures and an adequate space between words after one self- edit on first trial as monitored monthly for 3 consecutive probes. (Baseline: 50-75% letter to line placement, 75% space between words and 50% letters closures on random writing samples)
4. During classroom and therapy handwriting tasks, _____ will organize written work on paper without deviating from the vertical or the horizontal by more than one inch, attend to left and right margins to 1/2 inch and adjust handwriting to fit into designated spaces on worksheets 85% of the time, as measured once a month for 3 consecutive months.
5. Given writing task, will improve visual motor skills by copying a 4-sentence paragraph at 42 letters per minute with 4-5 letters per visual fixation on first trial as monitored monthly for 3 consecutive probes. (Baseline: 38 letters per minute, 2-3 letters per visual fixation)
6. During therapy sessions and in the classroom, _____ will improve visual motor skills to write three 5-7 word sentences writing within the designated boundaries (one-sixteenth inch of the baseline), making a distinct height difference in tall and short letter sizing, show improved attention to right margin and stop writing within 1/2 inch of margin and maintain horizontal handwriting to 1/2 inch on paper without lines 85% of the time when measured 2 times a month for 3 consecutive months.

Copy Near and Far

7. Given near and far point copying activities, _____ will complete the activity within the allotted time given by the teacher or therapist with two or fewer errors or omissions when copying 2-3 five word sentences 80% of the time when measured 2 times a month for 3 consecutive months.

Independent Writing

8. In OT and the classroom, ___ will improve visual motor skills by writing 2 creative writing sentences on dotted lined paper with letters on the line, space between words, sky letters to top of line and diving letters below the baseline on one random writing sample as monitored monthly for 3 consecutive months. (Baseline: Inconsistent legibility in the classroom)

Cursive

9. Given written task, will improve visual motor skills by writing his full name in cursive without a model on first trial as monitored monthly for 3 consecutive probes. (Baseline: needs model and demon- stration to write his first name in cursive)

TYPING

1. In OT and the classroom, will improve visual motor skills by typing a rate of 20 letters/ minute and independently accessing basic computer functions on first trial as monitored monthly for 3 consecutive probes. (Baseline: x UPM)

VISUAL OCULAR MOTOT SKILLS: SCANNING

1. Given visual task, will improve ocular motor skills by scanning a 150-letter grid and finding 95% of reversed letters as monitored monthly for 3 consecutive probes. (Baseline: able to find 50% of reversed letters)

SENSORY PROCESSING: SELF REGULATION

1. In OT and classroom, will improve sensory processing skills by completing one classroom task within 5 minutes without clues after implementation of sensory strategy on one observation as monitored monthly for 3 consecutive probes. (Baseline: to be determined within one marking period.

2. ____ will improve sensory processing skills by identifying how his body feels when his engine is high and choosing one appropriate strategy to bring his engine down so he is ready to work on one observation in Social Skills group as monitored monthly for 3 consecutive probes. (Baseline: identifies high engine 50% of time, needs assistance to problem solve appropriate strategies)

3. ____ will improve sensory processing/self-regulations skills by scoring 3 out of 4 points on the following sensory rubric as monitored monthly for 3 consecutive probes. (Baseline: 1 out of 4 points:

1.Accurately identify “engine” level

1.Choose an appropriate strategy to be ready to work

1.Implement sensory strategy during Social Skills group

1.Adapt strategy and choose an alternative if ineffective

Executive Function Skills:

Working Memory

1. Given combination lock, will improve working memory and visual motor skills by opening a locker lock independently on first trial as monitored monthly for 3 consecutive probes. (Baseline: 3rd trial with verbal prompts)

Time Management

2. In the classroom, _____will demonstrate estimate and complete a 3 step classroom task in the allotted time as monitored monthly for 3 consecutive probes.

Organization

3. In the classroom, ____ will have no loose papers in her desk on 2/2 random observations as monitored monthly for 3 consecutive probes. (Baseline: many loose papers in desk)

Motor planning/Task Completion

4. ___ will improve motor planning and work related skills by completing a novel task with less than 2 cues per step after review of task directions on first trial as monitored monthly for 3 consecutive probes. (Baseline: inconsistent ability to follow written checklist)

5. ____ will improve functional work skills by scoring 2 out of 3 on the following rubric as monitored monthly for 3 consecutive probes. (Baseline: 0 out of 3 points)

a. *Input data into computer program after initial set-up

b. *Follow 5-step written directions without assistance.

c. *File 5 cards in alphabetical order by second letter independently

Sustained Attention

6. In the classroom, _____will complete follow through a 3-step task without need for redirection as monitored monthly for 3 consecutive probes.

Occupational Therapy SDI Strategies

IEP Accommodations and Strategies for Environment

1. A quiet area to complete the work or take a test
2. Having someone read a test to them
3. "Preferential seating," means sitting near the front, or away from distraction or in their area of preference (if they prefer a left or right visual field)
4. Preferential seating for hearing/audio
5. Preferential seating away from distractions, windows, doors, speakers
6. Extra time to complete the work or reading given
7. Early dismissal from class to get to locker and to next class
8. Identify and limit distractions
9. Opportunity for practice
10. "Hot pass" or "cool off card" which is a card the student gets and they can leave class, flash the hot pass to the teacher, and go to office, guidance counselor, nurse (designated ahead of time) to cool off, if they feel a negative behavior coming on
11. High contrast materials, limited visual clutter
12. Adapted lunch setting to reduce sensory stressors
13. Adapted recess with adult lead activities to increase peer interactions
14. Recess and group activities to be designed with IEP goals in mind
15. Keep days and activities structured
16. Structured seating arrangements
17. Small group instruction
18. Access to resource room or learning support room

SDIs and Accommodations for Transitions

1. Visual cues in hallways to guide child to next classroom or cafeteria
2. Personal time outs to regroup and prepare for transition
3. Time warnings and increased transition time
4. Advance notice of transitions
5. Schedule on blackboard (or whiteboard/smartboard)

Tools and Equipment-SDIs and Accommodations

1. Visual charts
2. Visual schedules
3. Visual cues in locker, lunch box, on desk
4. Fidget spinners/fidget toys
5. Written schedules on locker, lunch box
6. Graphic organizers
7. Choice cards
8. Emotions cards
9. Ear plugs or headphones
10. Special seating-seat pads, sit-upon balls, etc.
11. Adaptive equipment-pens, pencils, calculators, fidgety toys, large print books, audio, etc.
12. Use of FM headsets to either have blocking out music, or FM transmission of teacher speaking, use Beatz or something else socially acceptable, blocks out outside noise
13. Rewards charts

14. Yoga, meditation, relaxation techniques
15. Use of a scribe or oral testing to open ended or essay formats
16. Provide a study guide
17. Provide audio recordings
18. Provide video/audio recordings
19. Voice recognition software
20. Extra set of text books-1 set for home, 1 for school
21. Pencil grips, slant boards
22. Develop a sensory diet
23. Spelling dictionary, spell checker
24. Provide notes, outlines or organizers with key concepts or terms highlighted
25. Mnemonics
26. Remind student to wear glasses/hearing aids
27. Allow use of preferred writing implement

Occupational Therapy Consultation Form

Student:	Case Manager:
Date of Birth:	Teacher:
Gender:	School:
Date:	Grade:

Please check areas of concern in the classroom.

◯ No concerns at this time

Functional Mobility:

◯ Difficulty maneuvering around school
◯ Consistently utilizes poor posture while sitting at desk or walking
◯ Falls frequently
◯ Tires easily, low endurance level

Fine Motor:

◯ Difficulty manipulating classroom objects (scissors, glue bottle, stapler, tape dispenser, book bag)
◯ Does not use fingers/fingertips to pick up objects
◯ Handwritting is illegible
◯ Difficulty controlling pencil pressure
◯ Awkward/poor pencil grasp

Self Help:

◯ Needs assistance with putting on/taking off coat
◯ Needs assistance with getting on/off toilet or managing clothes when in bathroom
◯ Difficulty feeding self
◯ Difficulty manipulating milk carton, utensils, lunch box

Sensory Issues:

◯ Easily distracted/hyperactive/impulsive
◯ Difficulty with visual perception (copying shapes/letters from board)
◯ Overreacts to touch/physical contact/unfamiliar textures
◯ Tends to touch every object he/she sees

Teacher comments/concerns for consultation:

_____

_____

Recommendations (to be filled out by OT):

_____

_____

Occupational Therapy Consultation Form

Student:	Case Manager:
Date of Birth:	Teacher:
Gender:	School:
Date:	Grade:

Discipline: ◯ Occupational Therapy ◯ Physical Therapy ◯ Speech Therapy

Consultation Schedule Per IEP: ◯ Weekly ◯ Monthly ◯ Quarterly ◯ As Needed

As stated in the IEP, your student has consultative occupational therapy services listed. This service is an effort to ensure success for your student within the classroom, special areas, lunch room, or other areas of the school. In the space provided below, please list any difficulties he/she may be experiencing and/or your concerns.

Please return this form to me no later than _____

◯ No difficulties at this time

◯ Yes, I have concerns. If so, please describe.

_____

_____

_____

_____

Teacher Signature: _____ Date: _____

Therapist comments: _____

_____

_____

_____

_____

Next follow-up on or before: _____

Therapist Signature: _____ Date: _____

Therapy Consultation Request

Dear (Teacher),
Your student, _____, has consultation services listed on his/her IEP to address the following:

- ◯ Attention and Self-Regulation
- ◯ Organizational Skills
- ◯ Handwriting Strategies

Please check the following observations you've made in your classroom:

- ◯ The student is demonstrating difficulty with attending to group lessons
- ◯ The student is demonstrating difficulty attending to independent work
- ◯ The student appears fidgety and restless
- ◯ The student appears lethargic and misses verbal directions
- ◯ The student is demonstrating difficulty with organization of classroom materials, assignments, papers, and/or assignment book
- ◯ The student is demonstrating difficulty with planning for multiple step directions
- ◯ The student is demonstrating difficulty maintain proper alignment, spacing, and/or legibility of the handwritten work
- ◯ The student is demonstrating difficulty with copying information from the board to the page of paper
- ◯ The student is demonstrating difficulty with alignment of math problems and spatial arrangement of written work on paper
- ◯ Other: _____
- ◯ This student is demonstrating no OT needs at this time

I would like to request a:

- ◯ Classroom observation by the OT – the child is available in my classroom at these times: _____
- ◯ Meeting with the OT – I am available at these times: _____
- ◯ No action required

Occupational Therapy Monthly Log

Student Name: _____ **Month/Year:** _____

SESSIONS THIS MONTH

Date:			
Total Time:			
Code:			

CA: Client Absent CU: Client Unavailable TA: Therapist Absent SC: School Closed (Holidays, Snow Days, etc.)

Did you fulfill the frequency of service this month as stated on the IEP?

☐ YES

☐ NO

If NO, why? (Answer below)

Data Collection

Goal & Criteria		Date __/__/__	Date __/__/__	Date __/__/__	Date __/__/__
1.	Data				
	Progress Summary				
	PC				

Goal & Criteria		Date __/__/__	Date __/__/__	Date __/__/__	Date __/__/__
2.	Data				
	Progress Summary				
	PC				

PC (Progress Code) Key: M – Mastered * I – Improvement * SI – Slight Improvement * NC – No Change * R - Regression

Top Items for your OT Tool Kit

- Mini colored pencils. Shorter pencils equal better grasp
- Scissors- Kids Fiskars, spring-open, lefty
- Crayons- Shorter crayons prevent fisting, stackable crayons facilitate nice grasp.
- Masking/Scotch Tap- Pulling, tearing, and rolling tape is quite the challenge!
- Eraser- Because kids make mistakes
- Rubber bands- Manipulation, dexterity, creating adapted grips
- Variety of pencil grips – to promote efficient grasp
- Glue stick with twist top and glue bottle
- Variety of markers and highlighters - assist letter sizing, baseline orientation, bolding
- Dry erase marker, eraser and small board
- Variety of pencils (thick, thin, golf)
- Weighted pencils
- Erasable pens
- Zoomball
- Clothespins
- Variety of tongs and tweezers
- Hole punchers and pieces
- Tennis ball mouth. Cut a slit in a tennis ball, give it a face and a name
- Travel-size ball mazes and board games
- Variety of beads/Lacing string
- Play dough
- Spot it! Travel game
- Beading wire or pipe cleaners
- Variety of small manipulatives
- Wikki Stix
- Straws
- Bubbles
- Deck of cards and UNO
- Rice bucket with hidden items
- Puzzles
- Tissue paper
- Construction paper
- Theraputty (variety of colors for different resistance and small beads/buttons to hide)
- Practice clothes/fasteners (buttons, zippers, snaps, tie shoes)
- Bumpy cushion/wedge cushion/ball chair, t-stool (ask special ed department to purchase for school)
- Variety of adapted paper – raised line, double line, three lines, highlighted
- Variety of board games (many teachers have an awesome collection to borrow from). Trouble, Sequence, Connect 4, Jenga, Battleship, Operation, Ants in myPants, etc.

Tips to Improve Focus/Attention

To increase student attention:

- Tips to Improve Focus
- Make a classroom "Exercise Wheel" with simple movement activities such as: toe touches, toe lifts/heal raises, squats, mountain climbers, marching, yoga poses.
  - Use with class prior to seated work tasks, prior to group listening activities, prior to taking tests
- Allow for water bottles, specifically ones with a straw
- Allow for crunchy or chewy snacks in classroom or nurses' office, access to gum
- Provide Velcro dots to put on pencils as a tactile fidget
- Allow for regular movement breaks between lesson segments
- Incorporate movement into interactive learning activities
- Allow students to stand at desk to complete writing assignments.
- Allow for doodling while listening
- Provide a quiet fidget such as a paper clip or rubber band when listening
- Try Mindfulness-Based Stress Reduction (see reference at the end of this document)
- When completing independent or "quiet work" add classical music or music with a solid rhythm such as Native American drumming
- Poses that focus on balance (i.e., Tree pose) and poses that invert the head (i.e., Downward dog)
- Ask for volunteers to erase whiteboard, pass out or collect papers, and collect supplies as needed
- Mountain pose when lined up in hallway and waiting
- Encourage a variety of ways to transition in the hallway (hopping like bunnies, marching, tip toes, galloping, etc)
- Decrease environmental distractions
- Encourage consistent classroom schedule
- Prior to tasks, complete overview of what will occur and teacher expectations
- Face desks towards sources of instruction
- Students that tend to be distracted should have preferential seating (often front of classroom away from the door, but not always)

Strategies for Material Organization

- Provide your student with large binder with envelope folders or expandable file folder (choose plastic not paper) which will become their basic organizational tool.
- Provide two pocket colored folders that can be designated for each class period
- Arrange folders in class schedule order/color code classes
- Organize desk with books on one side, folders on other
- Have one two pocket folder per subject. Label on pocket: 'in' for classwork, study guides, worksheets etc. and one pocket: 'out' for homework and projects to be handed in
- Try color coding; by subject or by morning classes and afternoon classes (use color cod- ed dots
- in top right corner of assignment or paper that corresponds with subject)
- Create a "daily schedule" that breaks down the full weekly schedule, have student
- change each day in his/her binder
- Use Velcro dots on pencil and binder to keep them together when transitioning classes
- Utilize a large flat pencil case with pockets and binder holes to keep school supplies (pencils, pens, erasers, scissors, tape etc.) with paperwork
- Keep a supply of lined paper or notebook with tear out pages in binder.
- Provide second set of books necessary at home
- Older students can use their phone camera to take picture of homework
- Younger students should be taught how to use their assignment books, teacher and parent checks daily at first

- Regardless of organizational strategy you decide to begin with, teacher support/checks and parent checks need to occur regularly and then can be titrated down once success is observed. Begin with daily, move to weekly, and so on.
- Having a picture as a reference of what the space should look like can be very helpful to encourage the student to monitor their own performance

Strategies for Homework& Assignments Organization

- Discuss and help your student set realistic time frames to complete homework and projects due at a future date. Encourage ‘chunking’ or breaking down larger projects into manageable segments and set completion dates.
- Use a calendar as a reminder when project segments are due.
- Plan ahead and purchase any needed materials for a specific project (ie poster board, art supplies, printer ink etc.) prior to starting assignment.
- On a weekly basis, use the ‘Trash’ & ‘Keep” method and go through binder or file folder with your student. Ask questions such as: “Will you need this worksheet to study for an upcoming test?”, “Is this work a ‘draft’ and if so, “Do you need it to turn in the final report?”, “Does this paper contain any information that you will need to study or complete and assignment in the future?
- Purge papers that are not needed and save test and projects by subject and date in folders to study for midterms and finals.

Strategies for Improving Handwriting

For Improvements in Legibility:

- Trial adapted paper for longer writing assignments (Size Matters Handwriting Program has a great comprehensive adapted paper master guide at RealOTSolutions.com)
- Provide enlarged graph paper for aligning math problems or turn notebook paper vertically
- Provide visual boundaries and lines - reduce the amount of “open space” for writing answers on worksheets.
- Adapt the assignment book/planner
- Allow the students to use the computer for longer writing assignments
- Encourage students to use cursive handwriting
- Only trial a pencil grip to change the student’s grasp if they are complaining of fatigue or pain in the hand when writing
- Use dictation on an I-Pad/Chrome Book: Dragon Dictation, Voicify, VoiceNote II
- Use Self Checklist (example at the end of this handout)

Technology Assessment

- A middle school performance skill
- Body mechanics and positioning
- Keyboard and Mouse
- Alphasmart
- Existing technology curriculum
- Role of district support services (SETT)
- Great free resources on Google and Just My Type program

Adaptations for Writing: Text to Speech

- For web sites and databases that do no provide listening capabilities, text can be copied and pasted into a variety of free text-to-speech generators. One ex- ample is Vozme. This siteallows text to be listened t instantly or downloaded as an MP#
- SpeakIt converts text into speech when you highlight a selected text and click the icon to beginlistening. It can read text in 50 languages.
- The “Speak” command can be added to the Quick Access Toolbar in Word, PowerPoint, etc. Directions may be found: http//office.microsoft.com/en-us/ word-help/using-the-speak-textto-speech-feature-HA102066711.aspx

Positioning Strategies

- Adjust the seat and desk/table height:
- Soles of feet should touch the ground; use a phone book wrapped in packing tape or a shoe box if desk/chairs are not adjustable
- Desk height should be no more than 2” below elbow when child is seated
- Lay prone (on stomach) to complete work
- Sit on a wedge to promote upright posture
- Use a back rest to promote upright posture
- Use a 3” 3-ring binder as a slant board to promote upright posture
- Stand to complete work task
- Designate a special desk in class away from distractions that any student could sit at (study is- land)
- Write on vertical surface or underside of desk

OT Strategies for Secondary School

Unique Challenges in Secondary School

- Social Awareness
- Middle School demands on students
- Student Motivation
- Scheduling
- Goals
- Frustration
- Transition from Elementary

What Does Occupational Therapy Address in a Secondary School?

- Pre-Vocational Vocational–Therapist collaborates with teachers and job coaches
- Fine motor delays (handwriting, keyboarding, difficulty in art class), use of tools
- Visual Perceptual and Visual motor delays (keeping materials organized, legibility with written work, maintaining schedule)
- Sensory Processing & Motor Planning skills (learning how to manage behaviors/self control when dealing with sensory processing dysfunctions), fatigue, perceived level of execution, time management, project completion
- Activities of Daily Living (ADLs) such as dressing, feeding, and bathroom/hygiene routines related to classroom routines
- Assistive Technology – the therapist collaborates with the team to identify assistive technology needs (use of computer, I-Pad, apps for dictation, etc.)
- Finding Classes, arriving on time
- Locker management
- Organization of self/physical supplies
- Written work
- Self regulation
- Self care
- Completing work in a timely manner

REFERENCES

- www.aota.org/practitioners/official/guidlines/36202.aspx
- www.aota.org/practitioners/official/standards/36194.aspx
- www.mypts.com
- American Occupational Therapy Association. (1999b). Occupational therapy services for children and youth under the Individuals with Disabilites Education Act (2nd ed).
- McEwen. (2000). Providing Physical Therapy Services Under Parts B & C of the individuals with Disabilites Education Act (IDEA), APTA
- [Dunn, W. (2000). Best Practice in Occupational Therapy in Community Service with Children and Families (p. 111-114), Thorofare, NJ: Slack, Inc.].
- www.aota.org

ADDITIONAL EXAMPLES OF DATA SHEETS

SELF-REGULATION DATA COLLECTION CHECKLIST

STUDENT NAME: _____ MARKING PERIOD: _____

DATA COLLECTION FREQUENCY: _____

GOAL: _____

DATE	PROMPT (VERBAL/VISUAL/GESTURAL)	TOOL UTILIZED	POSITIVE OUTCOME (Y/N)

CUTTING CHECKLIST

STUDENT NAME: _____ MARKING PERIOD:_____

DATA COLLECTION FREQUENCY: _____

PLACE A (+) IF STUDENT CAN MEET GOAL INDEPENDENTLY, A (-) IF CANNOT MEET GOAL WITH PERCENTAGE

DATE	GRIP	DEVIATION	STIMULUS LINE	SMOOTH CUTS?	GOAL MET?
GOAL					

FIGURE DRAWING CHECKLIST

STUDENT NAME: _____ MARKING PERIOD:_____

DATA COLLECTION FREQUENCY: _____

PLACE A (+) IF STUDENT CAN MEET GOAL INDEPENDENTLY, A (-) IF CANNOT MEET GOAL WITH PERCENTAGE

Date	Draw Image	Copy Image	Proportionality	Number of Parts	Number of Prompts	Goal met?

PRINT ALPHABET CHECKLIST

STUDENT NAME: _____ MARKING PERIOD:_____

DATA COLLECTION FREQUENCY:_____

GOAL: _____

PLACE A (+) IF STUDENT CAN PRINT LETTER INDEPENDENTLY OR A (-) IF CANNOT PRINT LETTER

UC letter	Date	Date	Date	Date	lC letter	Date	Date	Date	Date	Number	Date	Date	Date	Date
L					q					8				
E					t					2				
W					b					3				
M					k					5				
V					s					9				
C					y					1				
X					u					4				
Z					i					7				
R					o					6				
J					p					10				
H					a					TOTAL				
G					n									
F					d					NAME				
D					f					First				
N					g					Last				
A					h					TOTAL				
P					j									
O					r									
I					z									
U					x									
Y					c									
S					v									
K					m									
B					w									
T					e									
Q					l									
TOTAL					TOTAL									

SELF-CARE CHECKLIST

STUDENT NAME: _____ MARKING PERIOD:_____

PLACE A (+) IF STUDENT CAN MEET GOAL INDEPENDENTLY WITH PERCENTAGE, A (-) IF CANNOT MEET GOAL WITH PERCENTAGE, AND TALLIES (I) FOR NUMBER OF PROMPTS

DATE	BUTTONS	ZIPPERS	SNAPS	DONN/DOFF COAT	DONN/DOFF ART SMOCK	TIE SHOES
GOAL						

SENTENCE WRITING CHECKLIST

STUDENT NAME: _____ MARKING PERIOD:_____

DATA COLLECTION FREQUENCY: _____

PLACE A (+) IF STUDENT CAN MEET GOAL INDEPENDENTLY, A (-) IF CANNOT MEET GOAL WITH PERCENTAGE

DATE	HANDWRITING PROMPT (DPC, MPC, FPC, SELF-GENERATED)	SIZING	SPACING WITHIN	SPACING BETWEEN	ALIGNMENT	FORMATION/ REVERSALS/ LETTER LEGIBILITY	PENCIL GRASP	PROMPTS (TALLIES)	CLASS SAMPLE? (Y/N)	GOAL MET? (Y/N)
GOAL:										

VISUAL PERCEPTUAL CHECKLIST

STUDENT NAME: _____ MARKING PERIOD:_____

DATA COLLECTION FREQUENCY: _____

PLACE A (+) IF STUDENT CAN MEET GOAL INDEPENDENTLY, A (-) IF CANNOT MEET GOAL WITH PERCENTAGE

Date	SEQUENTIAL MEMORY	FORM CONSTANCY	CLOSURE	FIGURE GROUND	MEMORY	SPATIAL RELATIONS	DISCRIMINATION
GOAL							

PHYSICAL THERAPY

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- PA Guidelines for Obtaining Physical Therapy Prescriptions
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References

GUIDELINES FOR ELIGIBILITY

OT and PT Services in the Educational Setting

The following guidelines are PTS' company recommendations only based upon the suggested criteria currently used by some of the nations' largest school districts. There are no formal eligibility criteria from the AOTA or any other OT professional association to definitively define qualification of students in school based practice.

Legal Basis for Eligibility

Occupational and Physical Therapy are available as "related services" (IDEA Part B) in a child's IEP when the service is "required for a child with a disability to benefit from his or her special education program". The Individualized Education Program (IEP) team is responsible for deciding if the student needs OT/PT services to benefit from their educational program. These services are to provide a child with equal opportunity that would not exist without therapy service and not merely maximization of a child's potential. Legal mandates require the schoolbased therapist to deliver only those services that are necessary to assist students in benefitting from their educational programs. School based therapy must be focused on the IEP goals that therapy is intended to support. Eligibility for therapy services must be based on the student's educational goals and whether the expertise of OT or PT is needed to help the student achieve those goals. While some educational goals may be academic while other goals will focus on student function or the student's participation and success in the school environment, all must be critical to the student's ability to access the curriculum.

No individual team member, including therapists, can independently determine who does or does not need services. The decision to add OT/PT to a student's list of services is determined by the IEP team. Under PA education law the IEP team is not allowed to base OT or PT service options and frequencies on the following factors alone:

- Test scores
- Descriptions or quantifiers of either functional performance or deficits
- Discrepancies between developmental levels and chronological age
- Specific OT, PT, or teacher roles and responsibilities
- Special Education classification categories

Education law mandates that emphasis must be placed on the context of the child's learning and activity. The IEP team cannot consider a child's need for OT or PT in isolation from an educational program. Therefore, the IEP team should not ask, "Does the student need OT or PT in school?" The team should ask, " Does an OT or PT's knowledge and expertise provide a needed component of the student's program that will achieve identified educational outcomes?"

Steps to Inclusion of OT and PT in the IEP

1. To be eligible for special education related service, the evaluation team must establish the existence of a disability and an educational need.
2. Once the child is determined to be eligible for special education services, the IEP team will identify which related services (if any) the child needs in order to benefit from special education services. OT and PT may be added as related services only if they are needed for the student to benefit from the special education services being provided.

A small number of students may qualify for OT or PT services with a Service Agreement under Section 504 of the Rehab Act of 1973 and The Americans with Disabilities Act. These services should be provided only if:

1. The student has a mental or physical impairment (or has a record of an impairment or is regarded as having an impairment)
2. It is substantial, and
3. It limits one or more major life activities (e.g. caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working)

Assessment

Areas to be assessed are based on a top down approach and are dependent on the student's needs. For example, if a screening reveals that a student has sufficient motor skills to be successful in the school environment but is demonstrating behaviors indicative of sensory modulation difficulties, tests that focus on motor skills and visual motor integration will not be warranted. A questionnaire that addresses sensory processing abilities would be more appropriate for this student.

Use of Criteria

Upon completion of an occupational therapy or physical therapy assessment, the therapist and IEP team determine whether an exceptional student demonstrates/exhibits a need for occupational therapy or physical therapy in the school setting in order to benefit from his/her special education program. The therapist should keep in mind specific factors when using the criteria:

- The therapist should use the assessment of functional motor skills, and not the presence of developmental delay, with students who have medical diagnoses, such as spina bifida, muscular dystrophy, and cerebral palsy.
- Poor handwriting skills or lack of athletic skills alone do not constitute an IDEA disability for which a student should be identified as eligible for special education services. Difficulties in these areas must impede the student's ability to benefit from the special education program in order for these problems to justify the need for OT or PT services under an IEP.

Criteria for Physical Therapy in the Education Setting:

- The Child must have a problem with an observable, functional motor skill that is critical to his ability to function in the school environment.
- Mobility must be impaired to the degree that it affects the child's ability to move around the school environment.
- The services of a physical therapist are required to address the above needs

Criteria for Occupational Therapy in the Education Setting:

- Child has difficulty with writing and drawing legibly. This does not mean that the child with sloppy handwriting automatically should receive OT services; if writing is sloppy but still legible, therapy services are not typically warranted. The therapist should discuss strategies for promoting more efficient, neater handwriting with the teacher. Some students will have neat, legible handwriting while in a one-to-one therapy session but will demonstrate lesser quality writing in the classroom. Often, these issues can be best addressed by the teacher, using an incentive program for neat work. Teams should keep in mind that it is very difficult to change grasp and letter formation patterns after 4th grade and recommendations for therapy should be made accordingly. By fifth grade, accommodations for these problems are often better than direct therapy.
- Child has difficulty with manipulative tools such as scissors and it is judged that this difficulty will improve with occupational therapy services.
- Child has diminished ability to attend to tasks and organize work due to sensory processing problems. It is important that the OT assess the child to determine whether or not the attention problem s are due a sensory processing issue a opposed to another type of attention problem that is not likely to respond to OT intervention.
- Child has difficulty perform self-care skills that are necessary in the school setting. OT should only provide services to address these difficulties if they are not being specifically addressed in the child's education program (such as in a life skills curriculum).

Discharge Criteria

The student should be considered for dismissal from Occupational/Physical Therapy when one or more from the following conditions exist:

1. The student's level of educational functioning in the area(s) being addressed has reached age level, grade level and/or level of intellectual potential.
2. The student has developed the performance components needed to progress toward the educational goals established in the IEP.
3. The areas of concern being addressed in the therapy do not interfere with the student's ability to function or make progress in her educational setting.
4. Environmental or curricular adaptations have been established to allow for achievement of educational goals.
5. The student's needs for remediation and/or compensation in the area(s) being addressed are being fully met by the student's educational or other service providers without the need for continued therapist contact.
6. The student's rate of progress in the educational environment in the area(s) being addressed by therapy continues to be steady and commensurate with the student's overall level of progress in other areas despite a decrease in therapy services.
7. Therapy is no longer affecting change in the student's level of function or rate of skill acquisition (i.e. the student has reached a plateau).

CAN OT OR PT STAND ALONE?

It's an important question and one that will come up a lot as you go through your school year. One of our Director's of Pupil Services shared with us an email she sent to her team of psychologists about stand aloneOT evaluations. The information is below. Feel free to use this information during conversations with the teachers, psychologists, and teams you work with!

- OT evals should never be completed in isolation. They should always be part of a Chapter 14 eval or a Chapter 15 eval that is comprehensive. MDEs are preferable and legally defensible.
- Whether a student "qualifies" for OT or would benefit from/respond to OT intervention is not the question when considering 504 eligibility. The question we need to answer as a team is "Is the child exhibiting a performance deficit that is disabling?" or put another way "Does the child have a disability that causes a substantial limitation in school performance?"
- We need to be careful not to rely on parents to produce evidence of a disability (i.e. Dr. note). It is the district's child find obligation to conduct whatever evaluation is necessary to determine a student's needs under Chapter 14 or 15. We also do not presume eligibility based on a Dr. note indicating a disability or script for service. It is ok to ask if there are any DSM diagnoses however but this should not delay a needed action under our child find obligation.
- The threshold for determining "substantial limitation" is somewhat low. Nevertheless, it must be discussed by the team.
- Eligibility determinations must also consider whether the needed skill is available within the grade-level curriculum.

*A student can have OT or PT in a 504 (but typically the services are consult for accommodations and not a direct service). However, most districts are no longer providing "OT only" 504 plans.

*Counselors and Psychologists - remember that it is an essential step that all students undergo the 504 Evaluation process prior to drafting a 504. This is a procedural requirement. The 504 evaluation process may involve collection of data, team input, and observation. It does not have to involve a psychologist but the team should strongly consider the need for psych involvement & Chapter 14 eligibility when the CST nature of concern is related to ADHD like behaviors or OT-like needs.

*A 504 plan should not be developed strictly as a means to provide OT and/or PT services.

What PT's work on in an educational environment

- Transfers (ie. from wheelchair to and from changing table)
- Transitional Movements (ie. floor to sit)
- Modified Toileting Equipment 0
- Positioning (ie. standers, gait trainers)
- Wheelchair Mobility
- Modified Seating
- Balance
- Mobility (ie. walking)
- Assistive Technology
- Safety

Writing PT Goals

- Must be measurable
- Must be attainable in a 12 month period: we will be held accountable for lack of progress toward these goals
- Must relate to "skills as needed" section of IEP
- Must have an action word- ex. Develop, attain, increase etc.
- Can use age equivalence as the "measurable" component
- Directly related to needs identified in ER
- Contain objective criteria/ ie. measurement criteria for level of achievement
- State number of probes (number of times when data will be taken- incremental planned observations of the child}
- State the amount of time during which this data will be collected

ANNUAL GOALS: Most students get annual goals (which should be achieved within one academic year.

SHORT TERM OBJECTIVES - Required for children with disabilities who take alternate assessments aligned to alternate achievement standards (P ASA)

Progress Reporting

Occurs at report card time. You will enter specific measurable progress data for each goal. Ex:Lucas can have a catch with a peer in half kneel with a 4 inc h ball for 4 consecutive catches on 3/4 trials. He has had incidents of 6 consecutive catches. This is a difficult position for Lucas to maintain, but he is showing improved control.

MTSS Tier 1 PT Whole Class Consultation Tracker

Class: _____

Teacher: _____

IST Leader: _____

Therapist: _____

DATE: _____

Strategies or Skills Center

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

FOLLOW UP/DATE:

MTSS Tier 1 PT Student Observation Request Form

Student Name:	Date of Birth:
School:	Current Teacher:/Grade:
Case Manager:	Date:

Teacher/Team Concerns:

Mobility:

- ☐ Child is not able to keep up with peers moving around school
- ☐ Child is not able to play safely on playground
- ☐ Child falls/trips frequently, bumps into obstacles
- ☐ Child's movements appear clumsy
- ☐ Child requires an assistive device/equipment to move around school
- ☐ Child does not interact with peers during free play gross motor activities such as out on the playground
- ☐ Other:

Positioning in the Classroom

- ☐ Child has a slumped posture at the desk
- ☐ Child is not able to stay in chair in classroom
- ☐ Child cannot sit safely on a stool
- ☐ Other:

Physical Education Class

- ☐ Child is not able to keep up with peers during running games
- ☐ Child appears to have muscle weakness
- ☐ Child's ball skills are not
- ☐ Child is not able to follow instructions related to gross motor games or new skills
- ☐ Child is unsafe during gym class due to poor coordination/ balance
- ☐ Child is not participating in Physical Education class due to difficulty with gross motor skills
- ☐ Child has poor endurance
- ☐ Other:

Recommended Strategies:

_____

_____

_____

Data Collection Log:

List the strategies being implemented, the date for each of the 4 weeks, and a 1, 2 or 3 based on observations made (1= no progress made, 2= minimal progress, 3= sufficient progress made)

Strategies	Week 1 Dates:	Week 2 Dates:	Week 3 Dates:	Week 4 Dates:

MTSS Tier 1 PT Student General Strategies Data Tracker

Student Name:_____ School:_____ Grade:_____ Teacher:_____ Date Strategies Initiated: _____

Below, please find a form of common recommendations and strategies. Upon the completion of the 2 week trial period, I will consult with you to see how they have worked in your classroom. Please feel free to contact me with any questions!

Referral Period Data

Progress Code: N = No Improvement, I = Improving, R = Resolved

Strategies	Week 1	Week 2	Notes
Stairs			
☐ Yellow or red tape at the end of steps for visual cues	☐N ☐I ☐R	☐N ☐I ☐R	
☐ Give verbal prompt "pop corn" to help student put a different foot on each step	☐N ☐I ☐R	☐N ☐I ☐R	
☐ Model for the student	☐N ☐I ☐R	☐N ☐I ☐R	
☐ Place the student appropriately in line to allow more time to preform	☐N ☐I ☐R	☐N ☐I ☐R	
Playground			
☐ Identify some basic standing and less movement games that the student can be successful with	☐N ☐I ☐R	☐N ☐I ☐R	
☐ Set up student with a partner	☐N ☐I ☐R	☐N ☐I ☐R	
☐ Other	☐N ☐I ☐R	☐N ☐I ☐R	
Physical Education			
☐ Provide verbal and visual modeling	☐N ☐I ☐R	☐N ☐I ☐R	
☐ Provide a gym buddy for modeling	☐N ☐I ☐R	☐N ☐I ☐R	
☐ Allow time to practice skill	☐N ☐I ☐R	☐N ☐I ☐R	
☐ Other	☐N ☐I ☐R	☐N ☐I ☐R	
Hallways/improve pace/ endurance			
☐ Assign buddy when walking halls	☐N ☐I ☐R	☐N ☐I ☐R	
☐ Opportunities for student to move and walk more to improve endurance	☐N ☐I ☐R	☐N ☐I ☐R	
☐ Help student set the pace by walking along side of them	☐N ☐I ☐R	☐N ☐I ☐R	
☐ Other	☐N ☐I ☐R	☐N ☐I ☐R	
Classroom/Positioning			
☐ Recommend alternate seating like theraball	☐N ☐I ☐R	☐N ☐I ☐R	
☐ Provide different positional opportunities of writing (tummy on the floor, stand at desk/board, etc.)	☐N ☐I ☐R	☐N ☐I ☐R	
☐ Provide chair with arms	☐N ☐I ☐R	☐N ☐I ☐R	
☐ Provide movement breaks every 20 minutes	☐N ☐I ☐R	☐N ☐I ☐R	
Tripping/Falling/Bumping into objects			
☐ Keep student's area free of clutter	☐N ☐I ☐R	☐N ☐I ☐R	
☐ Keep walkways free of clutter	☐N ☐I ☐R	☐N ☐I ☐R	
☐ Use visuals to give the student spatial awareness	☐N ☐I ☐R	☐N ☐I ☐R	
☐ Other	☐N ☐I ☐R	☐N ☐I ☐R	

Follow Up Date:_____ Upon completion of interventions and data collection for the 2 week period, please send Screening Request form and this data collection sheet to the MTSS for review. Upon approval of the OT screening, the forms will be forwarded to the therapist for the Screening. Copies should be kept in the Guidance Counselor's file, Therapist file, and in the main student file in the Special Education Office.

_____ Concerns Resolved, no further action needed

_____ OT Screening requested (Please identify student's diagnosis if applicable): _____

PTS PEDIATRIC THERAPEUTIC SERVICES

Tier 3 Request for Physical Therapy: Screening

Student Name:	Date of Birth:
School:	Current Teacher/Grade:
Case Manager:	Date of Referral:

Student Diagnosis: _____

This student currently receives the following services:

☐ Speech Services Going through MTSS & will possibly go to MDE ☐ OT Services Learning Support ☐ Existing 504 plan ☐ No services at this time

Have parents been notified of your concerns? _____

I am concern with this student's :

Mobility

☐ Not able to keep up with peers
☐ Not able to play safely on playground
☐ Does not interact with peers during free play gross motor activities such as out on the playground
☐ Falls/trips frequently
☐ Movement appears clumsy
☐ Child requires as assistive device/equipment to move around school

Positioning in the Classroom

☐ Has slumped posture at their desk
☐ Is not able to stay in the chair in classroom
☐ Cannot sit safely on a stool

Physical Education Class

☐ Is not able to keep up with peers during running games
☐ Appears to have muscle weakness
☐ Ball skills are not adequate to play appropriately with peers
☐ Is not able to follow instructions related to gross motor games or new skills
☐ Is unsafe during gym class due to poor coordination/balance
☐ Is not participating in Physical Education class due to difficulty with gross motor skills
☐ Has poor endurance

What strategies have been utilized to address these concerns (teachers must have trialed strategies for at least 2 weeks and document them here)?

_____

_____

_____

_____

_____ _____

Teacher Signature **Principal Signature**

Physical Therapy Screening Report Form

Student Name:	Date:
School:	Current Teacher/Grade:

RESULTS OF PHYSICAL THERAPY SCREENING:

Mobility: Results of the screening indicate that:

☐	Mobility is within functional limits	Comments:
☐	Further interventions are recommended	
☐	Identified area of concern	

Positioning in the Classroom: Results of the screening indicate that:

☐	Positioning is within functional limits	Comments:
☐	Further interventions are recommended	
☐	Identified area of concern	

Physical Education Class: Results of screening indicate that:

☐	Participation in physical education within functional limits	Comments:
☐	Further interventions are recommended	
☐	Identified area of concern	

Other: Results of the screening indicated that:

☐		Comments:
☐	Further interventions are recommended	
☐	Identified area of concern	

RECOMMENDATIONS OF PHYSICAL THERAPY SCREENING:

☐	No further testing is recommended at this time.
☐	Participation in MTSS is recommended to address the following areas ☐ Mobility ☐ Positioning ☐ Physical Education *Please complete the MTSS intervention plan.
☐	Physical Therapy evaluation recommended (if student has IEP).

_____ _____

Physical Therapist **Date**

SAMPLE TEACHER LETTER WITH DATA COLLECTION SHEET

Dear_____ Date_____

Thank you for the opportunity to observe in your classroom today. I've attached a form of priority needs as well as recommendations and strategies. I've also attached a 6-week data collection form to chart the trial of these strategies. Upon the completion of the 6-week trial, I will consult with you to see how the strategies and recommendations have worked out. If we feel that there is a further need for support, we can recommend an evaluation. Highlighted recommendations are strategies I feel would be best to incorporate into the daily class times to address the above stated needs. Please feel free to contact me with any questions!

Sincerely,

THERAPIST NAME
THERAPIST PHONE NUMBER
THERAPIST EMAIL
DAYS AT PARTICULAR SCHOOL
TIMES AVAILABLE FOR CONSULT

MTSS Tier 3 PT Screen Recommendations Data Collection

Student Name:_____ Grade:_____Teacher:_____

Thank you for the opportunity to observe in your classroom today. Below, please find a form of priority needs as well as recommendations and strategies. Upon the completion of the 4 week trial period, I will consult with you to see how the strategies and recommendations have worked in your classroom. Please feel free to contact me with any questions!

	Referral Period Data *Progress Code: N(No Improvement),I (Improving), R(Resolved)*						
Strategies	**Week 1**	**Week 2**	**Week 3**	**Week 4**	**Week 5**	**Week 6**	**Notes**
	• I • N • R	• I • N • R	• I • N • R	• I • N • R			
	• I • N • R	• I • N • R	• I • N • R	• I • N • R			
	• I • N • R	• I • N • R	• I • N • R	• I • N • R			
	• I • N • R	• I • N • R	• I • N • R	• I • N • R			
	• I • N • R	• I • N • R	• I • N • R	• I • N • R			

Follow Up Date: _____ Upon completion of this form, please send Screening Request form and this data collection sheet to IST. Upon approval of the PT evaluation request, the PTE will be generated and sent home from the Special Education Department.

_____Concerns Resolved, no further action needed _____PT Evaluation requested (Please identify student's diagnosis):

For Special Education Department Use Only:

_____ Approved – Signature: _____ Date: _____ Date PTE issued: _____ Date returned: _____

_____ Declined- Reason: _____ Signature: _____ Date:

MTSS Tier 3 PT Data Collection Consult

Student Name: _____ Grade: _____ Teacher: _____

Thank you for the opportunity to discuss your student today. Please view the list of priority needs as well as recommendations and strategies. Upon the completion of the 6 week trial period, the CST will consult with you to see how the strategies and recommendations have worked in your classroom. Please feel free to contact the team with any questions.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Upon completion of this form, please send this data collection sheet to in the Child Study Team.

Follow Up Date: _____

- ☐ Concerns Resolved, no further action needed
- ☐ Concerns Continue, OT Screening needed: _____

Signature of Director of Student Services: _____

PHYSICAL THERAPY
Screening Reference Guide:

Student:	Screening Date:
Date of Birth:	Current Services:
Chronological Age:	School:
Referred By:	Grade:

SUBJECTIVE: Background/Consultations

Referral/Teacher Interview:

1. What functional difficulties is the child/student having?

- ☐ School Bus: getting on or off?
- ☐ Hallways: navigating, carrying items?
- ☐ Classroom:
  - ☐ Moving on the Floor
  - ☐ Positioning For Activities on the Floor, While Seated, and in Standing
  - ☐ Moving in a Wheelchair (If Applicable)
  - ☐ Transferring to/from Chair, Wheelchair, Floor
  - ☐ Walking
- ☐ Restroom:
  - ☐ Transferring to/from Toilet
  - ☐ Moving to/from Changing Table
  - ☐ Accessing Sink, Soap, Towels
- ☐ Cafeteria:
  - ☐ Viewing Food Display
  - ☐ Reaching/Obtaining Food
  - ☐ Carrying Food
  - ☐ Positioning For Eating
  - ☐ Disposing Of Tray/Utensils/Trash

2. Potential factors contributing to these difficulties

_____

_____

_____

3. Student's strengths and interests

_____

_____

_____

OBJECTIVE: Observations and Gross Motor Screen

Clinical Observation and Objective Data Collection:
Posture/Positioning:

Position	Posture Observed	Comments
Seated Posture (Upper Extremity)	• Upright, shoulders back, head directly over trunk • Slumped with rounded back, forward head position • Bottom sliding forward on chair • Propped head on hands • Head lying on arm/desk • Chest leaning against desk	
Seated Posture (Lower Extremity)	• Feet planted firmly on floor • Legs wrapped around chair legs • Dangled Legs • Swinging or kicking legs • Right leg underneath bottom • Left leg underneath bottom	
Standing Posture (Upper Extremity)	• Ear over acromion process (shoulder), neutral spinal alignment with appropriate curves of thoracic & lumbar spine • Forward head position, kyphosis of thoracic spine with appropriate lumbar curvature • Sway back observation • Increased lumbar lordosis	
Standing Posture (Lower Extremity)	• Femoral greater trochanter anterior to lateral femoral epicondyle, above lateral malleolus • Hyperextension of knees • Increased flexion of knees • Foot pronation • Foot supination	
Braces, Orthotics, Assistive Device		

Gross Motor Skills:

Skill	Observations	Comments
Broad (Long) Jump	• Arm swing to propel forward • Knees bend • Simultaneous foot take-off and landing • One foot takes off/lands before the other	
Single Leg Hop	• Hopped ___ times on LEFT Leg • Hopped ___ times on RIGHT Leg	
Gallop	• Smooth movement pattern • Able to complete leading with either leg	
Skip	• Smooth movement pattern • Able to complete leading with either leg	
Jumping Jacks	• Smooth movement pattern	
Scissor Jumps	• Smooth movement pattern • IPSILATERAL or ALTERNATING UE and LE	
Throwing & Catching a Tennis Ball	• Throwing accuracy • Reciprocal step prior to overhand throw • Reciprocal step prior to underhand throw	
Throwing & Catching a Large Ball	• Throwing accuracy • Reciprocal step prior to overhand throw • Reciprocal step prior to underhand throw	
Kicking Stationary & Moving Ball	• Ball travels in a linear pattern • Steps prior to kick • TOE or IN-STEP for contact with ball • Good balance and transfer of weight kicking both stationary and moving ball • Good coordination and timing of movement when kicking moving ball	
Dribble a Basketball	• Uses left hand • Uses right hand • Completes _____ dribbles in a row	
Balance	• Narrow Base of Support for _____ Seconds • Tandem or Semi Tandem Stance _____ Seconds • RIGHT Single leg Stance _____ Seconds • LEFT Single leg Stance _____ Seconds	
Gait Analysis	• HEEL or FOREFOOT contact • Neutral foot positioning • In-toeing or out-toeing • Knee hyperextended at any point in gait cycle • Increased knee flexion/Crouched gait posture • Equal step lengths • Unequal step lengths • Safe Speed with appropriate cadence • Unsafe Speed	

Skill	Observations	Comments
Running Analysis	• Flight phase • Reciprocal arm swing opposing leg movements with elbows bent • No arm swing, 1 arm swing only present, arms extended • Trunk rotation	
Stairs	• Reciprocal Pattern • Step to Pattern • No handrail • One handrail • Two handrails • Catches toe and/or stumbles ___# of times	
Playground Navigation	• Climbed equipment safely • Independently propelled self on swing	
PE Observation	• Actively participated in gym class • Followed multi-step commands	

ASSESSMENT and PLAN: Summary of Screen Findings

What was found to be significant? _____

_____

_____

_____

What do I do next?

- Send a written report to teacher of data collection and next plan of action
  - ◯ Move to a full evaluation
  - ◯ Trial 6 weeks of intervention and then re-assess
  - ◯ Student does not require further testing/interventions

PTS Gross Motor Screen Form

Student:
Date of Birth:
Therapist:
Date of Screen:

Recommendation (Fill out last)

- ☐ Age Appropriate
- ☐ Monitor Performance in class before referring for evaluation
- ☐ Needs Evaluation

Activities	Age Appropriate			Comments
1.Jumping forward: _____inches	Y	N	NA	
2.Jumping rope	Y	N	NA	
3.Standing on one foot:_____sec.	Y	N	NA	
4.Catches tennis ball from_____ft.	Y	N	NA	
5.Catches a small ball from _____ft.	Y	N	NA	
6.Throws tennis ball_____feet at target	Y	N	NA	
7.Throws large ball_____feet at target	Y	N	NA	
8.Skips 25 feet	Y	N	NA	
9.Dribbles basket ball	Y	N	NA	
10.Completes sequence of hopscotch	Y	N	NA	
11.Sit ups_____	Y	N	NA	
12.Jumping Jacks_____	Y	N	NA	
13.Prone Extension ("Superman")_____	Y	N	NA	
14.Stairs_____	Y	N	NA	
15.Playground Access	Y	N	NA	

Strength:

Motor Planning:

Quality of Movement:

Other

PTS GROSS MOTOR SCREEN

STUDENT:_____ DOB: _____

THERAPIST:_____ Date of Re-Screen: _____

	AGE APPROPRIATE		COMMENTS
1. Jumping Forward	**YES**	NO	40 inch-present 49 inch
2. Standing on one foot: right 6 sec, left 6 sec:	**YES**	NO	present-right 10 sec/left 17 sec
3. Catches small ball from 8ft:	**YES**	NO	present 9/10
4. Throws small ball:	**YES**	NO	present 9/10
5. Skips 25 feet:	**YES**	NO	was emerging; now present
6. Hopping: right=32x, left 8 x:	**YES**	NO	present right 33x; left 11x
7. Sit ups: 10/10 arms reaching out:	**YES**	NO	present 7/10
8. Jumping Jacks: 10/10x after demonstration:	**YES**	NO	present 10/10
9. Jump rope 3/3 singles:	**YES**	NO	
10. Jump over 6 inch height object:	**YES**	NO	not landing on 2 feet
11. Dribbles basketball:	**YES**	NO	present right 13x alternating 20x

*(CHILD) was observed to have decreased endurance while performing the above activities. *

Motor Planning: (CHILD) follows 3 step commands, skills have been maintained or slightly improved since (PREVIOUS SCREEN DATE).

Recommendation: At this time, (CHILD) is presenting with areas to develop in mobility/endurance and physical education but is not found to be eligible for special education services and/or does not qualify for evaluation for physical therapy services. Physical Therapy will support (CHILD) in (HIS/HER) regular education classroom through consultation with the teacher, staff education of strategies and accommodations, facilitation of alternative instruction and supplemental practice for (CHILD), specific interventions and strategies and Skills within the classroom for 6-12 weeks to collect data and then reassess if the needs are to extend another 6-12 weeks. The building Physical Therapist is available to answer any questions from the team should they arise.

Age Appropriate intervention/strategy Evaluation

*(NEW DATE)- PT is recommending evaluation at this time based on team discussion, previous screening, observation and support with teachers and team.

PT Sample Screening Write Up

Student:	Therapist Name:
Date of Screen	Review Tools: Observation, teacher input, gross motor screen
School:	

Background:

Student is a grader in __'s classroom. Student was referred for a physical therapy screen due to foot placement and concerns with tripping while ambulating in the halls. Teacher asked if a PT screen could be completed to determine if student has a need for in-school physical therapy services.

Consult:

Teacher's biggest concern was tripping risks for student. Teacher reported that student walks with feet in a mild in-toeing position. Reports that on multiple occasions this gait pattern has resulted in trips in the hallways. Also stated, student has instances of scissoring while walking. Student reports they enjoy playing outside, especially on swings. When asked about the playground, they stated they prefer to run around as opposed to climbing.

Gross Motor Screen:

Student's screen was completed in one session and included assessing gross strength, mobility, and access to school environment. Student demonstrated age-appropriate strength and mobility bilaterally. Regarding ambulation within the school environment, student safely transitioned from classroom to the PT gym and throughout the hallways on an extended walk. Student demonstrated in-toeing of left foot while walking and mild scissoring (legs crossing over one another) on a few occasions. However, student demonstrated a heel strike 100% of the time. Regarding step length, student showed a changing step length across our walk. The step length was dependent on what student was looking at and if any distractions were present. When cued to take either smaller or larger steps student followed 100% of the time. Across all walks and activities performed during the screen, student only had one trip. This trip occurred during single leg hopping when going from a tile floor up to a 1-inch mat height. Student maintained balance and was able to continue hopping following the toe catch. When running, student demonstrated age-appropriate running form with a reciprocal arm swing, flight phase (both feet off the ground), and no observed in-toeing.

Functional activities performed included skipping, galloping, jumping jacks, hopping (single and double limb), as well as strengthening exercises. Student needed demonstrations for skipping, galloping, and jumping jacks. However once shown student demonstrated good performance of all 3 skills and great coordination. Regarding jumping jacks, student performed 10 in a row with simultaneous movement of upper and lower extremities 100% of the time. Hopping showed good lower extremity strength and balance. Student consistently demonstrated a simultaneous takeoff and landing when completing double limb hops. Student was able to jump forward approximately 6-10 inches when performing double limb hops. When completing single leg hops, initially some difficulties were observed. Student was able to hop to 6 targets in a row on both left and right leg with good control and balance. Strengthening exercises included squats, bridges, knee pushups, sit ups, heel raises, and floor to stand transfers.

Student completed 5 squats with good, age-appropriate form. Bridges again showed good form and core strength by completing 10 with little to no need for cuing after initial demonstration. Pushups were the most challenging. Student benefited when cues of “begin on belly push up onto hands” were used and was able to push self up into this position 5 times. Sit ups were completed on a wedge to decrease challenge of skill. Again, student competed 10 reps with no compensations observed. Floor to stand transitions were completed in 2 fashions, the first one being a crab bridge to stand and the second being half-kneel to stand. Student demonstrated no difficulty with either movement and when using half kneel to stand did not need upper extremity support to complete the stand. Balance was also assessed. Student maintained a narrow base of support and tandem (heel-toe) stance for 30 seconds with no postural sway. When standing on right leg student held the position for 15 seconds, and then held the position for 30 seconds on left leg.

Overall, student demonstrates age-appropriate mobility and gross motor skills. Student demonstrated safe hallway navigation and transitions between different positions in both standing and sitting. It is not recommended for further evaluation to be completed at this time.

PHYSICAL THERAPY EARLY INTERVENTION EVALUATION:

Student & Grade:	Date of Birth
Date:	Therapist:

Background:

Teacher/Parent Concerns:

Observations

PHYSICAL THERAPY EARLY INTERVENTION EVALUATION:

Gross Motor Skills:

0= unable to perform 1= emerging skill 2= performing with visual, verbal, tactile prompting 3= age appropriate

Strength	Score	Comments
Prone positioning Superman		
Sit ups		
Bridge		
Jumping forward Up and down		
Stairs		
Transition from floor to stand		
GAIT/ Running		
Balance		
Standing on one		
Tandem standing-one foot in front of another		
Walking a line		
Stepping over obstacles		
Kick ball		
Ball skills: Catches,Throws		
Riding scooter		
Balance beam		
Jumping jacks		
Skip/gallop		
Hopping		

Playground equipment navigation:

Range of motion:

Adaptive Equipment Social-Emotional Behavior

Affect	Appropriate, flat, labile ,withdrawn, reacts well to praise, fearful, friendly, fussy
Concentration	Appropriate, distractible, not focused, responds well to direction
Responds to environment	Poor safety awareness, unaware of objects, unaware of people, brief eye contact, appropriate response to stimuli, aware of objects, aware of people, provides eye contact
Approach to task	Impulsive, disorganized, says "I can't"
Activity level	Appropriate, Hyperactive, Hypoactive
Coping	Cooperative, accepts limits, aggressive, difficulty separating, low frustration tolerance, unable to accept direction, separates easily, friendly, playful
Directions/Cueing	Unable to follow direction Follows verbal direction Follows physical direction Follows visual direction Follows 1 step direction Follows 2 step direction

Statistics

Timed Up & Down Stairs	E: Stopwatch, stairs, measuring tape, tape or other marker S: Student wears shoes but no orthotics. Student stands 12 inches from the bottom of one flight of stairs. Hands at sides D: "When I say go, quickly, but safely, go up the stairs, turn around on the top landing, and come right back down." Timing begins on the word "go" and ends when both feet reach the bottom landing.	Age		Mean pert step	2SD per Steps	*Range for 12 Step	Range for 13steps	Range for 14 steps
		5	190	0.91	.38	6.36-15.48	6.89-16.77	7.42-18.06
		6	244	0.80	.32	5.76-13.44	6.24-14.56	6.72-15.68
		7	217	0.72	.22	6.00-11.28	6.50-12.22	7.00-13.16
		8	196	0.66	.20	5.52-10.32	5.98-11.18	6.44-12.04
		9	200	0.62	.16	5.52-9.33	5.98-10.14	6.44-10.92
		10	177	0.59	.14	5.40-8.76	5.85-9.49	6.34-10.18
		11	95	0.57	.18	4.68-9.00	5.07-9.75	5.46-10.50
		12	105	0.56	.18	4.56-8.88	4.94-9.62	5.32-10.36
		13	43	0.57	.16	4.92-8.76	5.33-9.49	5.74-10.22
		14	11	0.55	.16	4.68-8.52	5.07-9.23	5.46-9.94

Timed Floor to Stand Normal (TFTS-N)9	E: Stopwatch, tape measure, tape or other marker S; Mark floor with 2 lines (using tape) 9 ft. 10 in. apart. Student is seated on floor behind one of the tines in cross-legged position with the front most part of the body touching the line. D: "When I say "go" stand up, walk to the line, turn around, walk back to the starting line, and sit back down, crisscross applesauce" (for 5-8 year olds), or "with your legs crossed" (for 9-17 year olds). "Walk, don't run. 1, 2, 3, GO." Timing begins on the word "go"			Range
		5	183	5.61-12.33
		6	239	5.54-11.54
		7	214	5.32-11.48
		8	195	4.61-11.21
		9	204	5.16-10.76
		10	178	5.26-10.62
		11	99	5.32-
		12		5.69-10.85
		13	12	5.92-11.80
		14	11	5.33-11.21

Thirty-second Walk Test	E: Stopwatch, rolator, 4 cones, tape or other marker S: Demarcate a walking course using tape making sure to round off at the corners (no sharp turns). Mark outside of each corner with a cone. D: "When I say go, walk like a line leader (5-8 year olds) or at a natural and comfortable pace (9-14 years old) until I say freeze, stay within the cones. Walk, don't run." Timing begins on the word "go" and the student stops on the verbal command "freeze." Distance measured to the nearest inch. The student's forward most foot placement is determined by the most advanced part of the foot in contact with the floor (e.g. heel at heel strike, toes at mid stance).			Range ft
		5	136	89.41-170.77
		6	188	99.05-181.13
		7	172	104.97-179.61
		8	151	106.66-192.06
		9	177	114.64-190.32
		10	158	125.75-200.23
		11	78	121.92-196.68
		12	100	113.68-190.00
		13	41	113.91-179.99
			8	119.30-173.06

Timed Up & GO (TUG)8	E: Stopwatch, chair, tape or other marker S: Mark floor with 2 lines (using tape) 9 ft. 10 in. apart. Place armless chair behind one of the lines so that student's toes are touching the line when starting. Student sits with knees and hips bent at 90°. Shoes are on. D: "When I say go, stand up, walk to the line, turn around, walk back to the starting line, and sit back down on the bench. Walk, don't run. 1, 2, 3, GO." Timing begins on the word "go" and ends when the student sits back down.	e	N	SD Range s)
		5	186	4.84-9.32
		6	244	4.44-9.12
		7	221	4.45-9.09
		8	197	4.00-8.68
		9	203	4.20-8.20
		10	180	4.33-8.17
		11	95	4.63-8.27
		12	110	4.86-8.54
		13	45	5.04-9.20
		14	10	4.89-8.85

PHYSICAL THERAPY Evaluation Reference Guide:

Student:	Evaluation Date:
Date of Birth:	School:
Chronological Age:	Grade:

SUBJECTIVE: Background/Medical History/Social Information

Review Student, Contextual, and Environmental Factors:

1. Current and Past Medical History:

- ☐ Heart Conditions
- ☐ Seizures
- ☐ Hearing Deficits
- ☐ Surgery
- ☐ Shortness of Breath
- ☐ Dizziness
- ☐ Muscle Weakness
- ☐ Allergies
- ☐ Neurological Conditions
- ☐ Visual Deficits
- ☐ Skeletal Abnormalities

2. Early Intervention History/Previous Therapies Received/IEP?

3. Social History

4. Communication Needs

5. Mobility Needs

6. Current Outside Services/Therapies

7. Precautions

Referral/Teacher Interview:

1. What functional difficulties is the child/student having?

- ☐ School Bus: getting on or off?
- ☐ Hallways: navigating, carrying items?
- ☐ Classroom:
  - ☐ Moving on the Floor
  - ☐ Positioning For Activities on the Floor, While Seated, and in Standing
  - ☐ Moving in a Wheelchair (If Applicable)
  - ☐ Transferring to/from Chair, Wheelchair, Floor
  - ☐ Walking
- ☐ Restroom:
  - ☐ Transferring to/from Toilet
  - ☐ Moving to/from Changing Table
  - ☐ Accessing Sink, Soap, Towels
- ☐ Cafeteria:
  - ☐ Viewing Food Display
  - ☐ Reaching/Obtaining Food
  - ☐ Carrying Food
  - ☐ Positioning For Eating
  - ☐ Disposing Of Tray/Utensils/Trash

2. Potential factors contributing to these difficulties

_____

_____

_____

_____

_____

3. Student's strengths and interests

_____

_____

_____

_____

_____

PHYSICAL THERAPY Evaluation Reference Guide:

- Posture/Range of Motion/Tone/Strength: The ability of the body to use core strength to maintain and transition between different positions to access their school environment (i.e sitting on the floor, floor to stand transition, sitting at lunch stool). Postural stability is the foundational component to allow for controlled movements with gross motor skills. Range of motion and strength both greatly impact what a student's access to their school environment and their gross motor skill performance. They also play a role in postural stability if contractures are present.
- Gross Motor Skills/Balance/Coordination: The ability to safely maneuver throughout the school environment.

Clinical Observation and Objective Data Collection:
Posture/Positioning:

Position	Posture Observed	Comments
Seated Posture (Upper Extremity)	• Upright, shoulders back, head directly over trunk • Slumped with rounded back, forward head position • Bottom sliding forward on chair • Propped head on hands • Head lying on arm/desk • Chest leaning against desk	
Seated Posture (Lower Extremity)	• Feet planted firmly on floor • Legs wrapped around chair legs • Dangled Legs • Swinging or kicking legs • Right leg underneath bottom • Left leg underneath bottom	
Standing Posture (Upper Extremity)	• Ear over acromion process (shoulder), neutral spinal alignment with appropriate curves of thoracic & lumbar spine • Forward head position, kyphosis of thoracic spine with appropriate lumbar curvature • Sway back observation • Increased lumbar lordosis	
Standing Posture (Lower Extremity)	• Femoral greater trochanter anterior to lateral femoral epicondyle, above lateral malleolus • Hyperextension of knees • Increased flexion of knees • Foot pronation • Foot supination	
Additional Observations from Teacher Interview	• i.e hallway/cafeteria/restroom navigation, getting on/off the bus, opening/closing doors	

- Range of Motion: Do not always need to take exact measures, just observe to see if within normal or functional limits. If significant mobility deficits are present that are impacting access to school environment, then it is a good time to measure since mobility based interventions will be part of your plan of care.

		AROM		PROM	
		Right	Left	Right	Left
Shoulder	Flexion				
	Extension				
	IR				
	ER				
	ABD				
Elbow	Flexion				
	Extension				
	Supination				
	Pronation				
Wrist	Flexion				
	Extension				
Hip	Flexion				
	Extension				
	IR				
	ER				
	Abduction				
Knee	Flexion				
	Extension				
Ankle	Plantarflexion				
	Dorsiflexion (knee ext)				
	Dorsiflexion (knee flex)				

Tone:

	Right	Left
Gastroc/Soleus		
Hamstrings		
Quadriceps		
Hip Adductors		

Functional Strength:

Movement	Comments
Comments	
Supine to Sit	
Floor to Stand	
Half Kneel to Stand	
Squat	
Sit Ups	
Bridge	
Plank	

Functional Strength/Endurance Standardized Outcome Measures:

30 Second Walk Test

- Need: Timer, 4 cones, tape or marker
- Demarcate a walking course using tape making sure to round off at the corners (no sharp turns). Mark outside of each corner with a cone.
- "When I say go, walk like a line leader or at a natural and comfortable pace until I say freeze, stay within the cones. Walk, don't run."
- Timing begins on the word "go" and the student stops on the verbal command "freeze."
- Distance measured to the nearest inch. The student's forward most foot placement is determined by the most advanced part of the foot in contact with the floor (e.g. heel at heel strike, toes at midstance).

Age	N	Range (ft)
5	136	89.41-170.77
6	188	99.05-181.13
7	172	104.97-179.61
8	151	106.66-192.06
9	177	114.64-190.32
10	158	125.75-200.23
11	78	121.92-196.68
12	100	113.68-190.00
13	41	113.91-179.99
14	8	119.30-173.06

6 Minute Walk Test

- Need: Timer, tape or marker
- Mark a walking course in large open space (gym, hallway) with tape and place a cone at start and end point of each lap
- At "go" student walks as fast as possible (without running) for 6 minutes.
- Therapist can provide verbal encouragement every 30 seconds. At the end of 6 minutes, measure laps completed & convert it to distance walked

From Lammers, et al (UK)

Age	N	Distance (ft)
4	36	987-1527
5	40	1122-1634
6	40	1257-1781

From Klepper, et al (NYC)

Age	N	Distance (ft)
7-8	28	1308-2151
9	27	1218-2271
10	35	1193-2069
11	8	1191-2311

Timed Up and Go (TUG)

- Need: Timer, chair, tape or marker
- Mark floor with 2 lines (using tape) 9 ft. 10 in. apart.
- Place armless chair behind one of the lines so that student's toes are touching the line when starting. Student sits with knees and hips bent at 90°. Shoes are on.
- "When I say go, stand up, walk to the line, turn around, walk back to the starting line, and sit back down on the bench. Walk, don't run. 1, 2, 3, GO."
- Timing begins on the word "go" and ends when the student sits back down.

Age	N	SD Range (s)
5	186	4.84-9.32
6	244	4.44-9.12
7	221	4.45-9.09
8	197	4.00-8.68
9	203	4.20-8.20
10	180	4.33-8.17
11	95	4.63-8.27
12	110	4.86-8.54
13	45	5.04-9.20
14	10	4.89-8.85

Timed Up and Down the Stairs (TUDS)

- Need: Timer, stairs - Student wears shoes but no orthotics. Student stands 12 inches from the bottom of one flight of stairs. Hands at sides. **If orthotics need to be worn for safety, note that in data collection.
- When I say go, quickly, but safely, go up the stairs, turn around on the top landing, and come right back down."

Age	N	Mean per step (s)	2SD per step (s)	Range for 12 steps (s)	Range for 13 steps (s)	Range for 14 steps(s)
5	190	0.91	.38	6.36-15.48	6.89-16.77	7.42-18.06
6	244	0.80	.32	5.76-13.44	6.24-14.56	6.72-15.68
7	217	0.72	.22	6.00-11.28	6.50-12.22	7.00-13.16
8	196	0.66	.20	5.52-10.32	5.98-11.18	6.44-12.04
9	200	0.62	.16	5.52-9.33	5.98-10.14	6.44-10.92
10	177	0.59	.14	5.40-8.76	5.85-9.49	6.34-10.18
11	95	0.57	.18	4.68-9.00	5.07-9.75	5.46-10.50
12	105	0.56	.18	4.56-8.88	4.94-9.62	5.32-10.36
13	43	0.57	.16	4.92-8.76	5.33-9.49	5.74-10.22
14	11	0.55	.16	4.68-8.52	5.07-9.23	5.46-9.94

- Timing begins on the word "go" and ends when both feet reach the bottom landing.

Shuttle Run

- Need: Timer, tape measure, tape, 2 cones, 2 blocks
- Mark off 30 ft. with 2 pieces of tape & cones; place 2 blocks just behind the line opposite the starting line
- When I say 'go', run, pick up a block, run back, put the block behind the starting line, then run, pick up the second block, and run back and put it behind the starting line. Don't throw the blocks."
- Timing begins with the word "go" and ends when the second block is placed behind the line.

Age	Male		Female	
	N	Range (s)	N	Range (s)
5	73	12.86-21.30	98	14.02-21.78
6	116	12.35-19.35	109	13.86-20.18
7	84	11.82-19.42	112	12.68-20.57
8	83	11.32-16.92	76	11.81-18.85
9	69	10.88-16.84	120	11.65-17.73
10	64	10.49-16.17	100	11.39-17.35
11	39	9.81-15.77	39	11.36-17.32
12	23	10.19-14.35	42	11.16-17.88
13	9	11.17-15.57	23	11.21-17.41

5 Times Sit to Stand (5x STS)

- Need: Armless chair
- Set up rope at the level of student's body height. Student sits with hip flexed 90 deg. & knee flexed 105 deg.
- "Fold your arms across the chest. Stand up and sit down as quickly as possible for 5 times. The test will be finished when you return to seated position the 5th time. Continue sit-to-stand movement till I ask you to stop. If you try but cannot stand up, just let me know.
- Ready, go!" Time starts with trunk-initiated flexion. Time stops when the buttocks touch the seat for the 5th time.

OBJECTIVE: Gross Motor Evaluations

Clinical Observation and Objective Data Collection:

Gross Motor Skills:

Position	Posture Observed	Comments
Gait Analysis	• HEEL or FOREFOOT contact • Neutral foot positioning • In-toeing or out-toeing • Knee hyperextended at any point in gait cycle • Increased knee flexion/Crouched gait posture • Equal step lengths • Unequal step lengths • Safe Speed with appropriate cadence • Unsafe Speed • Aware of surroundings while ambulating • Bumping/crashing into obstacles, walls,	
Running Analysis	• Flight phase • Reciprocal arm swing opposing leg movements with elbows bent • No arm swing, 1 arm swing only present, arms extended • Trunk rotation	
Stairs	• RECIPROCAL or STEP TO Pattern • No handrail • ONE or TWO handrail(s) • SAFE or UNSAFE speed	
Broad (Long) Jump	• Arm swing to propel forward • Knees bend • Simultaneous foot take-off and landing • One foot takes off/lands before the other	
Single Leg Hop	• Hop for ____ number of times on each leg	
Gallop	• Smooth movement pattern • Able to complete leading with either leg	
Skip	• Smooth movement • Able to complete leading with either leg	
Throwing/Catching a Ball	• Use different size and shaped balls (i.e tennis ball, basketball) • Throwing accuracy • Reciprocal step prior to throws	
Kicking Stationary and Moving Ball		

Playground Navigation		
Balance	• Narrow Base of Support • Tandem/Semi-Tandem Stance • Single Leg Stance • Tandem walk	
Coordination	• Jumping jacks • Scissor jumps • Hopscotch • Hand to Opposite Foot • Elbow to Opposite Knee	
Overall Safety Awareness	• Safe gait speed • Safely navigates around obstacles, through crowds • Safely transitions between classrooms, stairs	

Gross Motor Standardized Outcome Measures

- Choose which outcome measure you feel is most appropriate for your student (by age, diagnosis, or functional level) to compare their current gross motor skills to age-appropriate normative values.

Test of Gross Motor Development – 2nd Edition (TGMD -2)

- Age: 3-10 years
- Purpose: The TGMD-2 is composed of two subtests that measure gross motor abilities that develop early in life.
- Assessment Results: Table format.

	Locomotor	**Object Control**
Standard Score		
Percentile		
Gross Motor Quotient		
Descriptor		

- Assessment Results: Summary format.

Bruininks Oseretsky Test of Motor Proficiency (BOT-2)

- Age: 4-21 years old
- Purpose: to assess gross and fine motor skills
- The Body Coordination composite sections uses goal directed activities that involve bilateral coordination and balance abilities. The Strength and Agility composite section looks at running speed, agility, and strength. The student will perform several activities within each category to receive a standardized score based on age and gender.
  - Subtest 4: Bilateral Coordination
  - Subtest 5: Balance
  - Subtest 6: Running Speed and Agility
  - Subtest 8: Strength
  - ****Subtest 7: Upper-Limb Coordination – will usually complete as PT as opposed to OT
- Assessment Results: Table format.

	Raw Score	**Scale Score**	**Standard Score**	**Percentile**	**Age Equivalence**	**Descriptive Category**
7) Upper Limb Coordination						
(4) Bilateral Coordination						
(5) Balance						
(6) Running Speed & Agility						
(8) Strength						

- Assessment Results: Summary format.

The Peabody Developmental Motor Scale – 2 (PDMS-2)

- Age: 0-6 year, 11 months
- Purpose: To assess a student's gross motor development. There are (3) subtests that compose the gross motor part of this assessment STATIONARY, LOCOMOTION, and OBJECT MANIPULATION. The STATIONARY subtest measures a child's ability to control their body within their center of gravity and maintain equilibrium. The LOCOMOTION subtest measures a child's ability to move from one place to another via crawling, walking, running, hopping, and jumping forward. The LOCOMOTION subtest measures a child's ability to manipulate balls through catching, throwing, and kicking.
- Assessment Results: Table format.

	Raw Score	**Age Equivalence**	**Standard Score**	**Quotients**	**Percentile**
Stationary					
Locomotion					
Object Manipulation					

- Assessment Results: Summary format.

Gross Motor Function Measure – 66 (GMFM-66)

- Age: 0-12 years
- Purpose: Observational clinical measure to evaluate gross motor function in children with Cerebral Palsy ONLY
- Assessment Results: Table format.
- Assessment Results: Summary format

Dimension	Percentage Score
Lying & Rolling	
Sitting	
Crawling & Kneeling	
Standing	
Walking, Running, Jumping	
Total Score Percentage	
Goal Total Score Percentage	

Pediatric Balance Scale

- Age: 4-14 years
- 14 item test with specific procedures and scoring.
  - Similar to the Berg Balance Test for Adults
- Standard norms for age ranges to the right
- Copy of test is attached in additional documents with proceduresand scoring sheets
- Assessment Results: Summary format.

Age	N	Score
4.0-4.5	52	37.98-56
4.6-4.11	82	41.06-56
5.0-5.5	99	48.96-56
5.6-5.11	58	46.9-56
6.0-6.5	67	48.82-56
6.6-6.11	41	50.62-56
7.0 & 13.7	123	51.72-56

Summary of Gross Motor Skills Related to Student's School Performance:

- Report on findings from specific gross motor tasks, as well as their scores and table from the standardized outcome measure chosen.

ASSESSMENT and PLAN: Summary of Findings

What was found to be significant? What does the testing represent?

Relate standard scores to function in the school setting

RECOMMENDATIONS: A review of this evaluation report will be discussed with the IEP team in conjunction with other assessments/evaluations, data, and team observations to determine eligibility of services.

- Suggested recommendations for service may include RELATED SERVICES FREQUENCY, whether it's individual, group or consult for this type of service delivery.
- If the student does not need continued therapy services, please mention that no school-based physical therapy needs have been identified at this time.

Per the direction of the district, you may be asked to provide suggestions in the following areas on the evaluation report:

Suggested Educational Strengths and Learning Needs:

- Strengths: List PT specific strengths
- Needs: List PT specific needs as they pertain to student's ability to access their educational environment For every need, there must be an SDI or Goal

Suggested Goals:

- Measurable Annual Goal: Student's name, a behavior that the child is to exhibit, a description of the condition under which the child it to perform that behavior (situation, setting or type of material used) and the criteria by which mastery of that behavior will be measured and determined to measure the goal.
- Baseline performance: enter student's current level of function from present levels, for this goal
- Describe HOW the student's progress toward meeting this goal will be measured: Functional skill probes, rubric, checklist, writing samples, etc.
- Describe WHEN periodic reports on progress will be provided to parents: report card

Suggested Specially Designed Instruction (SDI):

Describe the type of replacement instruction, adaptation and modifications the child needs and will receive.

Each item of specifically designed instruction must be:

- Based on individual needs of the student.
- Be specific as to strategy
- Be generic regarding brand manes of programs
- And identify either a specific time and duration of each item, a specific condition to each item or a specific purpose for the item.
- Be reasonable, clear and practical suggested strategies.

Therapist Name, Title

DATE

PTS Tests and Measures

To clarify, these are not specific virtual evaluation tests, but they are tests that could be used to collect data and the evaluator would need to qualify that they were used in a non-standardized protocol due to COVID."

<table>
<tr>
<td>Timed Up & Down Stairs (TUDS)</td>
<td>E: Stopwatch, stairs (14 steps)
S: Student wears shoes but no orthotics. Student stands 1 foot from bottom of one flight of stairs (within 14 steps).
D:Instruct child to "Quickly, but safely go up the stairs, turn around of the top step (landing) & coming all the way down until both feet land on the bottom step (landing)."</td>
<td>8.1 sec (range 6.3 - 12.6 sec), age 8-14 y/o (N=27) or 0.58 sec per step</td>
</tr>
<tr>
<td>Timed Up & Go (Tug)</td>
<td>E: Stopwatch, chair tape or other marker
S: Student is barefoot; sits with knees & hips bent 90 degrees.
D: On "go" student stands up, walks 3 meters (9ft 10in) to a designated mark, turns around, walks back and sits on the chair.</td>
<td>5.2 sec (rang 4.4-6.7 sec), 8-14 y/o (N=27)- similar to that found in a study with larger sample (N=180) from Pakistan</td>
</tr>
<tr>
<td>Timed Floor to Stand</td>
<td>E: Stopwatch, tape measure, tape, or other marker
S: Student seated on floor in a cross-legged position.
D: Student is asked to get up from floor, walk as quickly as possible for 3 meters (9ft 10in), turn around, walk back to starting line, & sit back down on the floor in cross-legged position.</td>
<td>6.6 sec (range 4.4-12.1 sec), age 5-22 y/o (N=150)
<table>
<tr><th>Age</th><th>Mean (sec)</th><th>SD</th></tr>
<tr><td>5-6</td><td>7.5</td><td>1.5</td></tr>
<tr><td>7-8</td><td>6.4</td><td>1.1</td></tr>
<tr><td>9-10</td><td>6.4</td><td>0.7</td></tr>
<tr><td>11-12</td><td>6.3</td><td>1.2</td></tr>
<tr><td>13-16</td><td>6.6</td><td>1.0</td></tr>
<tr><td>17-21</td><td>6.6</td><td>1.0</td></tr>
</table>
</td>
</tr>
<tr>
<td>Thirty Second Walk Test</td>
<td>E: Tape measure, tape, or other marker
S: Demarcate a walking course using tape making sure to round off at the corners (-no sharp turns).
D: Instruct student to walk as if they are line leaders (walk not run), beginning when told & stopping when instructed (30 sec.). Measure the distance walked to the nearest inch. The student's forwardmost foot placement is determined by the most advanced part of the food in contact with the floor (e.g. heel at heel strike, toes at midstance).</td>
<td>(N=302)
<table>
<tr><th>Age</th><th>Mean (ft)</th><th>SD</th></tr>
<tr><td>5</td><td>135.3</td><td>11.6</td></tr>
<tr><td>6</td><td>140.5</td><td>23.5</td></tr>
<tr><td>7</td><td>152.9</td><td>16.8</td></tr>
<tr><td>8</td><td>158.2</td><td>17.2</td></tr>
<tr><td>9</td><td>162.6</td><td>20.0</td></tr>
<tr><td>10</td><td>164.6</td><td>17.9</td></tr>
<tr><td>11</td><td>156.3</td><td>17.8</td></tr>
<tr><td>12</td><td>159.7</td><td>18.0</td></tr>
<tr><td>13</td><td>155.2</td><td>16.6</td></tr>
<tr><td>14</td><td>151.5</td><td>20.5</td></tr>
<tr><td>15</td><td>146.4</td><td>23.0</td></tr>
<tr><td>16</td><td>138.5</td><td>17.0</td></tr>
<tr><td>17</td><td>135.8</td><td>20.9</td></tr>
</table>
</td>
</tr>
<tr>
<td>6- Minute Walk Test</td>
<td>E: Tape measure, tape, or other marker
S: Mark a walking course in a large open space (gym, large corridor) with tape, & place a cone or other marker at the starting point of each lap.
D: At "go" student walks as fast as possible (without running) for 6 minutes. The therapist can provide verbal encouragement every 30 seconds. At the end of 6 minutes, measure laps completed & convert it to distance walked.</td>
<td>(N=328)
<table>
<tr><th>Age</th><th>Distance (m)</th><th>Distance (ft)</th></tr>
<tr><td>4</td><td>383+/-41</td><td>1257+/-135</td></tr>
<tr><td>5</td><td>420+/-39</td><td>1378+/-128</td></tr>
<tr><td>6</td><td>463+/-40</td><td>1519+/-131</td></tr>
<tr><td>7</td><td>488+/-35</td><td>1601+/-115</td></tr>
<tr><td>8</td><td>483+/-40</td><td>1585+/-131</td></tr>
<tr><td>9</td><td>496+/-53</td><td>1627+/-174</td></tr>
<tr><td>10</td><td>506+/-45</td><td>1660+/-148</td></tr>
<tr><td>11</td><td>512+/-41</td><td>1680+/-135</td></tr>
</table>
</td>
</tr>
</table>

References:

1. Timed Up and Down Stairs Test: Preliminary Reliability and Validity of a New Measure of Functional Mobility. Zaino, Christopher A.; Marchese, Victoria Gocha; Westcott, Sarah L. Pediatric Physical Therapy. 16 (2):90-98, Summer 2004.
2. Assessment of balance ability in Pakistani children: a cultural perspective. Habib Z, Westcott S, Valvano J. Pediatr Phys Ther. 1999; 73-82.
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4. Standard Task Measurement for Mobility: Thirty-Second Walk Test. Knutson, Loretta M.; Schimmel, Patricia Ann; Ruff, Andrew; Pediatric Physical Therapy. 11(4): 183-190, Winter 1999.
5. Age Expansion of the Thirty- Second Walk Test Norms for Children. Knutson, Loretta M.; Busman, Barbara; Young, Janice Clark; Ward, Gary; Pediatric Physical Therapy. 21(3):235-243, Fall 2009.
6. The 6- minute walk test: normal values for children of 4-11 years of age, Lammers AE, Hislop AA, Flynn Y, Haworth SG, Archive of Childhood Diseases, August 2007.

PTS Tests and Measures

To clarify, these are not specific virtual evaluation tests, but they are tests that could be used to collect data and the evaluator would need to qualify that they were used in a non-standardized protocol due to COVID."

Modified Energy Expenditure Index (Modified EEI)

E: HR monitor, tape or other marker
S: Student wears a HR monitor.
D: 1. Student walks at a comfortable self-designated pace on a level pre-marked 50m (164 ft.) lap course, HR & distance completed are recorded at the end of 3 min. (This is called the Working HR: WHR.)
2. Student walks at a fast self-designated pace on a level pre-marked 50m (164ft.) lap course. HR & distance completed are recorded at the end of 3 mins. (This is called Working HR: WHR.)
Modified EEI = WHR / Distance (in meters) / 3 min.

(N=150)

Age	Comfortable Walk	Fast Walk
5-6	(1.86 (+/- 0.19)	(1.65 (+/- 0.13)
7-8	(1.73 (+/- 0.25)	(1.56 (+/- 0.15)
9-10	(1.60(+/- 0.23)	(1.54 (+/- 0.18)
11-12	(1.46(+/- 0.19)	(1.40 (+/- 0.15)
13-16	(1.52(+/- 0.24)	(1.35 (+/- 0.19)
>16	(1.56(+/- 0.32)	(1.40 (+/- 0.23)

Pediatric Reach Test (PRT)

E: Tape measure, paper, tape
S: Student stands barefoot on a piece of paper that is taped to the floor. Tester traces student's feet on the piece of paper. One end of the tape measure is secured to student's finders while evaluator holds the other end. Record initial reading from tape.
D: Student reaches one arm forward. Student is allowed to use whatever strategy he/she wishes as long as he/she does not touch the wall or take a step. Record final reading. Calculate final reading minus initial reading.

By Age (N=116)

Age	Mean Reach (cm)	Critical Reach (-2SD)
5-6	21.17	16.79
7-8	24.21	20.57
9-10	27.97	25.56
11-12	32.79	29.68
13-15	32.30	29.58

By Height (N=80) 7-16 y/o

Height (cm)	Mean (cm)	+/- SD
<130.2	23.07	4.34
130.2-148	30.66	4.45
148.1-168.5	33.61	5.18
>168.5	37.90	7.01

Pediatric Balance Scale (PBS)

E,S & D: The PBS is a 14- item test. Procedures & scoring for the PBS are very specific; see procedures & scoring sheets.

(N=634)

Age	Mean	+/-SD
4.0-4.5	49.5	5.76
4.6-4.11	51.2	5.07
5.0-5.5	54.0	2.52
5.6-5.11	53.3	3.20
6.0-6.5	53.8	2.49
6.6-6.11	54.4	1.89
7.0 & 13.7	55.2	1.74

Shuttle Run

E: Stopwatch, tape measure, tape, 2 cones, 2 blocks
S: Mark off 30 ft. with 2 pieces of tape & cones; place 2 blocks just behind the line opposite to the starting line.
D: At "go" student runs from starting line to the opposite line, picks up block, runs backwards to the starting line, placing the block behind the line. The student repeats this for the 2nd block. Measure time to complete task.

12.6 sec (range 9.0-16.7 sec.),age 5-22 years. (N=150)

Age	Mean (seconds)	+/- SD
5-6	15.1	1.1
7-8	13.0	1.0
9-10	12.4	0.9
11-12	11.5	0.8
13-16	11.7	1.2
17-21	11.3	1.2

References:
1. Timed Up and Down Stairs Test: Preliminary Reliability and Validity of a New Measure of Functional Mobility. Zaino, Christopher A.; Marchese, Victoria Gocha; Westcott, Sarah L. Pediatric Physical Therapy. 16 (2):90-98, Summer 2004.
2. Assessment of balance ability in Pakistani children: a cultural perspective. Habib Z, Westcott S, Valvano J. Pediatr Phys Ther. 1999; 73-82.
3. A physical performance measure for individuals with mucopolysaccharidosis type I, Developmental Medicine and Child Neurology, 2006, Haley et al, 576-581.
4. Standard Task Measurement for Mobility: Thirty-Second Walk Test. Knutson, Loretta M.; Schimmel, Patricia Ann; Ruff, Andrew; Pediatric Physical Therapy. 11(4): 183-190, Winter 1999.
5. Age Expansion of the Thirty- Second Walk Test Norms for Children. Knutson, Loretta M.; Busman, Barbara; Young, Janice Clark; Ward, Gary; Pediatric Physical Therapy. 21(3):235-243, Fall 2009.
6. The 6- minute walk test: normal values for children of 4-11 years of age, Lammers AE, Hislop AA, Flynn Y, Haworth SG, Archive of Childhood Diseases, August 2007.

PEDIATRIC BALANCE SCALE

Student:	Date:
Location	Examiner:

Item Description	Score 0-4	Seconds -optional
1. Sitting to standing		
2. Standing to sitting		
3. Transfers		
4. Standing unsupported		
5. Sitting unsupported		
6. Standing with eyes closed		
7. Standing with feet together		
8. Standing with one foot in front		
9. Standing on one foot		
10. Turning 360 degrees		
11. Turning to look behind		
12. Retrieving object from floor		
13. Placing alternate foot on stool		
14. Reaching forward with outstretched arm		
Total Test Score		

General Instructions

1. Demonstrate each task and give instructions as written. A child may receive a practice trial on each item. If the child is unable to complete the task based on their ability to understand the directions, a second practice trial may be given. Verbal and visual directions may be clarified through the use of physical prompts.

2.Each item should be scored utilizing the 0 to 4 scale. Multiple trials are allowed on many of the items. The child's performance should be scored based upon the lowest criteria, which describes the child's best performance. If on the first trial a child receives the maximal score of 4, additional trials need not be administered. Several items require the child to maintain a given position for a specific time. Progressively, more points are deducted if the time or distance requirements are not met; if the subject's performance warrants supervision; or if the subject touches an external support or receives assistance from the examiner. Subjects should understand that they must maintain their balance while attempting the tasks. The choice, of which leg stand on or how far to reach, is left to the subject. Poor judgement will adversely influence the performance and the scoring. In addition to scoring items 4, 5, 6, 7, 8, 9, 1 0, and 13, the examiner may choose to record the exact time in seconds.

Equipment

The Pediatric Balance Scale was designed to require minimal use of specialized equipment. The following is a complete list of items required for administration of this tool:

- adjustable height bench
- chair with back support and arm rests stopwatch or watch with a second hand masking tape - 1 inch wide
- a step stool 6 inches in height chalkboard eraser
- ruler or yardstick
- a small level

The following items are optional and may be helpful during test administration:

- 2 child-size footprints
- blindfold
- a brightly colored object of at least two inches in size flash cards
- 2 inches of adhesive-backed hook Velcro
- Two 1 foot strips of loop Velcro

Sitting To Standing

***** Special instruction: Items #1 .and #2 may be tested simultaneously if, in the determination of the examiner, it will facilitate the best performance of the child.
INSTRUCTIONS: Child is asked to "Hold arms up and stand up." The child is allowed to select the position of his/her arms.
EQUIPMENT: A bench of appropriate height to allow the child's feet to rest supported on the floor with the hips and knees maintained in 90 degrees of flexion.

Best Of Three Trials

4	able to stand without using hands and stabilize independently
3	able to stand independently using hands
2	able to stand using hands after several tries
1	needs minimal assist to stand or to stabilize
0	needs moderate or maximal assist to stand

Standing To Sitting

*****Special instruction: Items #1 and #2 may be tested simultaneously if, in the determination of the examiner, it will facilitate the best performance of the child.
INSTRUCTIONS: Child is asked to sit down slowly, without use of hands. The child is allowed to select the position of his/her arms.
EQUIPMENT: A bench of appropriate height to allow the child's feet to rest supported on the floor with the hips and knees maintained in 90 degrees of flexion.
Best Of Three Trials

4	sits safely with minimal use of hands
3	controls descent by using hands
2	uses back of legs against chair to control descent
1	sits independently, but has uncontrolled descent
0	needs assistance to sit

Transfers

INSTRUCTIONS: Arrange chair(s) for a stand pivot transfer, touching at a forty-five degree angle. Ask the child to transfer one way toward a seat with armrests and one way toward a seat without armrests.

Equipment: Two chairs, or one chair and one bench. One seating surface must have armrests. One chair/bench should be of standard adult size and the other should be of an appropriate height to allow the child to conformably sit with feet supported on the floor and ninety degrees of hip and knee flexion.

Best Of Three Trials

4	able to transfer safely with minor use of hands
3	able to transfer safely; definite need of hands
2	able to transfer with verbal cueing and/or supervision (spotting)
1	needs one person to assist
0	needs two people to assist or supervise (close guard) to be safe

Standing Unsupported

INSTRUCTIONS: The child is asked to stand for 30 SECONDS without holding on or moving his/her feet. A taped line or footprints may be placed on the floor to help the child maintain a stationary foot position. The child may be engaged in non-stressful conversation to maintain attention span for thirty seconds. Weight shifting and equilibrium responses in feet are acceptable; movement of the foot in space {off the support surface) indicates end of the timed trial.

EQUIPMENT: a stop watch or watch with a second hand a twelve inch long masking tape line or two footprints placed shoulder width apart

Best Of Three Trials

4	able to stand safely 30 SECONDS
3	able to stand 30 SECONDS with supervision (spotting)
2	able to stand 15 SECONDS unsupported
1	needs several tries to stand 10 SE CON OS unsupported
0	unable to stand 10 SECONDS unassisted

_____Time in seconds

Sitting With Back Unsupported And Feet Supported On The Floor

INSTRUCTIONS: Please sit with arms folded on your chest for 30 SECONDS. Child may be engaged in non-stressful conversation to maintain attention span for thirty seconds. Time should be stopped if protectiveieactions are observed in trunk or upper extremities.

EQUIPMENT: stop watch or watch with a second hand a bench of appropriate height to allow the feet to rest supported on the floor with the hips and knees maintained in ninety degrees of flexion.

4	able to sit safely and securely 30 SECONDS
3	able to sit 30 SECONDS under supervision (spotting) or may require definite use of upper extremities to maintain sitting position
2	able to sit 15 SECONDS
1	able to sit 10 SECONDS
0	unable to sit 10 SECONDS without support

_____Time in seconds

Standing Unsupported With Eyes Closed

INSTRUCTIONS: The child is asked to stand still with feet shoulder width apart and close his/her eyes for ten seconds. Direction: "When I say close your eyes, I want you to stand still, close your eyes, and keep them closed until I say open." If necessary, a blindfold may be used. Weight shifting and equilibrium responses in the feet are acceptable; movement of the foot in space (off the support surface) indicates end of timed trial. A taped line or footprints may be placed on the floor to help the child maintain a stationary foot position.
EQUIPMENT: a stop watch or watch with a second hand a twelve-inch long masking tape line or two footprints placed shoulder width apart blindfold

Best Of Three Trials

4	able to stand 10 seconds safely
3	able to stand 10 seconds with supervision (spotting)
2	able to stand 3 seconds
1	unable to keep eyes closed 3 seconds but stays steady
0	needs help to keep from falling

_____Time in seconds

Standing Unsupported With Feet Together

INSTRUCTIONS: The child is asked to place his/her feet together and stand still without holding on. The child may be engaged in non-stressful conversation to maintain attention span for thirty seconds. Weight shifting and equilibrium responses in feet are acceptable; movement of the foot in space (off the support surface) indicates end of timed trial. A taped line or footprints may be placed on the floor to help the child maintain stationary foot position.
EQUIPMENT: stop watch or watch with a second hand a twelve inch long masking tape line or two footprints placed together

4	able to place feet together independently and stand 30 seconds safely
3	able to place feet together independently and stand for 30 seconds with supervision (spotting)
2	able to place feet together independently but unable to hold for 30 seconds
1	needs help to attain position but able to stand 30 seconds with feet together
0	needs help to attain position and/or unable to hold for 30 seconds

_____Time in seconds

Standing Unsupported One Foot In Front

INSTRUCTIONS: The child is asked to stand with one foot in front of the other, heel to toe. If the child cannot place feet in a tandem position (directly in front), they should be asked to step forward far enough to allow the heel of one foot to be placed ahead of the toes of the stationary foot. A taped line and/or footprints may be placed on the floor to help the child maintain a stationary foot position. In addition to a visual demonstration, a single physical prompt (assistance with placement) may be given. The child may be engaged in non-stressful conversation to maintain his/her attention span for 30 seconds. Weight shifting and/or equilibrium reactions in the feet are acceptable. Timed trials should be stopped if either foot moves in space (leaves the support surface) and/or upper extremities support is utilized.

EQUIPMENT: a stop watch or watch with a second hand, a twelve inch long masking tape line or two footprints placed heel to toe

Best Of Three Trials

4	able to place feet tandem independently and hold 30 seconds
3	able to place foot ahead of other independently and hold 30 seconds. Note: The length of the step must exceed the length of the stationary foot and the width of the stance should approximate the subject's normal stride width.
2	able to take small step independently and hold 30 seconds, or required assistance to place foot in front, but can stand for 30 seconds.
1	needs help to step, but can hold 15 seconds
0	loses balanpe while stepping or standing

_____Time in seconds

Standing On One Leg

INSTRUCTIONS: The child is asked to stand on one leg for as long as he/she is able to without holding on. If necessary the child can be instructed to maintain his/her arms (hands) on his/her hips (waist). A taped line or footprints may be placed on the floor to help the child maintain a stationary foot position. Weight shifting and/or equilibrium reactions in the feet are acceptable. Timed trials should be stopped if the weight-bearing foot moves in space (leaves the support surface), the up limb touches the opposite leg or the support surface and/or upper extremities are utilized for support.

EQUIPMENT: stop watch or watch with a second hand, a twelve inch long masking tape line or two footprints placed heel to toe

3 Trials Average Score

4	able to lift leg independently and hold 10 seconds
3	able to lift leg independently and hold 5 to 9 seconds
2	able to lift leg independently and hold 3 to 4 seconds
1	tries to lift leg; unable to hold 3 seconds but remains standing
0	unable to try or needs assist to prevent fall

Turn 360 Degrees

INSTRUCTIONS: The child is asked to turn completely around in a full circle, STOP, and then turn a full circle in the other direction.

EQUIPMENT: A stop watch or watch with a second hand

4	able to turn 360 degrees safely in 4 seconds or less each way (total of less than eight seconds)
3	able to turn 360 degrees safely in one direction only in 4 seconds or less
2	completes turn in other direction requires more than four seconds able to turn 360 degrees safely but slowly
1	needs close supervision (spotting) or constant verbal cueing
0	needs assistance while turning

_____ Time in seconds

Turning To Look Behind Left & Right Shoulders While Standing Still

INSTRUCTIONS: The child is asked to stand with his/her feet still, fixed in one place. "Follow this object as I move it. Keep watching it as I move it, but don't move your feet."

EQUIPMENT: a brightly colored object of at least two inches in size, or flash cards, a twelve inch long masking tape line or two footprints placed shoulder width apart

4	looks behind/over each shoulder; weight shifts include trunk rotation
3	looks behind/over one shoulder with trunk rotation; weight shift in the opposite direction is to the level of the shoulder; no trunk rotation
2	turns head to look to level of shoulder; no trunk rotation
1	needs supervision (spotting) when turning; the chin moves greater than half the ·distance to the shoulder needs assist to keep from losing balance or falling;
0	movement of the chin is less than half the distance to the shoulder

Pick Up Object From The Floor From A Standing Position

INSTRUCTIONS: The child is asked to pick up a chalkboard eraser placed approximately the length of his/her foot in front of his/her dominant foot. In children, where dominance is not clear, ask the child which hand they want to use and place the object in front of that foot.

EQUIPMENT: a chalkboard eraser, a taped line or footprints

4	able to pick up an eraser safetly and easily
3	able to pick up eraser but needs supervision (spotting)
2	unable to pick up eraser but reaches 1 to 2 nches from eraser and keeps balance independently
1	unable to pick up eraser; needs supervision (spotting) while attempting
0	unable to try, needs assist to keep from losing balance or falling

Placing Alternate Foot On Step Stool While Standing Unsupported

INSTRUCTIONS: The child is asked to place each foot alternately on the step stool and to continue until each foot has touched the step/stool four times.
EQUIPMENT: a step/stool of four inches in height, a stop watch or watch with a second hand.

4	stands independently and safely and completes 8 steps in 20 seconds able to stand independently and
3	complete 8 steps >20 seconds
2	able to complete 4 steps without assistance, but requires close supervision (spotting)
1	able to complete 2 steps; needs minimal assistance
0	needs assistance to maintain balance or keep from falling, unable to try

_____ Time in seconds

Reaching Forward With Outstretched Arm While Standing

General Instruction And Set Up: A yardstick affixed to a wall via Velcro strips will be used as the measuring tool. A taped line and/or footprints are used to maintain a stationary foot position. The child will be asked to reach as far forward without falling, and without stepping over the line. The MCP joint of the child's fisted hand will be used as the anatomical reference point for measurements. Assistance may be given to initially position the child's arm at 90 degrees. Support may not be provided during the reaching process. If 90 degrees of shoulder flexion cannot be obtained, then this item should be omitted.
INSTRUCTIONS: The child is asked to lift his/her arm up like this. "Stretch out your fingers, make a fist, and reach forward as far as you can without moving your feet."
EQUIPMENT: a yardstick or ruler, a taped line or footprints a level

4	can reach forward confidently > 1 O inches
3	can reach forward >5 inches, safely
2	can reach forward >2 inches, safely
1	reaches forward but needs supervision (spotting)
0	loses balance while trying, requires external support

_____ Total Test Score

Maximum Score = 56

The Berg Balance Scale and the Pediatric Balance Scale

Berg's Balance Scale Items

1. Sitting to standing
2. Standing unsupported
3. Sitting unsupported
4. Standing to sitting
5. Transfers
6. Standing with eyes closed
7. Standing with feet together
8. Reading forward with outstretched arm
9. Retrieving object from floor
10. Turning to look behind
11. Turning 360 degrees
12. Placing alternate foot on stool
13. Standing with one foot in front
14. Standing on one foot

Pediatric Balance Scale Items

1. Sitting to standing
2. Standing to sitting
3. Transfers
4. Standing unsupported
5. Sitting unsupported
6. Standing with eyes closed
7. Standing with feet together
8. Standing with one foot in front
9. Standing on one foot
10. Turning 360 degrees
11. Turning to look behind
12. Retrieving object from floor
13. Placing alternate foot on stool
14. Reaching forward with outstretched arm

Sample Evaluation Write Ups

Student:	School:
Date of Birth:	Evaluation Tools:
Date of Report:	Evaluator:

Background: STUDENT is a cheerful and active __ years, __ month old BOY/GIRL. STUDENT currently attends ____ School. STUDENT currently receives direct physical therapy services for 30 minute durations every other week. An evaluation was completed to assess STUDENT'S current functional abilities. Data collected will be used to infer if school based physical therapy services are warranted.

Present Level of Functions:

- Mobility and Accessibility:
  - STUDENT demonstrates safe hallway navigation. STUDENT ambulates at a safe, yet effective speed and displays great environmental awareness. Mild in-toeing was observed across all gait trials, and increased mildly with more challenging skills (i.e ascending stairs without handrail). STUDENT also appeared to have pronated (flat) feet, which may have been more apparent due to the shoes worn today. STUDENT opened both push and pull doors with little to no assistance needed. When opening doors, no loss of balance was observed.
  - STUDENT prefers to walk up and down the steps using a single handrail with a step to pattern for descent and a reciprocal (one foot on each step) pattern for ascent. When descending without cues, STUDENT consistently leads with their right foot. When cued to descend the stairs using a reciprocal pattern, a single handrail was utilized, however STUDENT displayed no difficulties. When descending without a handrail, STUDENT reverted to their step to pattern. When cued to use no handrail while ascending the stairs, STUDENT continued with their reciprocal pattern but initially displayed mild trunk sway. As STUDENT continued up the stairs, improvements in control and confidence were observed. STUDENT is able to independently rise from the floor from sitting and lying prone or supine.
- Strength and Range of Motion: STUDENT displayed functional and age appropriate strength and range of motion. Mild bilateral hamstring tightness was observed during Frankenstein activity. As mentioned above, STUDENT was able to open both push and pull doors of significant weight with little to no assistance. STUDENT was observed squatting down to the ground and returned to stand without upper extremity support. STUDENT was able to transition from floor to stand without assistance.
- Gross Motor Skills: STUDENT completed the Bilateral Coordination, Upper-Limb Coordination, Balance, Running Speed and Agility, and Strength components of the Bruininks-Oseretsky Test-2nd edition (BOT-2) outcome measure. STUDENT fell within the 79th percentile rank for Body Coordination, 62nd percentile rank for Strength and Agility, and 76th percentile rank for overall Gross Motor Scoring. Direct scores and results are found in the table below.

	Scale Score	Age Equivalent	Descriptive Category
Upper Limb Coordination	22	6:3-6:5	Above Average
Bilateral Coordination	18	5:4-5:5	Average
Balance	19	5:8-5:9	Average
Running Speed & Agility	18	5:6-5:7	Average
Strength	15	5:0-5:1	Average

- Regarding Bilateral Coordination, STUDENT was observed to have the greatest difficulty with jumping jacks and movements that required upper and lower extremity alternating movements. Once these skills were reduced in speed and movements were stated aloud, great improvement in coordination was observed. STUDENT was able to complete 2 jumping jacks in a row before losing form. STUDENT successfully rode a tricycle and demonstrated good seated balance and reciprocal leg movements while doing so. STUDENT required no additional assistance to navigate around the playground.
- For Upper-Limb Coordination, ball skills were assessed. STUDENT displayed fair-good ball skills. STUDENT was able to have a catch and return 5 underhand passes in a row with the therapist. Underhand tossing accuracy was good, however STUDENT displayed only a small step prior to their throw. STUDENT demonstrated again a small step prior to overhand throws. Overhand throws traveled at least 5 feet in the air and were accurate to their target. Difficulties were observed when self tossing and catching with one hand, as well as dribbling the ball like a basketball.
- STUDENT demonstrated good balance with all double limb activities. Mild difficulties were observed when transitioning to single leg balance or heel-toe (tandem) standing with eyes opened and closed. STUDENT was observed to demonstrate increased in-toeing when tandem walking due to the increased difficulty of the task.
- Regarding running, STUDENT demonstrated age appropriate running form. STUDENT achieved a flight phase, demonstrated a reciprocal arm swing, and good body control. STUDENT was able to run 40 feet in 4.62 seconds. During one running trial, STUDENT did have a loss of balance anteriorly, resulting in a fall. Other activities completed in this subset included single leg hops and double leg hops. Greater difficulties were observed with single leg hops than double limb. STUDENT was able to complete 8 single leg hops in a row before needing assistance. Regarding double limb hopping, STUDENT consistently demonstrated a simultaneous, 2 footed, take off and landing.

- Strength assessments included a long jump, push ups, sit ups, wall sit, and v-ups. STUDENT was able to jump forward 41.5 and 43.5 inches. For both jumps, STUDENT was able to stick the landing. One push up was attempted, but then stopped after due to complaints of hand pain. Sit ups and v-ups required assistance from therapist in order to complete. For the wall sit, cues were needed to maintain contact with the wall, but once cued STUDENT held the position for 18 seconds

- Additional gross motor skills observed include kicking a ball, skipping, and galloping. STUDENT was able to kick both a stationary and moving ball in a straight path with good force. Regarding skipping and galloping, STUDENT demonstrated emerging patterns for both. When cued and demonstrated by the therapist mild improvements in quality and form were observed.

Summary and Recommendations:

- STUDENT demonstrated safe and independent navigation throughout our entire evaluation. STUDENT was found to be within age range and average for all subtests of the BOT-2, except for Upper-Limb Coordination. For this subset, STUDENT was found to be above average and scored at the age of a 6 year old. Despite their performance on the test, it is recommended for STUDENT to receive in-school Physical Therapy at a rate of one-30 minute session per month to address difficulties with balance, single limb hopping, and mature stair navigation.

Strengths:

- Independent school navigation
- Walks/runs on various surfaces
- Independently moves out of various positions
- Emerging stair skills
- Emerging ball skills

Needs:

- Improved balance, control, and coordination (particularly UE/LE and alternating patterns)
- Mature stair navigation

Suggested Goals:

PT Goal 1: STUDENT will ascend and descend a flight of stairs using a reciprocal pattern (one foot on each step) and no handrail on 3/5 assessment days.

- Baseline: STUDENT ascends the stairs using a reciprocal pattern and a step to pattern for descent with no handrail. However, with cues is able to transition to a reciprocal pattern for descending, but relies on a single handrail while doing so.

PT Goal 2: STUDENT will demonstrate improved motor sequencing, coordination, and balance by performing 10 alternating scissor jumps without any pauses on 3/5 assessment days.

- Baseline: STUDENT is able to complete 2-3 scissor jumps with ipsilateral (same side) arm and leg movements. When progressed to alternating movements greater difficulty was observed. When performing with alternating movements, STUDENT would state aloud what limb to move and take time between each jump therefore resulting in decreased fluency of jumps.

Sample Evaluation Write Ups

Student:	School:
Date of Birth:	Evaluation Tools:
Date of Report:	Evaluator:

Reason for Referral

STUDENT is a __ grade student at ___ School in ____'s class. A Physical Therapy evaluation was requested by parents due to concerns regarding STUDENT's mobility and gross motor skills in the school setting.

Record Review and Parent Input

STUDENT participated in physical therapy screenings during the 2019-2020 and 2020-2021 school year. STUDENT's first screening, completed in January 2020, revealed significant toe walking resulting in impaired balance, strength, and gait kinematics which impacted their ability to safely navigate through their school building. Also, during the January 2020 screening, STUDENT was undergoing serial casting of their left lower extremity and wore a walking boot on their right lower extremity. Due to this, certain testing measures were deferred due to orthopedic restrictions.

Following the January 2020 screening results, STUDENT began receiving direct PT services under RTI interventions on February 5, 2020. These services were provided at a rate of one session per week for 30 minutes duration. Sessions focused on ankle strengthening, balance activities, stair climbing, and school navigation. Over the span of 6 weeks, STUDENT demonstrated improvement in all areas and received bilateral MAFOs in March 2020. Final RTI session of the 2019-2020 school year was held on March 11th where improvements in gait and foot positioning were observed secondary to wearing MAFOs. Due to the COVID-19 pandemic school shutdowns occurred the following week and therefore no further interventions were given for the 2019-2020 school year.

For the 2020-2021 school year, STUDENT was seen for their final week of the RTI intervention program on September 21st and re-screened to determine recommendations moving forward. STUDENT was found to have significant improvements in ankle strength, ankle range of motion, balance abilities, gait pattern, and gross motor skills. In September, STUDENT also demonstrated significant improvement in their safety and school navigation since their initial screening in January 2020. Gross motor skills were also assessed during the September screen and found to be age appropriate.

Observations:

STUDENT presented in their classroom wearing bilateral MAFOs. STUDENT easily and willingly transitioned with the PT to participate in the evaluation. STUDENT reported they plays softball and soccer and enjoys both. STUDENT was pleasant and cooperative throughout the entire session. STUDENT followed 1-step directions and needed minimal verbal cues for any activity completed. During the evaluation, STUDENT demonstrated the ability to independently don and doff their braces.

Present Levels of Performance:

- Accessibility and Mobility: STUDENT demonstrated safe ambulation when traveling from classroom to therapy room and throughout the entire evaluation. STUDENT ambulated at an age appropriate speed with no losses of balance. When ascending the stairs, STUDENT used a reciprocal (one foot on each step) pattern with no handrail. When descending the stairs, initially STUDENT demonstrated a step to pattern with no handrail, however when cued was able to safely descend the remaining stairs using a reciprocal pattern.
- Transitions and Positions: STUDENT independently transitioned from floor to stand using either a half kneel to stand or pushing up from sitting. STUDENT was able to maintain a long sit position without upper extremity support and demonstrated no seated balance difficulties.
- Posture, Range of Motion, and Strength: STUDENT's posture is unremarkable in both sitting and standing. STUDENT's ankle range of motion (ROM) was assessed using a goniometer, and ankle strength was measured using standardized manual muscle tests (MMT). Measurements for both are recorded in the table below with a comparison to measures taken in September of 2020. Both ankle range of motion and strength demonstrate improvements and continue to be within functional ranges.

	Sep-20		May-21	
	LEFT ROM	RIGHT ROM	LEFT ROM	RIGHT ROM
Plantarflexion			10	10
Dorsiflexion w/ knee flexed	95	100	105	100
Dorsiflexion w/ knee extended	88	90	100	90
Inversion			50	58
Eversion			21	31

	Sep-20		May-21	
	LEFT MMT	RIGHT MMT	LEFT MMT	RIGHT MMT
Plantarflexion	5/5	5/5	5/5	5/5
Dorsiflexion	5/5	5/5	5/5	5/5
Inversion	4/5	4+/5	5/5	5/5
Eversion	4/5	4/5	5/5	5/5

- Gross Motor Screen: Gross motor skills were assessed using the Bruininks-Oseretsky Test of Motor Proficiency, Second Edition. This standardized test looks at different components of gross motor skills and compares STUDENT's performance to age and gender matched norms. STUDENT completed the Upper-Limb Coordination, Bilateral Coordination, Balance, Running Speed/Agility, and Strength portions of the test. STUDENT fell within the 93rd percentile for strength and agility and 73rd percentile for gross motor composite scores. The table below displays direct results.

	Scale Score	Age Equivalent	Descriptive Category
Upper Limb Coordination	18	7:3-7:5	Average
Bilateral Coordination	15	6:9-6:11	Average
Balance	12	5:6-5:7	Average
Running Speed & Agility	21	9:3-9:5	Above Average
Strength	21	10:0-10:2	Above Average

- For Upper-Limb Coordination, ball skills were assessed. STUDENT displayed good ball skills. STUDENT was able to have a catch and return 5 underhand passes in a row with the therapist using 2 hands to catch. Underhand tossing accuracy was good, and STUDENT demonstrated a step prior to their throws. STUDENT demonstrated again a step prior to overhand throws and cues were initially needed to remind STUDENT which foot to step with. Overhand throws traveled at least 7-10 feet in the air and had fair accuracy to the target. Difficulties were observed when catching a tossed ball with one hand, as well as when dribbling a basketball while alternating hands.
- Regarding Bilateral Coordination, STUDENT was observed to have the greatest difficulty with activities that required upper and lower extremity alternating movements. The tasks completed included jumping in place with opposite sides synchronized and while sitting tapping opposite feet and fingers. Once these skills were reduced in speed and movements were stated aloud, improvements in coordination were observed. Other coordination activities in this subset included jumping jacks and jumping in place with the same sides synchronized. No difficulties were observed with either of these activities.
- STUDENT demonstrated good balance with double limb, single limb, and tandem (heel-toe) stance with eyes opened and closed, as well as tandem walking. STUDENT scored perfect on these 7 components. The remaining 2 skills of this subset were challenging for STUDENT. The skills were tandem stance on a narrow balance beam and standing on one leg on the balance beam with eyes closed. These two activities demonstrated significant body sway and could be held for only 0-2 seconds.

- Regarding running, STUDENT demonstrated age-appropriate running form. STUDENT achieved a flight phase, demonstrated a reciprocal arm swing, and good body control. STUDENT was able to run 100 feet in 7.62 seconds. Other activities completed in this subset included single and double leg hops. STUDENT was able to complete 48 stationary single leg hops in 15 seconds with no difficulty. STUDENT completed 14 side single leg hops and 20 two-legged side leg hops in 15 seconds. STUDENT consistently demonstrated a simultaneous, 2 footed, take-off and landing across all trials.
- Strength assessments included long jump, push-ups, sit ups, wall sit, and v-ups. STUDENT was able to jump forward 49 and 54 inches. For both jumps, STUDENT was able to stick the landing. STUDENT completed 17 full push-ups with good form. As STUDENT fatigued form was mildly lost with maintaining back in neutral. STUDENT completed 18 sit ups in 30 seconds with bilateral lower extremity support from therapist and maintained a V-Up (supergirl) pose for 15 seconds. The final component of this subtest was a wall sit, which STUDENT maintained for 20 seconds.
- Additional gross motor skills observed include squats, skipping, and galloping. STUDENT was able to complete 5 squats with good form and little to no cues. Regarding skipping and galloping, STUDENT demonstrated good movement patterns for both.
- Summary: STUDENT is an active first grade student, who demonstrates safe and independent ambulation throughout their school environment. STUDENT was found to show further improvements in balance abilities and range of motion since September 2020. STUDENT demonstrates the functional range of motion, strength, and balance needed to safely navigate their school environment and participate with their peers on the playground or in PE. STUDENT also displays age appropriate and above gross motor skills. Due to these findings, STUDENT does not qualify for school-based Physical Therapy services. It is important to note that school-based services focus on movement and posture issues that may arise in the school environment, and at this time STUDENT does not demonstrate any.

CHILD: _____ SCHOOL: _____

DATE: _____ GRADE: _____

THERAPIST: _____

PHYSICAL THERAPY RECORD REVIEW:

(CHILD) is a morning (GRADE) in (TEACHER) class. (CHILD) is seen for physical therapy 1x per cycle x30 minutes in a small group to address functional mobility, strength, balance, coordination, and strength. (CHILD) is wearing (HIS/HER) glasses since Dec.2019. (CHILD) sessions can be limited by interfering behaviors of silliness and distraction to requested task especially if it is a non-preferred task. (CHILD) was evaluated in March 2019 for physical therapy upon transition to kindergarten.

GOALS AND PROGRESS:

(CHILD) will improved balance, coordination and strength as demonstrated by (HIS/HER) ability to ascend and descend a flight of steps with a step over step pattern, handrail as needed, decreasing time, and distant supervision in 3 consecutive data collections.

SHORT TERM OBJECTIVES:

(CHILD) will improve strength and balance as demonstrated by (HIS/HER) ability to Broad jump 24 inches with a two foot take off and a two foot landing in 4/5 trials over 3/4 data collections. (CHILD) will improve strength and balance as demonstrated by (HIS/HER) ability to hop 5x consecutively on each foot in 3 consecutive data collections.

	Dec.2019	Jan. 2020	Jan. 2020
Steps	Nov. 2019 data up: 15.29 sec turn:3.27sec down :23.71 sec total:42.27 sec down 50% step over step up needing prompts skipping steps	up: 13.59 turn:3.63sec down :20.75 sec total:37.97 sec step over step 90% with prompting	up: 12.19sec turn:2.71sec down : 12.47sec total:27.38 sec step over step 100% with (CHILD) self prompting "popcorn" on each step
Hops	1x each leg hand hold 5x each leg	2x each leg	1x without support 4x each leg with hand hold
Broad Jump	24 inch x5	24 inch x5	as previous

Distraction, decreased focus and silliness can limit participation in session, (CHILD) now has glasses (HE/SHE) wears all the time, (CHILD) has made consistent progress navigating the steps and maintaining ability to broad jump with two feet landing.

(CHILD) will improve (HIS/HER) ball skills as evident by (HIS/HER) ability to catch and throw a small tennis size ball with 80% accuracy with two hands for catching and throwing overhand in 3/4 monthly data collections.

SHORT TERM OBJECTIVES:
(CHILD) will improve (HIS/HER) ball skills as evident by (HIS/HER) ability to catch and throw a playground size ball size ball with 80% accuracy with two hands for catching and throwing overhand in 3/4 monthly data collections.

(CHILD) will improve (HIS/HER) ball skills as evident by (HIS/HER) ability to catch and throw a medium size ball with 80% accuracy with two hands for catching and throwing overhand in 3/4 monthly data collections.

	Dec.2019	Jan. 2020	Jan. 2020
Catch	stuffed animal 7/10/9/10 using body to trap from 5ft	rope ball 3/5 stuffed animal3/5 medium ball 3/5 from 8ft	3 inch diameter ball 5/10 hands and trapping with body
Throw	stuffed animal both hands 6/10	inconsistent using left hand and both hands	3 inch diameter ball 5/10 prompting for use of shoulder

Ball skills are an area (CHILD) requires continued focus, (CHILD) is attending to task with prompts and putting forth good effort. (CHILD) now wears glasses all the time after (HIS/HER) visual exam in Dec.2019.

RECOMMENDATION:
(CHILD) will continue with PT 1xper cycle to address balance, strength, coordination, endurance, and functional mobility to allow (HIS/HER) to safely navigate (HIS/HER) school and participate in school related activities.

Goals remain appropriate from most recent IEP Sept. 2019.

PHYSICAL THERAPY STRENGTHS:
-Likes physical activity
-Transitions without difficulty to PT
-Improved strength and balance

PHYSICAL THERAPY NEEDS:
-Improve navigation of steps quality and cadence
-Improve strength
-Improve balance and coordination
-Improve ball skills

PA Guidelines for Obtaining Physical Therapy Prescriptions

I. Upon initial evaluation and determination by the IEP team that the student is appropriate for school based Physical Therapy:

A. Send home Parent Contact Form along with MD letter and Prescription form

B. Follow up phone call to parents if no response in timely manner.

II. If no response or denial from MD for prescription request, send notice of such to parents. (see Sample Parent Letter for Denied Prescription Request)

III. If parents are not compliant with returning the scripts, it is the therapist's obligation to prompt the district for support. Document all of your parent and physician contact attempts in your daily notes. Also, email the Director of Special Education(save copy of email for your records) that there is a need for further action from the district to ensure that IEP's remain in compliance.

IV. Guidelines in PA PT Practice Act are vague concerning renewal of Physical Therapy prescriptions.

We consider it best practice to obtain annual prescription updates. Not having an annual prescription does not entitle you to stop services.

A. Fax renewal requests during or before first week of school to MDs for entire current caseload.

B. As new students are added through out the year, follow procedure as outlined above.

PA Physical Therapy Referral Requirements: Referral Requirements

The Pennsylvania Physical Therapy Practice Act (*http://www.ppta.org/site/1/docs/ptact.pdf*) regulates the provision of physical therapy in Pennsylvania. Intervention provided on an IEP or 504 Plan must meet the requirements for physician referral under the Physical Therapy Practice Act.

The Physical Therapy Practice Act states that a physician, physician assistant, or certified registered nurse practitioner referral is required to provide physical therapy treatment. If a physical therapist has met the requirements and maintains a certificate of authorization to practice physical therapy without a referral, treatment can be provided for a 30- day interval without referral. If treatment continues beyond 30 days, the therapist must obtain a valid referral from a physician, physician assistant, or certified registered nurse practitioner (practicing under a written/collaborative agreement with a physician), podiatrist, or dentist for continuance of physical therapy treatment within the school setting. Physical therapists in educational settings use professional judgment to determine how frequently new physician referrals should be obtained. An IU or school district may adopt a policy that requires a medical referral for physical therapy intervention.

NOTE: A medical referral for physical therapy is only one piece of input to a child's IEP team. Each team member's input must be considered within the context of the child's overall program. A physician or team member cannot make decisions in isolation. *"If a physician's referral specifies a type or intensity of physical therapy that is inconsistent with the decisions of the rest of the team, then a team member (usually the physical therapist or parent) must contact the physician and resolve the differences. The referral cannot be ignored; but neither can the physician order that the physical therapy be 24 provided."*

(McEwen, IR. "Providing Physical Therapy Services under Parts B & C of the Individuals with Disabilities Education Act (IDEA), Section on Pediatrics, APTA: 2009, p. 15

GOALS

All education-based goals MUST:

- Be **SMART**
- Specific: goal names the skill and targeted result
  - Must directly relate to “needs” identified in IEP
- Measurable: able to measure progress
  - -State number of probes when data will be taken (incremental planned observations of the child)
- Attainable: goal represents a skill/movement pattern that is achievable by the student in the academic year
- Results-Oriented: how the student achieves the goal
  - Contain objective criteria for level of achievement
- Timely: goal includes a time frame of when the goal will be achieved and how frequently progress will be monitored
- Have an action word ex: develop, attain, increase, etc
- State the method of evaluation/assessment procedure (teacher and/or therapist observation or use of an assessment tool)

Annual Goals

- Most students get annual goals, which should be achieved within one academic year.

Short Term Objectives

- Required for children with disabilities who take alternate assessments aligned to alternate achievement standards (PASA)

Example PT Goals:

Mobility

Transfers:

- Student will transfer from wheelchair to changing table via (sliding board, stand pivot) with (mod I, close-supervision, CGA), in 3 out of 4 trials over 3 consecutive data collections.
- Student will perform stand pivot transfers between level surfaces with minimal assistance in 4/5 trials as measured twice monthly for 2 consecutive month
- Student will stand for 3 minutes with minimal assistance 4/5 trials as measured twice monthly for 2 consecutive months.
- Student will tolerate 10 minutes of continuous standing in stander device while completed a school based activity (i.e coloring, typing) in 3 out of 4 trials over 3 consecutive data collections.

Ambulation/Running

- Student will navigate with distant supervision, with or without assistive device, between 5 familiar locations within his school environment with no more than 2 verbal cues for direction, safety, or gait pattern per location in 4/5 trials as measured twice monthly for 2 consecutive months.
- Student will ambulate (__) feet in gait trainer with no more than 3 verbal prompts for foot placement, in 3 out of 4 trials over 3 consecutive data collections.
- Student will clear a (6, 8, 12) inch obstacle in the classroom or on the playground, without a loss of balance, in 3 out of 4 trials over 3 consecutive data collections.
- Student will run a distance of __ feet while demonstrating appropriate trunk rotation, flight phase, and reciprocal arm swing in 3 out of 4 trials over 3 consecutive data collections.
- Student will run for __ minutes while demonstrating appropriate trunk rotation, flight phase, and reciprocal arm swing in 3 out of 4 trials over 3 consecutive data collections.
- Student will navigate uneven surfaces and obstacles safely and independently in 4/5 trials measured twice monthly for 2 consecutive months.
    - Objective 1 - Student will step over 5 consecutive obstacles (at least 8 inches in height) leading with his left foot (maintaining balance on right foot) in 4/5 trials.
- Student will independently navigate between surfaces on the playground including stepping over bumpers separating mulched playground equipment areas from blacktop or grass without loss of balance in 4/5 trials as measured twice monthly for 2 consecutive months.
    - Objective 1 – Student will step over a 4” obstacle independently and without loss of balance in 4/5 trials
    - Objective 2 – Student will step over a 7” obstacle independently and without loss of balance in 4/5 trials

Stairs:

- Student will ascend and descend 1 flight of stairs, using a (step to/reciprocal) pattern and (no/one/bilateral) handrail with (mod independence, close supervision) on the first trial over 3 consecutive data collections.
- Student will ascend a full flight of stairs with alternating pattern without rail support and descend a full flight of stairs with alternating pattern with single hand rail support with distant supervision in 4/5 trials as measured monthly for 2 consecutive months.

Gym Class Skills

Catch/Throwing:

- Student will independently catch a (__ inch ball/tennis ball) thrown to him/her from a peer who is at least __ feet away in 4 out of 5 trials over 3 consecutive data collections after initial demonstration.
- Student will improve his dynamic ball skills (to include catching off-midline tosses and incorporated movement challenges both laterally and front/back) by tossing/catching at a moderate speed with a partner from at least 10 ft in 4/5 trials as measured 2x/mo over 2 consecutive months.
- Student will complete a multi-step ball skills activity to include fielding a rolled tennis ball with immediate return to standing to throw overhand to a target with mature form and minimal pauses in 4/5 trials measured 1x/month for 2 consecutive months.
    - Objective 1 - Student will demonstrate knee flexion into a squat (versus bending at the waist) to retrieve objects from floor-height in 4/5 trials
- Student will engage in a reciprocal game of toss/catch with at least 3 different ball types (i.e. tennis ball, football, basketball, frisbee, foxtail, playground ball, gator ball) from 8-10 feet with mature throwing and catching form in 4/5 trials measured 1x/month for 2 consecutive months.
- Student will toss a ball (varying size) to a partner and catch a return pass for 5 consecutive cycles from 8 ft while continuously moving in a lateral direction with minimal pauses in 4/5 trials measured 1x/month for 2 consecutive months.
    - Objective 1 - Student will demonstrate a continuous shuffle/side step to both the right and left for 20 ft without pausing or crossing legs
    - Objective 2 - Student will toss a playground ball or gator ball to a partner and catch a return pass for 5 consecutive cycles from 5 ft while continuously moving in a lateral directions with minimal pauses

Soccer Skills

- Student will be able to independently kick a rolling soccer ball; in 4 out of 5 trials over 3 consecutive data point collections after initial demonstration.
- Student will successfully trap a soccer ball, by placing foot on top of ball, followed by a return kick to a partner from 10-12 feet distance 5x without losing balance, given only verbal cues in 4/5 trials measured monthly.
- Student will successfully push kick (contacting ball with inside of kicking foot) and trap a ball (stop ball movement by placing foot on top of ball) with a partner from 10 ft for 5 cycles without loss of balance in 4/5 trials as measured monthly for 2 consecutive months.
    - Objective 1 - Student will engage in alternating toe taps on a stationary object by placing his foot gently on top of the target and back onto the floor 10 times while maintaining his balance in 4/5 trials
- Objective 2 - Student will push kick a stationary ball to a target from 6-8 ft in 4/5 trials
- Objective 3 - Student will trap a slowly rolling ball by placing his foot on top of the ball from 6-8 ft in 4/5 trials

Basketball Skills

- Student will maintain control while dribbling a basketball for up to 10 consecutive bounces in 4/5 trials measured 1x/month for 2 consecutive months.
- Student will maintain control while dribbling a basketball for a distance of 10 feet in 4/5 trials measured 1x/month for 2 consecutive months.

Gross Motor Activities

- Student will be able to (skip/gallop/shuffle) __feet in proper sequence incorporating arm movement following initial demonstration; in 4 out of 5 trials over 3 consecutive data collections.
- Student will complete 10 consecutive alternating movement patterns (i.e jumping jacks, scissor jumps, hand to opposite foot) with no more than 2 verbal cues and 1 demonstration, in 4 out of 5 trials over 3 consecutive data collections.
- Student will complete a 3-step gross motor activity relevant to his PE curriculum in 4/5 trials as measured 1x/month for 2 consecutive months.
- Student will correctly complete a series of 3 multi-step gross motor tasks relevant to current PE curriculum with no more than 2 verbal cues/trial after initial cue in 4/5 trials measured 1x/month for 2 consecutive months.
- Student will participate 2 therapist-selected gross motor activities available during recess in 4/5 trials as measured twice monthly for 2 consecutive months.
    - Objective 1 - Student will chest pass a playground ball to a wall or trampoline from 5-6 ft in 4/5 trials
    - Objective 2 - Student will secure a playground ball tossed gently from 5-6 ft in 4/5 trials
    - Objective 3 - Student will secure a playground ball as it rebounds from a wall or trampoline from 5-6 ft in 4/5 trials
    - Objective 4 - Student will kick a stationary playground ball without loss of balance and the ball will travel 6-8 ft in 4/5 trials
    - Objective 5 - Student will kick a slowly rolling playground ball without loss of balance and the ball will travel 6-8 ft in 4/5 trials
- Student will participate in 6 minutes of continuous movement activities/exercises of increased intensity without a rest break on 4/5 trials.

Strength Based Goals

- Student will complete 3 core exercises (high plank, sit up, and bird dog) for 10 second hold/repetitions with no more than 2 verbal cues and 1 demonstration, in 4 out of 5 trials over 3 consecutive data collections.
- Student will complete 5 exercises independently with a visual handout or exercise log and will demonstrate the ability to progress the level of difficulty as his strength improves in 4/5 trials as measured 2x/mo for 2 consecutive months.

ADDITIONAL RESOURCE FOR SCHOOL BASED GOALS:

- - Great website that gives 100s of goals and ideas for gross motor skills, as well as community/school navigation.
  - https://www.bridges4kids.org/IEP/iep.goal.bank.pdf
- - “I CAN” Statements: Can be used as general guidelines for developmental milestones that students in the elementary schools should be hitting. Can be a good basis for goals as well, if they are found to have deficits in these areas.

Kindergarten:

- move to open space in general space.
- move in a variety of locomotor movements.
- move in general space safely.
- perform locomotor movements for up to 5 minutes.
- roll a ball at a target.
- transfer weight from feet to hand.
- move safely in relation to others and equipment.
- hold balance for three seconds.
- demonstrate beginning stages of underhand throwing
- safely move in both personal and general space using different pathways and speeds

First Grade:

- perform various locomotor skills (gallop,run,slide, jump,hop).
- move safely in general space.
- move at different levels and speeds.
- roll a ball with one hand.
- keep an object close to my body while moving.
- throw under/overhand at a target.
- catch an object with one or both hands.
- strike an object with a short handled implement.
- transfer weight from feet to hands.
- link simple balance, jump and travel actions.
- perform various locomotor skills while changing direction.
- strike an object with a long handled implement.
- link simple balance, jump and travel actions.

- **Second Grade:**
- skip, gallop, hop and slide in a mature pattern
- perform various motor skills on command
- catch using proper hand position.
- use body weight as resistance for developing strength.
- dribble with my hands/ feet in self-space and general space with control.
- catch using my hands without trapping or cradling against the body.
- strike an object upward with a short-handled implement.
- jump using a self-turned rope.
- combine balance and weight transfer.
- throw underhand using a mature pattern
- throw overhand using a mature pattern
- consecutively volley an object upward with hands/implement.

- **Third Grade:**
- throw overhand, demonstrating a mature pattern.
- dribble in general space.
- pass a ball with the insides of the feet to a stationary partner.
- apply simple offensive and defensive strategies and tactics.
- Fourth Grade:
- throw overhand (using a mature pattern) to a target with accuracy from a given distance.
- dribble with the feet in general space with control of ball and body
- apply simple offensive and defensive strategies and tactics.

SPECIALLY DESIGNED INSTRUCTIONS

What are Specially Designed Instructions?

- SDIs are a type of replacement instruction, adaptation, and/or modification the child needs and will receive.

Each item of specially-designed instruction must be:

- Based on the individual needs of the student, not on "the program" as it exists in a particular building or classroom and not on every passing notion of what might "benefit" the child.
  - Child-specific need is the critical factor for determining the items that are included in this section.
- Based on "peer-reviewed research, to the extent practicable." Although identifying support for every adaptation and modification in a published, peer-reviewed journal is not "practicable," the selection can offer research support that is both practicable and necessary. Only when research-supported programs are not working after trial, or are demonstrably inappropriate for the individual child, can the IEP team safely include a child-specific approach that does not have research support.

The following rules apply to the drafting of specially-designed instruction and program modifications:

- Rule 1: Be specific as to strategy
- Rule 2: Be generic. regarding brand names of programs (i.e. Zones of regulation).
- Rule 3: Identify either a specific time and duration for each item, a specific condition to which each item applies, or a specific purpose for each item.
  - Although IDEA used the phrase "frequency and duration" to describe the manner in which items of specially designed instruction must be quantified, not all specially designed instruction lends itself to such numerical quantification. Certainly replacement instruction should always include specific frequency and duration commitments, as should time during which the child will receive scheduled tutoring or support in the special education classroom.
  - Most items of specially designed instruction that describe adaptations and modifications, on the other hand, will need to abandon time commitment language in favor of descriptions of the conditions under which the particular item of specially-designed instruction will be used or the purpose that the item will serve.
- Rule 4: Be cognizant when writing SDIs for an elementary student who will be transitioning to middle school or middle school student who will be transitioning to high school during that IEP year to make sure the SDI is still relevant and/or able to be carried out in the new school.

PT SDI EXAMPLES

Area of Need:

Positioning:

- Seating and positioning as needed in the educational environment, including _____.
  - back support when eating.
  - lateral trunk support when in class/eating
- Complete daily ROM/stretching activities provided by PT to promote and maintain functional mobility
- Frequent opportunities throughout the day for positional changes (including but not limited to a tumbleform chair, mat, and stander)
  - Student to spend a minimum of 1 hour per school day in stander and other alternative seating options. (Another way of phrasing)
- MAFOs donned (ankle braces from home/doctor) when sitting in his wheelchair and during any standing activities to assist with support and proper positioning of his feet
- Complete daily ROM/stretching activities to promote and maintain functional mobility

Transitions

- Increased transition time between classes (i.e leaving early to ambulate in less crowded hallways)

Unsafe Ambulation

- Student must wear gait belt/harness while at school due to decreased safety awareness while ambulating, unpredictable activity, and fall risk

Difficulty getting off the bus:

- Allow student to back down stairs
- Provide additional support (i.e. someone else carry backpack while going down the
- stairs)

Unsafe stair navigation

- Have student at the end of the line when ascending/descending stairs
- Have a back up plan for stairs in an emergency situation (i.e fire)
- Train teachers/staff how to safely guard on stairs
- Practice climbing and descending the stairs while carrying belongings with supervision when navigating with peers. Encourage safety (rail as needed) and pace similar to peers, especially when descending
- Direct and close supervision while navigating stairs and playground equipment for safety due to decreased safety awareness and unpredictable activity

Gym Class/Recess

- Supervision/cues/assistance/modifications as needed in gym class for safety and following directions/activities.
- Supervision and assistance as needed during gym class for safety and to facilitate gross motor skills and interaction with peers
- Provide opportunities to engage in challenging balance and strengthening activities for legs needed to improve strength and balance (squatting, getting up from floor without hands, stepping over obstacles, stairs as able)
- Supervise and facilitate playground equipment use and provide opportunities to engage in ball play with peers during recess time
- Opportunities to practice gross motor skills (ball skills, jumping, stairs) throughout the school day as appropriate
- Small group instruction via pre-teaching prior to gym classes to practice skills before
- having to perform them with the entire class

Functional Activities

- Load and push cart 2x per day in hallway for functional strengthening
- Place plates/cups/books etc in overhead cabinet 2x per day for functional strengthening

Services:

- At least one Physical Therapy session per month during PE class and one Physical therapy session per quarter during recess

Consulting Not Direct Based on PT Practice Act

- Walk hill back from recess
- Walking program count laps
- Steps opportunity
- Floor to stand opportunities
- Use visuals on the floor to give awareness for body
- Extra time on playground opportunities to climb, slide swing, run, navigate varied terrains
- Ask to see a skill, skip, gallop, hop Model it if student is not sure how to do
- Exercise of the week i.e jumping jacks – more opportunity to practice and master skill
- Tabata is great for short bursts
- Have different stations for them to move through
- Simon says – great easy movement break
- Jump from square to square on floor tiles -hot lava
- Walk on toes, walk on heels
- How to calm after movement especially for students who can't regulate or may need more time to transition back to sitting at desk
- Posture observe how sitting at desk
- Work with OT and ST

PHYSICAL THERAPIST TOOL KIT & TREATMENT ACTIVITIES

- Therapy Ball
- Thera Band
- Playground ball
- Jump rope
- Zoom Ball
- Masking tape/gym floor tape
  - Use to make balance beams or starting lines for jumping/running
  - Make indoor obstacle paths
  - Mark space in classroom around desk or on floor
- Hula Hoop
  - Can be used to work on increasing jumping height, core strengthening and motor planning activities
- Rubber Maid Step Stool
  - Great for step ups, quad and glut strengthening
- Variety of Balls (beach ball, tennis ball, playground ball, knobby ball)
- Bean Bags
- Paper and Markers/Stickers
  - Have kids step up and down from stool to reach up to play a game/draw on a white board or other vertical surface
- Sidewalk Chalk
  - Can be used to create balance games by drawing a long curvy magic road that kids must walk on heel to toe
  - Write letters on macadam and have kids jump from letter to letter to spell Have kids try to trace their own bodies or a friend's body to learn body awareness
  - Hopscotch
- Tennis Ball
- Measuring Tape
- Balloons
- Prone scooters-get 2
  - Use for extensor strengthening. Play prone hockey/soccer and have races
- Puzzles
  - Use for reaching outside base of support or to add a "goal" to a mobility task- have student walk, crawl, etc. to get pieces one at a time
- Twister game
  - Great for UE weight-bearing, body awareness, L/R orientation, core stability
- Small stuffed animals (beanie baby)
  - Try using these to teach catching. Many kids are afraid of balls, but not afraid to catch a bunny

GENERAL PHYSICAL EDUCATION ADAPTATIONS

Equipment:

- Larger/lighter bat
- Use of Velcro
- Larger goal/target
- Mark positions on playing field
- Lower goal/target
- Scoops for catching
- Vary balls (size, weight, color, texture)

Rules Prompts, Cues:

- Demonstrate/model activity
- Partner assisted
- Disregard time limits
- Oral prompt
- More space between students
- Eliminate outs/strike-outs
- Allow ball to remain stationary
- Allow batter to sit in chair
- Place student with disability near teacher

Boundary/Playing Field:

- Decrease distance
- Use well-defined boundaries
- Simplify patterns
- Adapt playing area (smaller, obstacles removed)

Actions:

- Change locomotor patterns
- Modify grasps
- Modify body positions
- Reduce number of actions
- Use different body parts

Time:

- Vary the tempo
- Slow the activity pace
- Lengthen the time
- Shorten the time
- Provide frequent rest periods

Bowling

- Simplify/reduce the number of steps
- Use two hands instead of one
- Remain in stationary position
- Use a ramp
- Use a partner
- Give continuous verbal cues

Basketball

- Use various size balls (size, weight, texture, color)
- Allow travelling
- Allow two hand dribble
- Disregard three second lane violation
- Use larger/lower goal
- Slow the pace, especially when first learning
- If student uses wheelchair, allow him to hold ball on his lap while pushing wheelchair
- Use beeper ball, radio under basket for individual with visual impairment

Golf

- Use a club with a larger head
- oUse shorter/lighter club
- Use colored/larger balls
- Practice without a ball
- Use tee for all shots
- Shorten distance to hole

Soccer

- Use walking instead of running
- Have well defined boundaries
- Reduce playing area
- Play six-a-side soccer
- If student uses a wheelchair, allow him to hold ball on his lap while pushing the wheelchair
- Use a deflated ball, nerf ball, beeper ball, brightly colored ball
- Use a target that makes noise when hit

Softball

- Use velcro balls and mitts
- Use larger or smaller bats
- Use a batting tee
- Reduce the base distances
- Use Incrediballs
- Shorten the pitching distance
- If individual is in wheelchair, allow them to push ball off ramp, off lap, or from tee
- Use beeper balls

Volleyball

- Use larger, lighter, softer, bright colored balls
- Allow players to catch ball instead of volleying
- Allow student to self toss and set ball
- Lower the net
- Reduce the playing court
- Stand closer to net on serve
- Allow ball to bounce first
- Hold ball and have student hit it

Tennis

- Use larger, lighter balls
- Use shorter, lighter racquets
- Use larger head racquets
- Slow down the ball
- Lower the net or do not use a net
- Use brightly colored balls
- Hit ball off tee
- Allow a drop serve
- Stand closer to net on serve
- Do not use service court
- Use a peer for assistance

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SPEECH THERAPY

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- Articulation Data Collection
- Data Sheet
- Data Sheet with Attendance

Treatment

- Language and Literacy Development

References

SPEECH THERAPISTS CASE MANAGER INFORMATION

- A student can be eligible for speech, and not receive speech services. If the primary disability category service for the student can address the need identified by the speech pathologist during the evaluation process (think semantics, phonemic awareness), then speech services are not warranted. Speech service is only required when there is a documented need that REQUIRES the expertise of the speech pathologist.
- December 1st Special Education census: You will hear lots of discussion about the 12/1 child count. This is how Pennsylvania determines the number of students receiving special education services in a district, and ultimately determines funding for that district. It is imperative that every student be counted. All new evaluations that are in progress, should be completed and have IEP held prior to December 1, some districts will tell you the date is mid-November. You will be notified about this. Any reevaluation that fall within this window should be completed early, and have IEP held prior to December 1.
- You can ALWAYS hold an IEP meeting early. You can NEVER hold an IEP meeting late.
- IEP goals: There are NO speech goals on an IEP. There are only student goals. Even if a goal is only being addressed by the speech pathologist due to documented need for their expertise, the goal belongs to the student, and as such, data should be collected by all team members as the behavior should be happening across the student day, not just in speech therapy. The speech pathologist should spearhead the collection efforts.
- IEP Goals can be shared by more than 1 discipline. Learning support and speech can overlap on a writing goal.
- Students in reduced ration or special education classrooms: The primary person responsible for the student education and IEP is the case manager. If a student is in a low ration special education classroom, that teacher or case manager is responsible for all aspects of student education, including communication. The speech pathologist's role in these cases is to be consultative according to PDE documents.
- Patriot Act: Anything you put in an email on a district machine should be considered public information. No complaining about teachers, parents, or students. No forwarding jokes, pictures, etc.

Local educational agency: As defined in ESEA, a public board of education or other public authority legally constituted within a State for either administrative control or direction of, or to perform a service function for, public elementary schools or secondary schools in a city, county, township, school district, or other political subdivision of a State, or for a combination of school districts or counties that is recognized in a State as an administrative agency for its public elementary schools or secondary schools.

MTSS Tier 1 SLP Whole Classroom Strategies Tracker

Class: _____

Teacher: _____

IST Leader: _____

Therapist: _____

DATE: _____

Strategies or Skills Center

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

FOLLOW UP/DATE:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PTS

Multi-Tiered System of Supports

MTSS Tier 1 SLP Student Classroom Observation Request Form

Student Name:	Date of Birth:
School:	Current Teacher:/Grade:
Case Manager:	Date:

Teacher/Team Concerns:

Quality of Speech:

- ☐ Child is difficult to understand
- ☐ Child stutters when he or she speaks
- ☐ Child mispronounces words or substitutes one sound for another
- ☐ Child speaks too loudly or too softly (please circle)
- ☐ Other:_____

Expressive Language Skills

- ☐ Child speaks in short phrases rather than sentences
- ☐ Child seems to have difficulty finding the right word
- ☐ Child is not able to read out loud
- ☐ Child has difficulty telling a story or giving an explanation
- ☐ Child substitutes incorrect words in his or her speech
- ☐ Child does not participate in classroom discussions
- ☐ Child has a very limited vocabulary for his or her age
- ☐ Child has difficulty naming
- ☐ Child does not answer questions in class

Receptive Language Skills

- ☐ Child is not able to follow spoken directions
- ☐ Child does not seem to have the vocabulary to comprehend discussions and direction
- ☐ Child has difficulty understanding information that has been read or said to him or her
- ☐ Chilld is not able to follow direction in sequence
- ☐ Child is not able to find the main point of the story
- ☐ Other:_____

Recommended Strategies:

_____

_____

Data Collection Log:

List the strategies being implemented, the date for each of the 4 weeks, and a 1, 2 or 3 based on observations made (1= no progress made, 2= minimal progress, 3= sufficient progress made)

Strategies	Week 1 Dates:	Week 2 Dates:	Week 3 Dates:	Week 4 Dates:

PTS

Multi-Tiered System of Supports

Speech Classroom Observation Request Form for MTSS (Multi-Tiered System of Supports)

Student Name:	Date of Birth:
School:	Current Teacher:/Grade:
Case Manager:	Date:
Student Diagnosis:	

Student is Receiving:

☐ Therapy Services ☐ Other_____

☐ CST and Possible MDE ☐ No other services

Teacher/Team Concerns: ☐ Quality of Speech ☐ Receptive Language ☐ Expressive Language

_____

_____

_____

_____

_____

Recommended Strategies:

_____

_____

_____

_____

_____

_____ _____

Therapist **Date**

Data Collection Log:

List the strategies being implemented, the date for each of the 4 weeks, and a 1, 2 or 3 based on observations made (1= no progress made, 2= minimal progress, 3= sufficient progress made)

Strategies	Week 1 Dates:	Week 2 Dates:	Week 3 Dates:	Week 4 Dates:	Week 5 Dates:	Week 6 Dates:

Speech Therapy Classroom Observation Form for MTSS (Multi-Tiered System of Supports)

Student Name:	Date of Birth:
School:	Current Teacher:/Grade:
Case Manager:	Date:

Teacher/Team Concerns:

Quality of Speech

- ☐ Child is difficult to understand
- ☐ Child speaks too loudly or too softly (please circle)
- ☐ Child stutters when he or she speaks
- ☐ Other:
- ☐ Child mispronounces words or substitutes one sound for another

Expressive Language Skills

- ☐ Child speaks in short phrases rather than sentences
- ☐ Child has difficulty telling a story or giving an explanation
- ☐ Child has a very limited vocabulary for his or her age
- ☐ Child seems to have difficulty finding the right word
- ☐ Child substitutes incorrect words in his or her speech
- ☐ Child has difficulty naming
- ☐ Child is not able to read out loud
- ☐ Child does not participate in classroom discussions
- ☐ Child does not answer questions in class

Receptive Language Skills

- ☐ Child is not able to follow spoken directions
- ☐ Child has difficulty understanding information that has been read or said to him or her
- ☐ Child does not seem to have the vocabulary to comprehend discussions and directions
- ☐ Child is not able to find the main point of the story
- ☐ Child is not able to follow direction in sequence
- ☐ Other:

Therapist Findings:

The therapist completed an observation on _____. The following recommendations are being made:

- ☐ No further intervention is recommended at this time
- ☐ Participation in MTSS is recommended to address the following areas:
  ___Language ___Articulation ___Voice ____Fluency
  Please complete the MTSS intervention plan.
- ☐ A screening is recommended to further assess _____
  *Please obtain parent permission and parent signature to proceed with screening

_____ _____

Speech Therapist **Date**

Parent Permission for Screen

☐ **I give permission to proceed with Speech screening**

☐ **I do not give permission to proceed with Speech**

_____ _____

Parent signature Date

_____ _____ _____

Parent name (Printed) Daytime Phone Number E-mail

Request for Speech Therapy-Screen Process Instructions

1. Teacher completes speech language referral form to initiate process.

2. Building Speech Pathologist provides form for speech language screening process in electronic format.

3. Referring teacher completes the speech language screening process (can be done in conjunction with building SLP) by answering the questions and checking appropriate boxes in each of area of communication listed. N/A can be used for areas not of concern to the teacher.

4. Teachers are asked to provide information on educational impact.

5. Teachers are asked to provide data on strategies implemented prior to referral, as well as current grades in content areas.

6. Completed screen process form to be submitted to building Speech Pathologist. A time will be scheduled to complete an observation, discuss student concerns, and determine a course of action.

Request for Speech Therapy-Screen Recommendations

Date: _____

Dear,

Thank you for the opportunity to observe in your classroom today. I've attached a form of priority needs as well as recommendations and strategies. I've also attached a 6 week data collection form to chart the trial of these strategies. Upon the completion of the 6 week trial period, I will consult with you to see how the strategies and recommendations have worked out. If we feel that there is a further need for support, we can recommend an evaluation. Highlighted recommendations are strategies I feel would be best to incorporate into the daily class times to address the above stated needs. Please feel free to contact me with any questions!

Sincerely,

Therapist Contact Information:

Days available at school:

Times available for consultation:

Phone:

Email:

Request for Speech Therapy-Screen Recommendations

Student Name:_____ Date:_____

Teacher Name:_____ Therapist Name: _____

Follow up consultation to be scheduled for 6 weeks. Date:

Needs	Recommendations	Equipment or Materials Needed
Articulation		
Connected Speech/Fluency		
Receptive Language		
Expressive Language		
Pragmatics/Social Skills		

PTS PEDIATRIC THERAPEUTIC SERVICES

MTSS Tier 3 SLP Screen Report

Student Name:	Date:
School:	Current Teacher/Grade:

RESULTS OF SPEECH-LANGUAGE SCREENING:

Articulation: Results of the screening indicate that:

☐	Articulation is within functional limits	Comments:
☐	Further interventions are recommended	
☐	Identified area of concern	

Language: Results of the screening indicate:

☐	Receptive and expressive language is within functional limits	Comments:
☐	Further interventions are recommended	
☐	Identified area of concern	

Voice: Results of screening indicate that:

☐	Voice quality is within functional limits	Comments:
☐	Further interventions are recommended	
☐	Identified area of concern	

Fluency: Results of the screening indicated that:

☐	Rate and rhythm are within functional limits	Comments:
☐	Further interventions are recommended	
☐	Identified area of concern	

RECOMMENDATIONS OF SPEECH-LANGUAGE SCREENING:

☐	No further testing is recommended at this time.
	Participation in MTSS is recommended to address the following areas: ☐ Articulation ☐ Fluency ☐ Language ☐ Voice * Please complete the MTSS intervention plan.
☐	Speech-Language evaluation recommended

_____ _____

Speech Therapist **Date**

MTSS Tier 3 SLP Screen Recommendations Data Collection

Student Name:_____ Grade:_____Teacher:_____

Thank you for the opportunity to observe in your classroom today. Below, please find a form of priority needs as well as recommendations and strategies. Upon the completion of the 4 week trial period, I will consult with you to see how the strategies and recommendations have worked in your classroom. Please feel free to contact me with any questions!

	Referral Period Data *Progress Code: N(No Improvement),I (Improving), R(Resolved)*						
Strategies	**Week 1**	**Week 2**	**Week 3**	**Week 4**	**Week 5**	**Week 6**	**Notes**
	• I • N • R	• I • N • R	• I • N • R	• I • N • R			
	• I • N • R	• I • N • R	• I • N • R	• I • N • R			
	• I • N • R	• I • N • R	• I • N • R	• I • N • R			
	• I • N • R	• I • N • R	• I • N • R	• I • N • R			
	• I • N • R	• I • N • R	• I • N • R	• I • N • R			

Follow Up Date: _____ Upon completion of this form, please send Screening Request form and this data collection sheet to IST. Upon approval of the PT evaluation request, the PTE will be generated and sent home from the Special Education Department.

_____Concerns Resolved, no further action needed _____OT Evaluation requested (Please identify student's diagnosis):

For Special Education Department Use Only:

_____ Approved – Signature: _____ Date: _____ Date PTE issued: _____ Date returned: _____

Speech Therapy-Eval

Student Name: _____

Address and Phone Number: _____

Date of Birth: _____

Date(s) of Evaluation: _____

School: _____

Therapist Name: _____

Reason for Referral:

The purpose of this assessment was to determine if there (is / continues to be) evidence of an oral communication disorder that impacts (N's) educational performance.

- Why was student referred?
- What are educational concerns?
- Are there any special considerations? Hearing or visual impairment; limited English proficiency, behaviors that impede learning, assistive technology?

History/ Background Information:

- Include information relevant to the child's educational program, including medical diagnosis.

Evaluation and Analysis:

- Screen results if completed
- Classroom assessments or observations
- Best practice calls for assessment in areas of Articulation, Language, Voice, and Fluency.

Formal and informal measures were used to assess N's speech and language skills.

ARTICULATION:

- Standardized evaluation of phonemes
- Connected speech sample

ORAL LANGUAGE:

- Receptive
- Expressive
- Pragmatic

VOICE:

- Observation/analysis of parameters of voice
- Reminder that ENT physician needs to rule out laryngeal pathology.

Standards Alignment: Common Core State Standards

	K	1	2	3	4	5	6	7	8	9-10	11-12
Problem Solving	SL.K.3	SL.1.3	SL.2.3	SL.3.3	SL.4.3	SL.5.3	SL.6.3	SL.7.3	SL.8.3	SL.9-10.3	SL.11-12.3
Attention	SL.K.1	SL.1.1	SL.2.1	SL.3.1	SL.4.1	SL.5.1	SL.6.1	SL.7.1	SL.8.1	SL.9-10.1	SL.11-12.1
Sequencing a Task	W.K.3	W.1.3	W.2.3	W.3.3	W.4.3	W.5.3	W.6.3	W.7.3	W.8.3	W.9-10.3	W.11-12.3
Cause/Effect	RI.K.8	RI.1.8	RI.2.8	RI.3.8	RI.4.8	L.5.4	L.6.5	RI.7.8	RI.8.8	RI.9-10.8	RI.11-12.8
Planning	W.K.5	W.1.5	W.2.5	W.3.5	W.4.5	W.5.5	W.6.5	W.7.5	W.8.5	W.9-10.5	W.11-12.5
Digit/Sentence Memory	RF.K.4	RF.1.4	RF.2.4	RF.3.4	RF.4.4	RF.5.4	RL.6.10	RL.7.10	RL.8.10	RL.9-10.10	RL.11-12.10
Following Directions	SL.K.2	SL.1.2	SL.2.2	W.3.10	W.4.10	W.5.10	W.6.10	W.7.10	W.8.10	W.9-10.10	W.11-12.10
Listening for Details	RL.K.1	RL.1.1	RL.2.1	RL.3.1	RL.4.1	RL.5.1	RL.6.1	RL.7.1	RL.8.1	RL.-10.1	RL.11-12.1
Syntax/Morphology	L.K.1	L.1.1	L.2.1	L.3.1	L.4.1	L.5.1	L.6.1	L.7.1	L.8.1	L.9-10.1	L.11-12.1
Categorization	L.K.5	L.1.5	L.2.5	L.3.5	L.4.5	L.5.5	L.6.5	L.7.5	L.8.5	L.9-10.5	L.11-12.5
Compare/Contrast	RL.K.9	RL.1.9	RL.2.9	RL.3.9	RL.4.9	RL.5.9	RL.6.9	RL.7.9	RL.8.9	RL.9-10.9	RL.11-12.9
Multiple Meaning Words	L.K.4	L.1.4	L.2.4	L.3.4	L.4.4	L.5.4	L.6.4	L.7.4	L.8.4	L.9-10.4	L.11-12.4
Synonyms/Antonyms	L.K.5	L.1.5	L.2.5	L.3.5	L.4.5	L.5.5	L.6.5	L.7.5	L.8.5	L.9-10.5	L.11-12.5
Figurative Language	L.K.5	L.1.5	L.2.5	L.3.5	L.4.5	L.5.5	L.6.5	L.7.5	L.8.5	L.9-10.5	L.11-12.5
Word Associations	L.K.5	L.1.5	L.2.5	L.3.5	L.4.5	L.5.5	L.6.5	L.7.5	L.8.5	L.9-10.5	L.11-12.5
Functions of Objects	SL.K.4	L.1.5	L.2.5	L.3.5	L.4.5	L.5.5	L.6.5	L.7.5	L.8.5	L.9-10.5	L.11-12.5
Concepts	L.K.1	L.1.1	L.2.6	L.3.6	L.4.6	L.5.6	L.6.6	L.7.6	L.8.6	L.9-10.6	L.11-12.6
Context Clues	L.K.6	L.1.4	L.2.4	L.3.4	L.4.4	L.5.4	L.6.4	L.7.4	L.8.4	L.9-10.4	L.11-12.4
Affixes	L.K.4	L.1.4	L.2.4	L.3.4	L.4.4	L.5.4	L.6.4	L.7.4	L.8.4	L.9-10.4	L.11-12.4
Defining/Describing	SL.K.4	L.1.6	L.2.6	L.3.6	L.4.6	L.5.6	L.6.6	L.7.6	L.8.6	L.9-10.6	L.11-12.6
Wh-?s	L.K.1	SL.1.2	RL.2.1	RL.3.1	SL.4.1	SL.5.1	SL.6.1	SL.7.1	SL.8.1	SL.9-10.1	SL.11-12.1
Main Idea/Details	RL.K.2	RL.1.2	RL.2.2	RL.3.2	RL.4.2	RL.5.2	RL.6.2	RL.7.2	RL.8.2	RL.9-10.2	RL.11-12.2
Inferencing	RL.K.1	RL.1.1	RL.2.1	RL.3.1	RL.4.1	RL.5.1	RL.6.1	RL.7.1	RL.8.1	RL.-10.1	RL.11-12.1
Summarizing	RL.K.2	RL.1.2	RL.2.2	RL.3.2	RL.4.2	RL.5.2	RL.6.2	RL.7.2	RL.8.2	RL.9-10.2	RL.11-12.2
Sequencing a Story	RL.K.2	RL.1.2	RL.2.2	RL.3.2	RL.4.2	RL.5.2	RL.6.2	RL.7.2	RL.8.2	RL.9-10.2	RL.11-12.2
Yes/No ?s	RL.K.1	SL.1.2	RL.2.1	RL.3.1	SL.4.1	SL.5.1	SL.6.1	SL.7.1	SL.8.1	SL.9-10.1	SL.11-12.1
Fact/Opinion	W.K.1	W.1.1	W.2.1	W.3.1	W.4.1	W.5.1	W.6.1	W.7.1	W.8.1	W.9-10.1	W.11-12.1
Phonemic Awareness	RF.K.2	RF.1.2	RF.2.3	RF.3.3	RF.4.3	RF.5.3	RL.6.10	RL.7.10	RL.8.10	RL.9-10.10	RL.11-12.10
Narrative	RL.K.2	RL.1.2	RL.2.2	RL.3.2	RL.4.2	RL.5.2	RL.6.2	RL.7.2	RL.8.2	RL.9-10.2	RL.11-12.2
Fluency	SL.K.6	SL.1.4	SL.2.4	SL.3.4	SL.4.4	SL.5.4	SL.6.4	SL.7.4	SL.8.4	SL.9-10.6	SL.11-12.6
Social Language	SL.K.1	SL.1.1	SL.2.1	SL.3.1	SL.4.1	SL.5.1	SL.6.1	SL.7.1	SL.8.1	SL.9-10.1	SL.11-12.1
Speech Sound Production	SL.K.6	SL.1.4	SL.2.4	SL.3.4	SL.4.4	SL.5.4	SL.6.4	SL.7.4	SL.8.4	SL.9-10.6	SL.11-12.6
Voice/Resonance	SL.K.6	SL.1.6	SL.2.6	SL.3.6	SL.4.6	SL.5.6	SL.6.6	SL.7.6	SL.8.6	SL.9-10.6	SL.11-12.6

Skills listed reflect tasks that underlie achievement of aligned standards. Standards listed are suggestions as communication skills can be linked to many different standards.

Choosing Speech and Language Assessments for School-Based Speech and Language Therapy

Assessing Sound Production: Articulation, Phonology, Oral-Motor						
Measure	**Purpose**	**Constructs Evaluated**	**Age**	**Time to Administer**	**Format/ Type of Administration**	**Format and Scores**
Goldman-Fristoe Test of Articulation (GFTA-3)	Examine a child's ability to pronounce different speech sounds to diagnose different disorders which can inhibit a child's articulation	Assess multiple occurrences of high frequency phonemes in words and sentences	ages 2:0-21:11 years	5 to 15 minutes for Sounds-in-Words Section, varied for Sounds-In-Words, Intelligibility, and Stimulability sections	Workbook, administered by speech therapist	Norm-Referenced Standardized Test
Arizona Articulation and Phonology scale, Fourth Revision (Arizona- 4)	Measure of articulation and phonology to help clinicians identify individuals in need of speech sound services	Assesses Word Articulation, Sentence Articulation, and Phonology	ages 18 months-21:11 years	5-20 minutes	Workbook, administered by speech therapist	Norm-Referenced, Standardized test
Photo Articulation Test-Third Edition (PAT-3)	Documents the presence of articulation errors	Examines sounds at the word level of production	3:0- 8:11	20 minutes	Workbook, administered by speech therapist	Norm-Referenced, Standardized test
Structured Photographic Articulation Test III (SPAT-D III)	Provides clinicians with a quantitative tool and a way to gather qualitative information to assess speech production skills	Assessment of speech sounds at the word level of production, includes a multi-syllable word screener	3:0- 9:11	15 minutes	Workbook, administered by speech therapist	Norm-Referenced, Standardized test
The Entire World of /r/ Advanced Screening Complete Kit	Research-based program to evaluate and treat the difficult /r/ phoneme	Evaluate the 32 /r/ allophones in single words, phrases, and sentences	No age specified	5-10 minutes	Worksheet (picture or imitation), administered by speech therapist	Criterion-Based Assessment

Hodson Assessment of Phonological Patterns, Third Edition (HAPP- 3)	Designed to assess highly unintelligible speech in children	Determining severity intervals/ratings & identifying major phonological patterns that need to be targeted	2 years to any age (if intelligibility is an issue); Normative data provided for Ages 3-0 to 8-0	15-20 minutes (comprehensive); 2-5 minutes (screening)	Workbook, administered by speech therapist	Norm-Referenced Standardized Test & Criterion-Referenced Test
Kauffman Speech Praxis Test for Children	Assists in the diagnosis and treatment of developmental apraxia (dyspraxia) of speech	Assesses simple to complex motor-speech movements, using meaningful words	2:0- 5:11	5-15 minutes	Workbook, administered by speech therapist	Norm-Referenced, Standardized test
Marshalla Oral Sensorimotor Test (MOST)	Comprehensive and quick assessment designed to put a numerical value on oral movement, oral-tactile sensitivity, facial and oral tone, as well as basic respiration, phonation, and resonation skills	Jaw movement, lip movement, tongue movement, Oscillating Jaw, Lip, and Tongue Movements, oral & facial tone, respiration & phonation skills, resonance, oral-tactile sensitivity	4:0- 7:11	15- 30 minutes	Workbook and oral- motor supplies, administered by speech therapist	Criterion Referenced
Dworkin-Culatta Oral Mechanism Examination	Assesses the oral mechanism	Facial status, lip functioning, jaw functioning, hard palate, tongue functioning, velopharyngeal functioning, dentition, motor speech	All ages	5-10 minutes	Checklist, administered by speech therapist	Screening

Assessing Language: Receptive & Expressive Language						
Measure	**Purpose**	**Constructs Evaluated**	**Age**	**Time to Administer**	**Format/ Type of Administration**	**Format and Scores**
Preschool Language Scales-Fifth Edition (PLS-5)	Comprehensively evaluates Receptive and Expressive language abilities.	Evaluates a range of skills from pre-verbal, interaction-based skills to emerging language to early literacy	Birth- 7:11 years	45-60 minutes	Workbook with manipulatives, administered by speech therapist	Norm-Referenced Standardized Test
Clinical Evaluation of Language Fundamentals, Fifth Edition (CELF- 5)	Comprehensively evaluates Receptive and Expressive language abilities as well as Listening Comprehension, Memory, and Abstract Language Skills	Sentence Comprehension, Linguistic Concepts, Word Structure, Word Classes, Following Directions, Formulated Sentences, Recalling Sentences, Understanding Spoken Paragraphs, Word Definitions, Sentence Assembly, Semantic Relationships, Reading Comprehension, Structured Writing, and Pragmatic Profile	5:0 –21:11 years	30–45 minutes for the Core Language Score. Total assessment: variable	Workbook, administered by speech therapist	Norm-Referenced Standardized Test
Test of Language Development–Primary: Fifth Edition (TOLD P:5)	Identify primary children who are significantly below peers in oral language proficiency & determine their specific strengths and weaknesses in	Picture Vocabulary, Relational Vocabulary, Oral Vocabulary, Syntactic Understanding, Sentence Imitation, Morphological Completion, Word Discrimination, Word	4:0- 8:11 years	30- 60 minutes	Workbook, administered by speech therapist	Norm-Referenced Standardized Test

	oral language skills	Analysis, and Word Articulation				
Test of Language Development–Intermediate: Fifth Edition (TOLD I:5)	Identify intermediate aged children who are significantly below peers in oral language proficiency & determine their specific strengths and weaknesses in oral language skills	Sentence Combining, Picture Vocabulary, Word Ordering, Relational Vocabulary, Morphological Comprehension, and Multiple Meanings	8:0- 17:11 years	30- 60 minutes	Workbook, administered by speech therapist	Norm-Referenced Standardized Test
Receptive One-Word Picture Vocabulary Test, Fourth Edition (ROWPVT-4)	Assesses Receptive Vocabulary	Evaluates ability to receptively identify vocabulary by pointing to a given object, action, or idea.	2:0- 95 years	20 minutes	Workbook, administered by speech therapist	Norm-Referenced Standardized Test
Expressive One-Word Picture Vocabulary Test, Fourth Edition (EOWPVT-4)	Assesses Expressive Vocabulary	Evaluates ability to expressively label an object, action, category, or idea.	2:0- 95 years	20 minutes	Workbook, administered by speech therapist	Norm-Referenced Standardized Test
Peabody Picture Vocabulary Test | Fourth Edition (PPVT-4)	Assesses Receptive Vocabulary	Evaluates receptive vocabulary using two separate, but comparable versions so items cannot be “learned.”	2:6- 90+ years	10-15 minutes	Workbook, administered by speech therapist	Norm-Referenced Standardized Test
Expressive Vocabulary Test | Second Edition (EVT-2)	Assesses Expressive Vocabulary	Evaluates expressive vocabulary using two separate, but comparable	2:6- 90+ years	10-20 minutes	Workbook, administered by speech therapist	Norm-Referenced Standardized Test

		versions so items cannot be “learned.”				
The Word Test-3 Elementary	Assesses a student's ability to recognize and express semantic attributes critical to vocabulary growth and language competency	Associations, Synonyms, Semantic Absurdities, Antonyms, Definitions, Flexible Word Use (great to use in conjunction with language processing assessments)	6:0- 11:11 years	25-30 minutes	Workbook, administered by speech therapist	Norm-Referenced Standardized Test
The Word Test-2 Adolescent	Identify semantic weaknesses that impact academic, social, and vocational success by examining a student’s expressive vocabulary and semantic skills	Associations, Synonyms, Semantic Absurdities, Antonyms, Definitions, Flexible Word Use (great to use in conjunction with language processing assessments)	12:0- 17:11 years	25-30 minutes	Workbook, administered by speech therapist	Norm-Referenced Standardized Test

Assessing Processing: Auditory and Language Processing						
Measure	**Purpose**	**Constructs Evaluated**	**Age**	**Time to Administer**	**Format/ Type of Administration**	**Format and Scores**
The Listening Comprehension Test- 2 (LCT- 2)	Assesses listening through natural classroom situations. The tasks reveal students' strengths and weaknesses in integrated language problem solving, reasoning, and comprehension of material presented auditorily	Main ideas, Details, Reasoning, Vocabulary, Understanding Messages	6:0- 11:11 years	35-40 minutes	Presented auditorily, administered by speech therapist	Norm-Referenced Standardized Test
Listening Comprehension Test–Adolescent: Normative Update (LCT-A: NU)	evaluates a student's abilities in specific listening comprehension skills	Main ideas, Details, Reasoning, Vocabulary, Understanding Messages	12:0- 17:11	35-40 minutes	Presented auditorily, administered by speech therapist	Norm-Referenced Standardized Test
Language Processing Test 3: Elementary (LPT-3)	Assesses a hierarchy of discrete language-processing skills, ranging from simple to complex	Labeling, Stating Functions, Associations, Categorization, Similarities, Differences, Multiple Meanings, Attributes	5:0- 11:11 years	35 minutes	Workbook for Labeling subtest and all other subtests presented auditorily,	Norm-Referenced Standardized Test

					administered by speech therapist	
TAPS- 4 A Language Processing Skills Assessment	provides information about language processing and comprehension skills across three intersecting areas: phonological processing, auditory memory and listening comprehension	Processing Oral Directions, Word (Pair) Discrimination, Phonological Deletion, Phonological Blending, Syllabic Blending, Auditory Figure-Ground, Number Memory Forward, Number Memory Reversed, Word Memory, Sentence Memory, Auditory Comprehension of Language	5:0- 21 years	60- 90 minutes	Presented auditorily, administered by speech therapist	Norm-Referenced Standardized Test

Assessing Fluency: Stuttering & Cluttering						
Measure	**Purpose**	**Constructs Evaluated**	**Age**	**Time to Administer**	**Format/ Type of Administration**	**Format and Scores**
Stuttering Severity Instrument (SSI-4)	Measures stuttering severity in children and adults	Frequency, Duration, Physical Concomitants, Naturalness of the individual's speech	2:10 and older	15-20 minutes	Workbook, administered by speech therapist	Norm-Referenced Standardized Test
Test of Childhood Stuttering (TOCS)	Provides clinicians and researchers with a sound method for assessing a child's speech fluency skills and stuttering-related behaviors	Rapid Picture Naming, Modeled Sentences, Structured Conversation, Narration	4:0- 12:0 years	20-30 minutes	Workbook, administered by speech therapist	Norm-Referenced Standardized Test
Predictive Cluttering Inventory	Assisting clinicians in making differential diagnostic discriminations among people who clutter, people who both clutter and stutter, and those who do not have a fluency problem	Assesses fluency in pragmatics, speech-motor, language-cognition, motor coordination- writing problems	All ages	5-10 minutes	Checklist, completed by speech therapist	Screening Instrument

Assessing Pragmatics: Social and Emotional Skills						
Measure	**Purpose**	**Constructs Evaluated**	**Age**	**Time to Administer**	**Format/ Type of Administration**	**Format and Scores**
Social Language Development Test–Elementary Normative Update (SLDT-E: NU)	Assesses language-based skills of social interpretation and interaction with friends	Making inferences, interpreting photographed scenes, and explaining how they would resolve problems with peers	6:0- 11:11	45 minutes	Workbook, administered by speech therapist	Norm-Referenced Standardized Test
Pragmatic Language Skills Inventory (PLSI)	Determines whether a student exhibits a pragmatic language disorder	Personal interaction skills, social interaction skills, classroom interaction skills	5:0- 12:11	5-10 minutes	45 item rating scale, completed by teachers	Norm-Referenced Standardized Test
Test of Pragmatic Language Second Edition (TOPL-2)	Examines social skills and conflict resolution	Examines effectiveness and appropriateness of a student's pragmatic language skills based upon physical setting, audience, topic, speech acts, visual-gestural cues, and abstraction	6:0- 18:11	45-60 minutes	Workbook, administered by speech therapist	Norm-Referenced Standardized Test

Speech and Language Support Effective Practices in Caseload Selection, Service and Dismissal- A Program Assessment Matrix

The Connection to General Education

Pennsylvania Technical Assistance and Training Network
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The following considerations represent technical assistance content. They are based on considerable experience with providing speech and language support services. They represent current research practices and are responsive to the IDEA. These considerations do not represent rules, but rather initial considerations that can be modified, based on individual student needs and overall program delivery

Table of Contents

Instructions: Read and discuss the effective practice listed within each program area. Place a checkmark in the appropriate column that describes where you are with the particular effective practice. Getting Started—I really do not utilize this practice or do not know much about it. Along the Way—I know about the practice and utilize it intermittently. Regular and Frequent—I utilize the practice on a weekly and daily basis in operating my caseload.

Effective Practice	Getting Started	Along the Way	Regular and Frequent Practice
Content and management practices to serve students who are being considered or are already on the caseload			
Initial Assessment			
1. The use of current, typical standardized tests should only be used to assist in narrowing large numbers of students who may need additional assessment. They should not be used as the main criteria to select students for the caseload. These tests often only measure communication skills in isolated and artificial situations. For example, most of the comprehension tests ask students to identify an abstract picture or action. Most of the expression tests ask students to name and describe abstract pictures in isolated situations. The depth of commercially available assessments in most content areas is lacking.			
2. The use of more than one or two standardized tests at the initial assessment/IEP is not advised.			
3. The use of curriculum-based measures and developmental indices (checklists) is advised in order to more adequately assess communication skills and their effects on academic performance, particularly a form on which to record a language sample.			
4. Keep in mind that academic performance or educational significance is not determined solely by a student's grades. The significance of a communication problem is determined by comparing a student's current levels with what the curriculum (not an individual teacher; not only the textbook) requires him or her to do at			

Effective Practice	Getting Started	Along the Way	Regular and Frequent Practice
specific grade levels in specific subjects.			
5. We need to increase the credibility and importance of curriculum-based and developmental indices to a level above the credibility we place on current standardized measures. Just because an instrument is standardized does not mean that it is valid, reliable, and objective in assessing communication skills.			
6. Ironically, curriculum-based and developmental indices are more valid indicators of a student's communication skills because they assess the student in actual contextual situations that are content-based. It is these types of assessments that are more objective in determining what a student can and cannot do.			
IEP Review Assessment			
1. An important principle in teaching and assessment is that the assessment should correspond to the teaching and vice versa. Determining a student's progress according to current commercial standardized tests is a wide band practice that may or may not correspond to what the student has learned since the last assessment.			
2. Standardized assessments in speech and language are fairly reliable through nine years of age for making wide band, global correspondences to what is taught in the early grades. After nine years of age, there is a large drop in their correspondence to what is taught in the grades.			
3. The decision as to whether a student has made			

Effective Practice	Getting Started	Along the Way	Regular and Frequent Practice
progress or whether to continue the student in speech and language support should be made according to the IEP goals, objectives, and specially designed instruction, and not based on standardized tests that likely do not correspond to what was taught and learned since the previous assessment.			
4. Assessment at IEP review should include curriculum-based and developmental checklists that correspond to the curriculum and to what is in the current IEP, as well as the level to which the student has mastered his goals.			
Dismissal Assessment			
1. Successful completion or unsuccessful completion of the IEP should be the criteria in deciding on dismissal. When a student completes the IEP (assuming it was accurately developed and implemented), he or she is dismissed as corrected from speech and language support.			
2. There is no need to administer standardized tests to decide on dismissal. For many of the students who also receive another form of special education, in addition to speech and language support, the standardized test may indicate little or no improvement. This situation exists because the standardized test does not correspond to the IEP, and because the student will not necessarily gain one year of growth, as measured by these tests, in a calendar year.			

Effective Practice	Getting Started	Along the Way	Regular and Frequent Practice
Additional Practices for Caseload Selection			
1. In many instances, speech and language support clinicians are presented with a large number of students who may have speech and language differences. All of these students are typically not appropriate for the IEP caseload. Certain criteria need to be employed in determining whether a student has a speech and language disability and whether he also needs specially designed instruction.			
2. Generally, single sound articulation errors (lisp is one error, r variation is one error) in preschool, kindergarten, first grade, and possibly even second grade should not be on the IEP caseload. Nor should these cases be served in pre-referral intervention (inst support, rtii or child study). Unfortunately these cases dominate the caseloads (as much as 50% in some schools) in both educational and medical settings, and reduce the time needed for more appropriate cases.			
3. When the sound errors mentioned above exist with additional problems, such as intelligibility, phonemic awareness, and language comprehension or expression difficulties, these students are appropriate for the caseload.			
4. A student placed on the caseload at the preschool, kindergarten, or first grade levels who completes his "language-based" objectives, and still has the single sound errors, should be dismissed from the caseload and reassessed at a later time.			
5. Students who are served for syntax problems should indeed have a syntax problem, as differentiated from a grammar problem. A			

Effective Practice	Getting Started	Along the Way	Regular and Frequent Practice
grammar problem is one or two errors not interfering with intent. A syntax problem may emerge when there are three or more grammar errors. A syntax problem has more to do with having difficulty with intent, as well as with the student being understood.			
6. Students who have multiple articulation problems are high risk for phonemic awareness difficulties and difficulty in learning to read. They need to learn the phonological base of the language from the speech and language support clinician because no one else in the school has the expertise at this point in time.			
Effective Practices for students who require more than one mode of service			
1. Different modes of service should be established in each school served. These modes include prereferral intervention, therapy pullout and classroom. Each of these modes, except prereferral intervention requires an IEP.			
2. When different modes of service are established properly in each school, it is possibly more effective for students who need special education in addition to speech and language support. The problem over the years has been that modes other than therapy pullout are often not treated with the same importance as traditional pull out therapy. If all modes are treated equally, and all stakeholders can see that this is the case, then they understand that their child can receive appropriate services.			
3. Young students are best served with a combination of therapy and classroom modes. The classroom mode includes contact by the speech and language support person teaching in			

Effective Practice	Getting Started	Along the Way	Regular and Frequent Practice
the classroom, as well as teaching the student in the therapy setting. The classroom mode has goals, materials, structure and specific classroom teacher follow through.			
4. There is an assumption in the medical model that one-on-one instruction results in more improvement than small group, or even classroom instruction. There is no evidence base to prove this point. There is a significant amount of research to prove that small group and classroom instruction results in more improvement. This information is from general education.			
5. A recurring problem is that many speech and language support providers do not believe that modes other than pullout therapy are as valued as traditional therapy, and therefore project the same belief to teachers, parents, students, and others.			
6. We have to work hard to improve the credibility of all modes of service. The common, incorrect assumption is that if speech and language modes other than therapy pullout are as well developed as therapy pullout, that speech and language support providers will not be needed. Fifteen years of revised special education rules allowing the different modes of service do not support this assumption.			
7. The basic decision is that a student needs speech and language support or he does not. The main person in that decision is still the speech and language support provider.			
8. If the student needs speech and language support in any mode, then he needs goals and specially designed instruction, and hence, the speech and language support provider. Even students who are very low functioning who are			

Effective Practice	Getting Started	Along the Way	Regular and Frequent Practice
only seen intermittently in a classroom mode require goals and specially designed instruction. Students seen on a regular basis, whether inside or outside of the classroom, should have specific goals and objectives and specially designed instruction.			
9. Consultation or Monitoring should not be used unless the student has goals and specially designed instruction that result in the speech and language support specialist physically instructing the student inside or outside of the classroom. Either a student needs you or he does not. If he does, it requires an IEP with credibility.			
10. When different modes of service delivery are established in each school, more students who need speech and language support can be served appropriately.			
11. Reduce the practice of comparing a student's mental age with his language age. ASHA refers to this as cognitive referencing and does not support it. This practice is old, and has resulted in students who could benefit from intervention from receiving services. Particularly, students who can be taught to improve their speech intelligibility benefit from intervention at the younger and intermediate ages, even though some standardized test equates their mental age with their language age. Students who need augmentative communication or social language skills are also adversely affected by this old practice.			
12. At the young elementary levels, you will probably have students who have other special education needs on both the therapy mode and the classroom mode. The classroom mode referred to here is the self-contained or resource room classroom. Providing both modes of service for young students allows us to obtain			

Effective Practice	Getting Started	Along the Way	Regular and Frequent Practice
very good baselines of performance, and establishes the consistency of service over the years.			
13. As the students get older, age 9-10, and they have been on the speech and language caseload for the 4-5 years prior, it is time to start to reduce the comprehension area that addresses vocabulary, and move it more to practical considerations. Continue with the expression skills. Hopefully you have only been working on articulation in a spoken language context to this point.			
14. Differentiate at the 9-10 year age level between articulation, spoken language, grammar, and syntax. The point is to direct efforts toward spoken language. Spoken language differs from articulation in that spoken language addresses the motor planning and production of words, phrases, and sentences to make oneself understandable. Spoken language is more concerned with syllables, approximations, intelligibility, rate of speech, syllable distortions and "run-on" words and syllables. Articulation is concerned more with precise production of single sounds in words and sentences.			
15. At the 9-10 year old age level, move the comprehension and association objectives to the classroom mode.			
16. At the 9-10 year old age level, start to decide who will be served in the classroom mode only, and who will continue to be served in both classroom and therapy pullout modes.			

Special Diagnostic Categories

Effective Practice	Getting Started	Along the Way	Regular and Frequent Practice
While it is not correct to equate diagnostic category with whether a student needs services, it is appropriate to consider these categories when delivering consistent service over time to a particular school. *Certain diagnostic categories, when combined with communication difficulties, represent a high profile for the speech and language support provider.* *This means that the credibility of the speech and language service over time rests with handling certain cases well.*			
1. Stuttering cases receive a high priority over time.			
2. Asperger's cases receive a high priority and service over time.			
3. Hearing impairment cases receive a high priority and service over time.			
4. Head trauma cases receive a high priority and service over time.			
5. Voice cases receive a high priority and service for a short period of time.			
6. Articulation cases receive a high priority and service over time in older students.			
7. These special diagnostic category cases can often be served effectively through the high school when speech and language support has more than the pullout therapy mode of service in a particular school.			
Whole school instructional issues directly determining			

Effective Practice	Getting Started	Along the Way	Regular and Frequent Practice
the effectiveness of speech and language support			
Vocabulary Instruction and A Speech and Language Disability			
1. Vocabulary instruction presents a special situation for speech and language support because vocabulary is often associated with language development and a language disability. However it is important to understand that teaching vocabulary is everyone's responsibility, and that the major responsibility for teaching vocabulary lies with classroom teachers because vocabulary instruction occurs in every subject and is exponential in its development.			
2. To expect that speech and language support can carry the main responsibility for vocabulary teaching is incorrect. This incorrect assumption often emanates from many tests, particularly psychological and individual achievement tests that provide a subtest of vocabulary. When the particular test reveals a low score in vocabulary, a referral often occurs to speech and language because of the language connection.			
3. There are three main types of vocabulary words. They are basic language concepts, specific subject area words and relational words that are necessary to understand the particular subject, including reading.			
4. The basic language concept words consist			

Effective Practice	Getting Started	Along the Way	Regular and Frequent Practice
of approximately 200 or so words that students need to be able to communicate at basic levels, such as locations, prepositions, self care verbs, basic naming of objects, etc. When a student does not understand these words, he may be considered to have a speech and language disability.			
5. The specific subject area words, including stories in reading, are words that most all students need to be taught in an explicit manner during the actual teaching of the subjects. When a student does not understand these words, a speech and language disability typically does not exist, unless the problem is word finding.			
6. Relational words are words that are necessary to function within the subject, such as compare, contrast, classify, categorize, construct, etc. These words must also be taught in an explicit manner in each subject because they may have different meanings in different subjects. Even if students understand the specific subject area words, they will miss important information. Therefore, attention needs to be provided to these words. When a student has difficulty understanding these words, a speech and language disability may exist, but it is not in isolation to the overall depressed pattern of his or her learning.			
7. The speech and language support specialist has specific contributions to make to the teaching of vocabulary, particularly with young students for basic concepts, and should assist the classroom and special teachers. However, having students on the caseload for strictly vocabulary work beyond the basic concepts is questionable.			

Effective Practice	Getting Started	Along the Way	Regular and Frequent Practice
It is better to provide the IEP team with specific demonstrations on how to introduce new words.			
Following Directions			
1. Following directions is not a speech and language disability in and of itself. It is critical to differentiate between following directions and understanding the basic language concept words that go along with the directions.			
2. Typically, once this distinction is made, we come to realize that many requests to work on following directions do not involve the inability to understand directions. They involve the rate, length and complexity of the directions, which is not a speech and language disability. It is an instructional issue for all classroom and special teachers to address.			
Scheduling Practices			
1. Schedule an assessment period in each school first.			
2. Schedule a classroom language period or two next (more are needed to effectively serve the school, as well as when there are very needy students in special education on the caseload)			
3. Schedule your lunch next.			
4. Do not yield on the first three tips.			

Effective Practice	Getting Started	Along the Way	Regular and Frequent Practice
5. Schedule time slots to work with kindergarten students. During September and October, these times should be in the classroom only, and then shift to pull-out, as you determine who really has a speech and language problem and who is developmental.			
6. Next schedule the older articulation students from the upper grades. The credibility of speech and language support to work with language cases is diminished when we do not clear up the older articulation students.			
7. Next schedule students from classes who have spoken language difficulties, as distinguished from articulation problems. Students with multiple articulation errors count as students with spoken language problems.			
8. A last priority is students who have understandable spoken language (sentences, multi syllable words, syntax intact) who are referred for auditory processing or comprehension problems. There are other providers, such as instructional support, remedial reading and special education who should work with these students, whose primary problem is not in speech and language.			

ARTIC GOAL BANK

Goal:
During structured speech sessions, the student will accurately articulate the _____ sound(s) to the _____ level with 90% accuracy as measured by data collection taken in 2 consecutive sessions in which the skill is targeted for each skill at each level of production (isolation, syllable, words, phrases, sentences, answering questions, oral reading, conversation) from the following baseline:_____

Objectives:

- The student will demonstrate articulatory placement for the targeted sounds with 90% accuracy.
- The student will accurately articulate the targeted sounds in isolation with 90% accuracy.
- The student will accurately articulate the targeted sounds in syllables with 90% accuracy.
- The student will accurately articulate the targeted sounds in words with 90% accuracy.
- The student will accurately articulate the targeted sounds in phrases with 90% accuracy.
- The student will accurately articulate the targeted sounds in sentences with 90% accuracy.
- The student will accurately articulate the targeted sounds when answering questions with 90% accuracy.
- The student will accurately articulate the targeted sounds during ___ minutes of oral reading with 90% accuracy.

The student will_____

Goal:
During structured speech sessions, the student will decrease the use of the phonological processes of ____ to 10% of each level of production through the hierarchy of syllables, words, phrases, and sentences by data collection taken in 2 consecutive sessions in which the skill is targeted from a baseline of: _____

Objectives:

- The student will decrease the use of targeted processes to 50%
- The student will decrease the use of targeted processes to 30%

The student will_____

The student will_____

ARTIC GOAL BANK

Goal:
During structured speech sessions, the student will accurately produce words of 10 different word shapes (ex. cvcv, vc, cv, cvc, etc.) independently with 85% accuracy per word shape as measured by data collection taken in 2 consecutive sessions in which the skill is targeted from a baseline of 0% accuracy.

Objectives:
- The student will accurately articulate 3 targeted words shapes with 85% accuracy
- The student will accurately articulate 6 targeted words shapes with 85%accuracy.

The student will_____

The student will_____

Goal:
During structured speech sessions, the student will demonstrate improved motor planning for speech by repeating sentences of increasing complexity at each targeted skill level (7-9 syllables, 10-11 syllables, and 12-13 syllables) with 90% accuracy as measured by data collection taken in 2 consecutive sessions in which each skill is targeted from a baseline of: _____

Objectives:
- The student will repeat sentences of 7-9 syllables with 90% accuracy.
- The student will repeat sentences of 10-11 syllables with 90% accuracy.

The student will_____

The student will_____

ARTIC GOAL BANK

Goal:
During structured speech sessions, the student will accurately articulate multisyllabic words (2-4 syllables) a) while repeating the clinician's model and b) independently with 90% accuracy of each skill at each level as measured by data collection taken in 2 consecutive sessions in which each skill is targeted from a baseline of: (a); (b)

Objectives:

- The student will accurately articulate 2 syllable words with 90% accuracy when repeating the clinician's model.
- The student will accurately articulate 3 syllable words with 90% accuracy when repeating the clinician's model.
- The student will accurately articulate 2 syllable words independently with 90% accuracy.
- The student will accurately articulate 3 syllable words independently with 90% accuracy.

The student will_____

The student will_____

Language Goals–Syntax

Goal:
During structured speech sessions, the student will use three-word utterances consisting of ___ to describe pictures, objects, or ongoing events in the therapy room with 80% accuracy as measured by data collection taken in 2 out of 3 consecutive sessions in which the skill is targeted. Baseline _____

- The student will use single-word utterance to describe pictures, objects, or ongoing events with 80% accuracy.
- The student will use two-word utterances consisting of “noun + verb”, “verb + noun”, adjective + noun”, and “pronoun + verb” to describe pictures. Objects, or describe pictures, objects, or ongoing events with 80% accuracy.
- The student will use three-word utterances consisting of ___ to describe pictures, objects, or ongoing events with 80% accuracy when provided with one model or cue.
- The student will _____
- The student will _____

Goal:
When presented with pictures or questions in the therapy setting, the student will use the following grammatical constructions in simple sentences with 80% accuracy as measured by data collection take in 2 out of 3 consecutive sessions in which the skill is targeted: (list forms). Baseline: _____

- The student will point to the picture that matches the target grammatical form with 85% accuracy.
- The student will repeat simple sentences containing target structures with 80% accuracy.
- The student will describe pictures using simple sentences containing target structures with 80% accuracy when provided with on cue/prompt.
- The student will _____
- The student will _____

Goal:
During structured therapy sessions, the student will independently formulate complete sentences of __ or more words that include (insert target grammar/syntax skill) to describe pictures and/or answer questions with 80% accuracy as measured by data collection taken in 2 out of 3 consecutive sessions in which the skill is targeted.
Baseline: _____

- The student will repeat sentences of ____or more words containing the target skill with 80% accuracy.
- The student will independently formulate sentences of __ to __ words containing the target skill with 80% accuracy.
- The student will _____
- The student will _____

Pragmatic Language Goals- Nonverbal Language

Goal:
Given a picture or role-play scenario, the student will accurately interpret the following nonverbal cues _____ (facial expression, body language/position, eye contact/ gaze, tone of voice, vocal volume) by stating the communication intent or message in 80% of trials as measured by therapy data taken in 2 out of 3 consecutive sessions in which the skill was targeted.

The student will _____

The student will _____

The student will _____

Goal:
Given a picture or role-play scenario, the student will accurately identify the emotion presented and then infer the - possible cause or reason for the person's emotional response to the situation in 80% of trials as measured by therapy data taken in 2 out of 3 consecutive sessions in which the skill was targeted.

The student will _____

The student will _____

The student will _____

Goal:
The student will accurately identify -pictured or role-played facial expressions and state at least two specific non-verbal cues that helped determine the answer (i.e. position of - eyebrows, eyes, mouth, etc.) in 80% of trials as measured by therapy data taken in 2 out of 3 consecutive sessions in which the skill was targeted

The student will _____

The student will _____

The student will _____

Pragmatic Language Goals- Nonverbal Language

Goal:
The student will demonstrate - shared/joint attention to a (preferred/non-preferred) object or (structured/ un-structured) activity with a (peer/adult) for_ (time period) as measured by therapy data taken in 2 out of 3 consecutive sessions in which the skill was targeted

The student will _____

The student will _____

The student will _____

Goal:
While engaged in a structured activity/ conversation with others, the student will show improved engagement and awareness of others by independently exhibiting at least one of the following three skills: a.) engaged, positive, non-verbal communication (i.e. turning body, eye gaze/eyecontact, smiling and gestures), b.) spontaneous initiation of a request, greeting or question within 3-5 seconds, in 4 of 5 trials as measured by therapy data taken in 2 out of 3 consecutive sessions in which the skill was targeted.

The student will _____

The student will _____

The student will _____

Pragmatic Language Goals- Conversation skills:

Goal:
The student will increase conversation skills by: a) stating the expected and unexpected conversation skills for gaining attention, starting a conversation, maintaining a conversation, and closing a conversation and then, b) demonstrating the expected conversational behaviors listed above during interaction in (structured therapeutic session/unstructured therapeutic session, unstructured activity, etc.) with 80% accuracy for each skill set as measured by therapy data taken in 2 out of 3 consecutive sessions in which the skill was targeted.

The student will _____

The student will_____

The student will_____

Goal:
The student will maintain the topic and focus of a conversation by asking questions and/ or making comments that extend the dialogue for a minimum of 3 conversational turns in 4 out of 5 trials as measured by therapy data taken in 2 out of 3 consecutive sessions in which the skill was targeted.

The student will _____

The student will_____

The student will _____

Goal:
The student will maintain the topic and focus of a conversation by asking questions and/ or making comments that extend the dialogue for a minimum of 3 conversational turns in 4 out of 5 trials as measured by therapy data taken in 2 out of 3 consecutive sessions in which the skill was targeted.

The student will _____

The student will_____

The student will _____

Pragmatic Language Goals- Conversation skills:

Goal:
The student will identify appropriate topics of conversation for the communicative partner (adult vs. peer) and setting (time and place) in 4 out of 5 trials as measured by therapy data taken in 2 out of 3 consecutive sessions in which the skill was targeted.

The student will _____

The student will _____

The student will _____

Goal:
The student will state conversation repair strategies (ask for repetition/clarification, rephrasing, and starting "I don't know) then demonstrate the strategy during real or structured conversational activities in 4 out of 5 trials measured by therapy data taken in 2 out of 3 consecutive sessions in which the skill was targeted.

The student will _____

The student will _____

The student will _____

Goal:
In a role-play or "real time" situation, the student will initiate and/or respond to greetings/farewells from peers and adults within a ___ second time period in 80% of trials as measured by therapy data taken in 2 out of 3 consecutive sessions in which the skill was targeted.

The student will _____

The student will _____

The student will _____

Pragmatic Language Goals- Perspective taking:

Goal:
Given a social scenario (real or hypothetical) the student will demonstrate the ability to take the perspective of those involved by observing and interpreting verbal and nonverbal information by 1) starting thoughts/feelings of the characters and 2) identifying at least one nonverbal cue that helped determine the answer in 80% of trials as measured by therapy data taken in 2 out of 3 consecutive sessions in which the skill is targeted.

The student will _____

The student will _____

The student will _____

Goal:
The student will improve perspective taking skills by defining how others make an impression of him/her and how he/she makes an impression on others given social scenarios or real life situations during therapy activities by a) defining how others make an impression on him/her using the parameters of what a person says, does or looks like, b) define how he/she makes an impression on others using the parameters of what de does, says or looks like and, c) role play the situation using expected social behaviors to make a positive impression on others in 80% of opportunities as measured by therapy data taken in 2 out of 3 consecutive sessions in which the skill was targeted

The student will _____

The student will _____

The student will _____

Goal:
After listening to a peer or adult tell a story, describe an event or tell a personal narrative, the student will demonstrate ability to attend to the speaker and functionally use the information given by completing at least 2 of the following tasks: 1) listing at least 2 relevant details, 2) asking at least 2 “good” questions, 3) making a relevant comment (i.e. stating a fact or opinion) in 80% of trials as measured by therapy data taken in 2 out of 3 consecutive sessions in which the skill was targeted.

The student will _____

The student will _____

The student will _____

Pragmatic Language Goals- Self-advocacy

Goal:
To improve functional self-advocacy skills, given a variety of role-play social scenarios the student will communicate wants and needs in a clear, social scenarios the student will communicate wants and needs in a clear, socially appropriate manner (requesting assistance, persuade others, negotiate, protest, stating/justifying opinions) on 4 out of 5 opportunities as measured by therapy data taken in 2 out of 3 consecutive sessions in which the skill was targeted.

The student will _____

The student will _____

The student will _____

Pragmatic Language Goals- Problem solving/making inferences:

Goal:
When provided with a picture or verbal information about a real or hypothetical social situation, the student will make inferences to respond to questions about the scene or situation and identify “clues” (nonverbal information, situation information, background knowledge, tec.) that helped determine the answer in 80% of trials as measured by therapy data taken in 2 out of 3 consecutive sessions in which the skill was targeted

The student will _____

The student will _____

The student will _____

Goal:
When provided with a picture or verbal information about a real or hypothetical social situation, the student will make inferences to make a prediction about what will happen next in 80% of trials as measured by therapy data taken in 2 out of 3 consecutive sessions in which the skill was targeted.

The student will _____

The student will _____

The student will _____

Goal:
Given a real or hypothetical problem or unexpected behavior, the student will state a social strategy that could help solve the problem (i.e. social fake, social filter, problem triangle, self talk , self calming strategies) and demonstrate use of the strategy (as necessary) in 80% of trials as measured by therapy data taken in 2 out of 3 consecutive sessions which the skill was targeted.

The student will _____

The student will _____

The student will _____

Pragmatic Language Goals- Expected/Unexpected behavior:

Goal:
The student will identify expected and unexpected behaviors for a variety of social situations given a target scenario or picture with 80% accuracy as measured by therapy data taken in 2 out of 3 consecutive sessions in which the skill was targeted.

The student will _____

The student will_____

The student will_____

Goal:
When presented with real or hypothetical situations, the student will 1) identify expected behaviors or “hidden rules” for the situation of group, 2) identify potential unexpected behaviors that could occur, and 3) explain possible outcomes of expected/unexpected behaviors as they may affect the group as a whole as well as the thoughts/feelings of individuals involved in 80% of trials as measured by therapy data taken in 2 out of 3 consecutive sessions in which the skill was targeted

The student will _____

The student will_____

The student will_____

Goal:
In a structured situation and given a preview-review of skills, the student will engage in socially expected behaviors (including but not limited to: insert target skills for student here) in 80% of trials as measured by therapy data taken in 2 out of 3 consecutive sessions in which the skill was targeted.

The student will _____

The student will_____

The student will_____

Pragmatic Language Goals- Self-monitoring:

Goal:
The student will identify, monitor and apply adaptive behaviors to present himself/herself as considerate, friendly and/or socially aware of others/peers by exhibiting the following 3 skills: 1) with adult questioning, Independently identify 2 consistent self-identified behaviors to improve upon; 2) with adult questioning, independently identify and explain at least 2 adaptations or strategies to appropriately change the two above self identified behaviors (i.e. use my social filter); 3) independently practice or attempt one adaptation/strategy during real-life social interactions 1-3 times per week in 4 out of 5 opportunities for each skill as measured by therapy data taken in 2 out of 3 consecutive sessions in which the skill was targeted.

The student will _____

The student will _____

The student will _____

Goal:
In the context of a therapy session, the student will completer these three components to analyze his/her social behavior/interactions in 4 out of 5 trials as measured by therapy data taken in 2 out of 3 consecutive sessions in which the skill was targeted:
a. Participate in discussion about his social interactions and choices,
b. Accept constructive feedback without negative response
(i.e. excuses, withdraw from group, negative self-talk, etc.),
c. Independently model or explain an alternative positive behavior in response to the feedback in 80% of trials over two consecutive sessions.

The student will _____

The student will _____

The student will _____

Pragmatic Language Goals- “Early Learner” goals

Goal:
The student will increase use of social skills through responding to greetings, initiating greetings, and initiating interactions with peers in 4 out of 5 trials as measured by therapy data taken in 2 out of 3 consecutive sessions in which the skill was targeted.

- The student will respond to greetings/farewells from peers 80% of the time.
- The student will initiate greetings/farewells with adults at least 80% of the time.
- The student will approach peers or peer buddies to initiate an interaction, using a verbal request to the peer, with no more than one prompt in 80% of the time.

Goal:
The student will greet a person and ask a question about an activity using “who” “What”, or “where” questions to keep a conversation going for a minimum of 4 exchanges in 4 out of 5 trials as measured by therapy data taken in 2 out of 3 consecutive sessions in which the skill was targeted.

- The student will greet a person and ask a question about an activity using “who”, “what”, or “where” questions to keep a conversation going for a minimum of 2 exchanges on 4 out of 5 opportunities/ trials.
- The student will greet a person and ask a question about an activity using “who”, “what”, or “where” questions to keep a conversation going for a minimum of 2 exchanges on 4 out of 5 opportunities/trials.
- The student will greet a person and ask a question about an activity using “who”, “what”, or “where” questions to keep a conversation going for a minimum of 3 exchanges on 4 out of 5 opportunities/trials.

Voice Goal Bank

Goal:
During structured therapy sessions, the student will recognize and define selected voicerelated vocabulary and characteristics of the vocal mechanism with 90% accuracy as measured by data collections taken in 2 out of 3 consecutive sessions in which the vocabulary is targeted. Baseline: _____

Objectives:

- The student will recognize and define voice-related vocabulary including “voice hygiene” and “vocal abuses” with 90% accuracy.
- The student will recognize and define characteristics of the vocal mechanism including: the speech helpers and speech production processes with 90% accuracy.
- The student will_____
- The student will_____

Goal:
During structured therapy sessions, the student will name the factors that contribute to vocal abuse and good vocal hygiene with 90% accuracy as measured by data collection taken in 2 out of 3 consecutive sessions in which the skill is targeted.
Baseline: _____

Objectives:

- The student will name the factors and behaviors that contribute to vocal abuse with 90% accuracy
- The student will name the behaviors that facilitate good vocal hygiene with 90% accuracy
- The student will _____
- The student will _____

SPECIALLY DESIGNED INSTRUCTION SPEECH AND LANGUAGE SUPPORT

In most instances, specially designed instruction is an additional technique, practice, activity, and assessments that can be used for all students. Students being instructed using the regular education curriculum, sometimes with modifications, regardless of where they receive their instruction. Should be delivered in many settings by all educators.

- Specially Designed Instruction is specific to skill deficits identified in the assessment process.
- It is not particular to specific subjects.
- SDI is the “skilled” portion of your service
- It flows directly from assessment
- It includes the specific skills that the SLP brings to the casebrings case
- It includes a highly skilled service that on one else on the IEP team can deliver
- It includes wording that is understandable to others, but it first includes what the student needs according to your assessment
- SDI includes program and materials modifications, but more importantly
- SDI includes the “what” of what the student needs in order to be successful with the SL goals and with the overall curriculum
- SDI should not be “watered down” to only include what the SLP might want others to do
- SDI includes what the SLP does in therapy as well as what the SLP or others will do in a classroom or carryover situation

Speech Language Data Collection Sheet

PTS PEDIATRIC THERAPEUTIC SERVICES

↓ Total Number of Trials ↓

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	
100%	50%	33%	25%	20%	17%	14%	13%	11%	10%	9%	8%	8%	7%	7%	6%	6%	6%	5%	5%	5%	5%	4%	4%	4%	1
	100%	67%	50%	40%	33%	29%	25%	22%	20%	18%	17%	15%	14%	13%	13%	12%	11%	11%	10%	10%	9%	9%	8%	8%	2
		100%	75%	60%	50%	43%	38%	33%	30%	27%	25%	23%	21%	20%	19%	18%	17%	16%	15%	14%	14%	13%	13%	12%	3
			100%	80%	67%	57%	50%	44%	40%	36%	33%	31%	29%	27%	25%	24%	22%	21%	20%	19%	18%	17%	17%	16%	4
				100%	83%	71%	63%	56%	50%	45%	42%	38%	36%	33%	31%	29%	28%	26%	25%	24%	23%	22%	21%	20%	5
					100%	86%	75%	67%	60%	55%	50%	46%	43%	40%	38%	35%	33%	32%	30%	29%	27%	26%	25%	24%	6
						100%	88%	78%	70%	64%	58%	54%	50%	47%	44%	41%	39%	37%	35%	33%	32%	30%	29%	28%	7
							100%	89%	80%	73%	67%	62%	57%	53%	50%	47%	44%	42%	40%	38%	36%	35%	33%	32%	8
								100%	90%	82%	75%	69%	64%	60%	56%	53%	50%	47%	45%	43%	41%	39%	38%	36%	9
									100%	91%	83%	77%	71%	67%	63%	59%	56%	53%	50%	48%	45%	43%	42%	40%	10
										100%	92%	85%	79%	73%	69%	65%	61%	58%	55%	52%	50%	48%	46%	44%	11
											100%	92%	86%	80%	75%	71%	67%	63%	60%	57%	55%	52%	50%	48%	12
												100%	93%	87%	81%	76%	72%	68%	65%	62%	59%	57%	54%	52%	13
													100%	93%	88%	82%	78%	74%	70%	67%	64%	61%	58%	56%	14
														100%	94%	88%	83%	79%	75%	71%	68%	65%	63%	60%	15
															100%	94%	89%	84%	80%	76%	73%	70%	67%	64%	16
																100%	94%	89%	85%	81%	77%	74%	71%	68%	17
																	100%	95%	90%	86%	82%	78%	75%	72%	18
																		100%	95%	90%	86%	83%	79%	76%	19
																			100%	95%	91%	87%	83%	80%	20
																				100%	95%	91%	88%	84%	21
																					100%	96%	92%	88%	22
																						100%	96%	92%	23
																							100%	96%	24

↓ Total Number Correct ↓

LEVEL OF CUEING:

No Cues:
Independent or only needed wait time.

Minimal Cues = Cues provided in less than 40% of trials.
(e.g., cues given 1-2x in 5 trials)

Moderate Cues = Cues provided between 40-80% of the time.

Maximum Cues= Cues provided in over 80% of trials.

TYPES OF CUES:

Verbal			
(Indirect) Comment	**Visual**		
Open Ended Question	Written Directions	**Tactile**	
Cloze Statement	Visual Directions	Hand Over Hand	**Gestural**
Binary Choice	Model Articulatory Posture	Partial Physical	Specific or General Pointing
Yes/No Question	Facial Expression	General Tactile	Sign Language
Modeling	Body Language	Touch/Tap	Hand Cue
Explicit Direction	Eye Gaze	Positional	Pantomime

Rubric

PTS PEDIATRIC THERAPEUTIC SERVICES

Name_____

Target	Syllable Structure	Consistent Production	Vowel Accuracy	Prosody	Date/Progress/Cueing/ Comments

Current Targets Monthly Practice

PTS PEDIATRIC THERAPEUTIC SERVICES

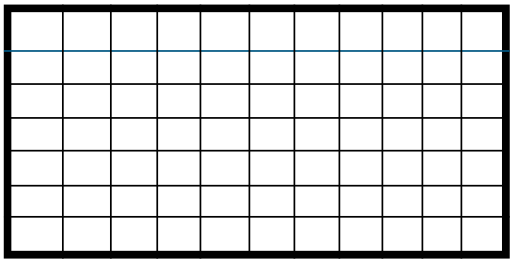
Target	Level of Production	Cumulative Average	Goal Met	Moved to Maintenance

Articulation Data Collection

Name: _____

Date:

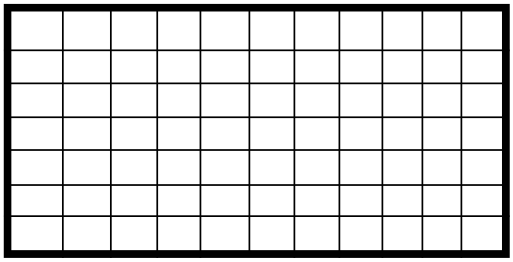
Sound:



Results: _____

Date:

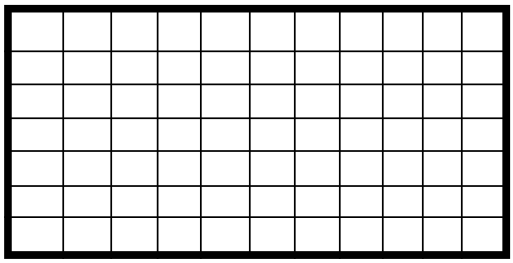
Sound:



Results: _____

Date:

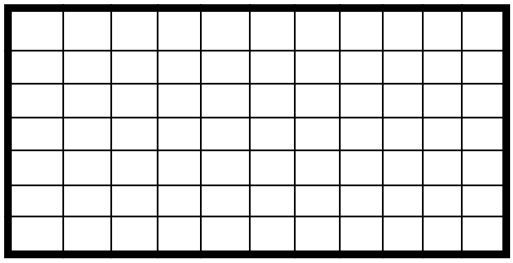
Sound:



Results: _____

Date:

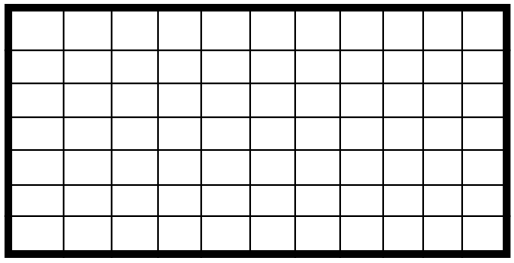
Sound:



Results: _____

Date:

Sound:



Results: _____

Data Sheet

PTS PEDIATRIC THERAPEUTIC SERVICES

Date of Session: _____

Date of Next Session: _____

Targets:

Data Collection with Attendance

PTS PEDIATRIC THERAPEUTIC SERVICES

IEP Date: _____

Name: _____

Goals: _____

Therapist: _____

January	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Febraury																															
March																															
April																															
May																															
June																															
July																															
August																															
September																															
October																															
November																															
December																															

January	February
March	April
May	June
July	August
September	October
November	December

LANGUAGE AND LITERACY DEVELOPMENT

Expressive Language

- Given verbal [and visual] prompts [and models] faded to elimination, or the number of prompts required to elicit the target response for each trial, observation, or assessment by the end of the year, student name, will outcome from those listed below in ___ of _____consecutive trials [observations] [assessments.,
- Babble two syllables together
- Imitate ___ facial expressions (up to 5) and ___ gestures (up to 5)
- Wave goodbye and hello, claps hands to indicate approval, and move head to indicate “yes” and “no”
- Use sound or gestures, or both, to obtain a desired object or activity and to refuse, without disruptive behavior, a disfavored object or activity
- Produce the following phonemes in isolation: /p/, /m/, /h/, /n/, /w/, /b/, / k/, /g/, /d/, /t/, /ng/, /f/, /y/, /r/, /l/, /s/, /ch/, /sh/, /z/
- Vocalize ___ different vowel-consonant combinations (up to 10)
- Vocalize ___ different syllable strings (up to 10) consisting of up to three syllables with inflection similar to adult speech
- Imitates ___ on or two syllable words (up to 20)
- Speaks at a volume and pace sufficient to be understood by an adult listener
- Verbally [use a learned communication system to] request ___ new objects or actions (up to 24)
- Verbally [use a learned communication system to] use ___ new adjectives describe a given objects (up to 15 adjectives)
- Verbally [use a learned communication system to] identify ___ new actions (up to 23 actions)
- Verbally [use a learned communication system to] produce ___ novel ___ word phrases or sentences (up to 10 phrases consisting of up to four words)
- Engage in joint attention across five novel opportunities
- Verbally [use a learned communication system to] identify ___ familiar adults (up to five) and then ___ peers (up to five) by name
- Verbally [use a learned communication system to] identify ___ familiar adults (up to 5) and then ___ peers (up to 5) by name
- Verbally [use a learned communication system to} make ___ different request for objects or activities form an adult and then from a peer (up to five from each)
- Verbally [use a learned communication system to] make ___ different comments (up to 10) during play
- Verbally [use a learned communication system to] answer ___ yes/no (up to five), ___ what (up to five), ___ where (up to five), _____ when (up o five), ___ who (up to five) questions
- Engage in ___ conversational exchanges with an adult and then a peer (up to 4 with each) on one topic across five topics.

- Verbally [use a learned communication system to} express ____ different present progressive words (verb + ing) (up to 10)
- Verbally [use a learned communication system to] produce ____ different phrases using the articles “a” and “the” (up to ten phrases for each article)
- Verbally [use a learned communication system to] produce ____ different words with possessive endings (up to 10)
- Verbally [use a learned communication system to] produce ____ different words
- with plural endings (up to 10)

Receptive Language

Given verbal [and visual] prompts [and models] faded to elimination, or the number of prompts required to elicit the target response for each trial, observation, or assessment by the end of the year, student name, will outcome from those listed below in ____ of _____consecutive trials [observations] [assessments.,

Localize to sounds other than voices by looking or turning toward the source in the environment

- Actively search to find a person who is talking
- Attend to someone speaking to him or her by orienting his [her] head toward the speaker and discontinuing other activities for at least ____ seconds (up to 10)
- Discontinue an activity when his/her name is called
- Point to or select from a field of ____ choices ____ new objects (up to 43)
- Point to or select from a field of ____ choices ____ new actions (up to 23)
- Point to or select from a field of ____ choices the function of ____ given objects (up to 43)
- Place given objects to demonstrate understanding of ____ new spatial concepts (up to 10)
- Point to or select from a field of ____ pictures the picture that depicts one of ____ given ____ word phrases (up to 10 phrases of up to four words)
- Follows ____ different ____ step commands (up to 10 commands, up to 10 steps)
- Point to or select form a field of ____ objects or pictures to correct response to ____ different yes/no questions (at least ____ factual or at least ____ preferential questions) (up to 14 total questions)
- Point to or select from a field of ____ objects or pictures the correct response to ____ novel who questions and ____ novel what questions (up to 5)
- Point to or select from a field of ____ objects or pictures the correct response to ____ novel where questions and ____ novel when questions (up to 5 each)

Presentation of Knowledge and Ideas-Content

Given verbal [and visual] prompts [and models] faded to elimination, or the number of prompts required to elicit the target response for each trial, observation, or assessment

by the end of the year, student name, will outcome from those listed below in ____ of _____consecutive trials [observations] [assessments.,

- Verbally [use a learned communication system to] describe an event depicted in a picture using a sentence or phrase of at least ____ words (up to 4)
- Verbally [use a learned communication system to] describe a self-selected object or activity that is “fun,” “sad,” “good,” “bad,” “pretty,” and “ugly” (up to 2 of each)
- Verbally [use a learned communication system to] describe each step of a ____ step (up to three steps) routine activity in which he [she] is presently engaged for each of ____ activities (up to 5 activities)
- Verbally [use a learned communication system to] describe ____ novel activities in which he [she] has recently engaged 9up to 5 activities) using a sentence or phrase of at least ____ words (up to 4)

Standard Area: Reading

Given verbal [and visual] prompts [and models] faded to elimination, or the number of prompts required to elicit the target response for each trial, observation, or assessment by the end of the year, student name, will outcome from those listed below in ____ of _____consecutive trials [observations] [assessments.,

- Produce the following phonemes in isolation and in the initial ending position of one or two syllable words: /p/, /m/, /h/(initial only), /n/, /w/, /b/, /k/, /g/, /d/, /t/, /ng/ (end only), /f/, /y/, /r/, /l/, /s/, /ch/, /sh/, /z/
- Attend to a teacher-selection story by remaining seated and not engaged in an attention-interfering activity, with eyes oriented toward the reader or person responding to the reader, for five minutes (use this goal only if attention to language stimuli is a particular area of weakness, as opposed to attention to non-preferred tasks in general)
- Identify the front and back cover of a book and scan a picture book on page at a time from front to back and from left to right
- Pair the verbal and visual presentation of a given word with a field of three pictures for each of ____ words (up to 20 words)
- Verbally [use a learned communication system to] retell a story that an adult has read to him [her] in correct sequence (up to 10 stories)
- Verbally [use a learned communication system to] predict what happens next in a story (up to then stories)
- Pair the verbal and visual presentation of a given word with one of a field of three pictures for each of ____ words (up to 20 words)
- Read or point to his [her] name in print and select from a field of three choices words that begin that begin with the same letter as his [her] name.

Standard Area: Writing

Given verbal [and visual] prompts [and models] faded to elimination, or the number of prompts required to elicit the target response for each trial, observation, or assessment by the end of the year, student name, will outcome from those listed below in ____ of _____consecutive trials [observations] [assessments.,

- Draw or scribble a distinct, even if unrecognizable, figure in response to a prompt to draw a familiar person, object, or action, for each of ____ novel prompts (up to 5 prompts)
- Verbally [use a learned communication system to] describe what he [she] plans to draw in response to a given topic, for each of ____ topics (up to 5 topics)
- Verbally [use a learned communication system to] label a distinct, even if unrecognizable, person, object , or action that he [she] has drawn or scribbles
- Sequence 3 pictures that depict a story or event in the correct order
- Draw or scribble ____ (up to 3) distinct, even if unrecognizable, figures and then verbally [use a learned communication system to] describe each figure and the action or activity depicted using a sentence or phrase of at least ____ words (up to 4)
- Dictate {use a learned communication system to dictated] to a scribe a description of a real or imagined experience or event using at least ____ sentences or phrases (up to 3) and then attend to the scribe as he or she reads the dictated description back, of each or ____ narratives (up to 5)

REFERENCES

- 2015 SLP Toolkit
- mypts.com
- The Connection to General Education-Speech and Language Support Effective Practices in Caseload Selection, Service and Dismissal- A Program Assessment Matrix
- www.pattan.net

BEHAVIOR THERAPY

TABLE OF CONTENTS

Board Certified Behavior Analyst (BCBA)

Credentials:

- Master's in Applied Behavior Analysis
- Supervised experience hours
- Pass the BCBA exam

Responsibilites:

- BCBA's are the team leaders and experts when it comes to behavior management. Their role is to help IEP teams create plans tomanage behaviors that affect a student's learning; they work with the team to provide a comprehensive approach to behavior management that includes evaluation, data collection, interventions and regular progressmonitoring. The BCBA certification requires a graduate level education and specialized training in behavior analysis and modification.

Licensed Behavior Specalist Consultant

Credentials:

- Masters in Special Education, Social Work, Psychology, or related field
- Completion of Behavior Specialist License through PA State Board of Medicine.

Responsibilites:

- The LBSC's are not credentialed by the Behavior Analyst Certification Board but by the State Board ofMedicine. LBSC's are qualified to treat a variety ofmental health disorders that result in problem behaviors that impede one's ability to learn and function adequately in the school setting. LBSC's provide consultation, training, classroom support, and behavioral strategies for regular education teacher, special education teachers, site personnel, and others providing instructional services to students within the school setting.

Register Behavior Technician

Credentials:

- A high school diploma
- At least one year workign with students with developmental disabilites
- The RBT certification of willingness to get one within 60 days of hire

Responsibilites:

- The RBT is a paraprofessional who practices under the close, ongoing supervision of a BCBA, BCaBA, or FL-CBA. The RBT is primarily responsible for the direct implementation of behavior analytic services but does not design intervention or assessment plans. It is the responsibility of the RBT supervisor to determine which tasks an RBT may perform as a function of his or her training, experience, and competence. The BACB certificant supervising the RBT is responsible for the work performed by the RBT on the cases they are overseeing.

Behavior Technician

Credentials:

- A high school diploma
- At least one year working with students with developmental disabilities

Responsibilites:

- A Behavior Technician often works 1:1 with one student all day. A Behavior Technician's role may be similar to that of a Personal Care Assistant or Instructional Assistant with more focus on behavior management and functional communication training. .

RBT SUPERVISION

Forms

- RBT Monthly Supervision Form
- Contract RBT Supervision Contract.doc
- Feedback Forms

Logs

- PTS has a RBT supervision log that can be used. This will be sent by your Clinical Director to you. You will share it with your supervising BCBA.

RBT® Task List (2nd ed.)

The BACB's Registered Behavior Technician™ (RBT®) Task List includes the primary tasks that are likely to be performed by behavior technicians with some, but not necessarily all, clients. It is at the discretion of an RBT supervisor to determine any activities outside of this task list that a behavior technician is competent to perform as a behavior technician.

The RBT Task List content serves as the basis for the RBT training requirement and the RBT examination. The Task List is organized into the following primary content areas: Measurement, Assessment, Skill Acquisition, Behavior Reduction, Documentation and Reporting, and Professional Conduct and Scope of Practice.

A. Measurement

A-1 Prepare for data collection.

A-2 Implement continuous measurement procedures (e.g., frequency, duration).

A-3 Implement discontinuous measurement procedures (e.g., partial & whole interval, momentary time sampling).

A-4 Implement permanent-product recording procedures.

A-5 Enter data and update graphs.

A-6 Describe behavior and environment in observable and measurable terms.

B. Assessment

B-1 Conduct preference assessments.

B-2 Assist with individualized assessment procedures (e.g., curriculum-based, developmental, social skills).

B-3 Assist with functional assessment procedures.

C. Skill Acquisition

C-1 Identify the essential components of a written skill acquisition plan.

C-2 Prepare for the session as required by the skill acquisition plan.

C-3 Use contingencies of reinforcement (e.g., conditioned/unconditioned reinforcement, continuous/intermittent schedules).

C-4 Implement discrete-trial teaching procedures.

C-5 Implement naturalistic teaching procedures (e.g., incidental teaching).

C-6 Implement task analyzed chaining procedures.

C-7 Implement discrimination training.

C-8 Implement stimulus control transfer procedures.

C-9 Implement prompt and prompt fading procedures.

C-10 Implement generalization and maintenance procedures.

C-11 Implement shaping procedures.

C-12 Implement token economy procedures.

D. Behavior Reduction

D-1 Identify essential components of a written behavior reduction plan.

D-2 Describe common functions of behavior.

D-3 Implement interventions based on modification of antecedents such as motivating operations and discriminative stimuli.

D-4 Implement differential reinforcement procedures (e.g., DRA, DRO).

D-5 Implement extinction procedures.

D-6 Implement crisis/emergency procedures according to protocol.

E. Documentation and Reporting

E-1 Effectively communicate with a supervisor in an ongoing manner.

E-2 Actively seek clinical direction from supervisor in a timely manner.

E-3 Report other variables that might affect the client in a timely manner.

E-4 Generate objective session notes for service verification by describing what occurred during the sessions, in accordance with applicable legal, regulatory, and workplace requirements.

E-5 Comply with applicable legal, regulatory, and workplace data collection, storage, transportation, and documentation requirements.

F. Professional Conduct and Scope of Practice

F-1 Describe the BACB's RBT supervision requirements and the role of RBTs in the service-delivery system.

F-2 Respond appropriately to feedback and maintain or improve performance accordingly.

F-3 Communicate with stakeholders (e.g., family, caregivers, other professionals) as authorized.

F-4 Maintain professional boundaries (e.g., avoid dual relationships, conflicts of interest, social media contacts).

F-5 Maintain client dignity.

RBT Supervision Log

This is an example of how to document RBT supervision in accordance with the BACB's RBT Supervision Standards.

Meeting Date	Duration of Meeting (hours)	Mode of meeting	Individual or group	Observed with clients?	Supervisor(s)

Total RBT behavior-analytic hours for this month	120		Minimum of two face-to-face requirement this month	0
Total supervision hours for this month	0		Individual minimum requirement met for this month	Requirement not met
Supervision minimum requirement met for this month	0%		Observation minimum requirement met for this month	Requirement not met

ADMINISTRATORS AND SUPERVISION

- You are an Independent Contractor. You are contracted through PTS to work in a school/district/program.
- PTS provides clinical support and direction from the Directors of Behavioral Health. There is often a second Clinical Director assigned to your school/district/program. The Directors will guide you in issues concerning your contract and can advocate for you when issues arise in the district.
- Leaders in the district or program include the Director of Special Education and/or The Special Education Supervisor.
- If you are in a school, there will also be a Principal and sometimes a Vice Principal.
- You will work directly with General Education and Special Education Teachers. The Special Education teacher serves as the case manager.
- In many cases, an RBT or BT will follow a Behavior Intervention Plan written by a BCBA. The BCBA may also provide clinical supervision. This is training and feedback on the direct service you provide. This is not administrative supervision.
- RBTS requires supervision for 5% of their direct supervision hours. This is clinical supervision. It is not administrative supervision.

PTS PEDIATRIC THERAPEUTIC SERVICES

MTSS Behavioral & Social-Emotional Supports

Teacher presents a concern to the Core Team

Core Team requests a therapist Consultation (observation)

- Therapist completes Consultation
- Therapist makes recommendation for Tiered Intervention
- Therapist documents recommendations on the Core Team's tracking log

Universal

(All Students) School/class wide (75-90%)

Tier 1

- Schoolwide PBIS
- Good Behavior Game"
- SEL (social-emotional learning) curriculum
- PTS Teacher Website Resources
- Teacher Tip Time at Staff Meeting
- Reinforcement assessments and behavior contracts for the classroom
- Procedures for teaching classroom wide expected behaviors
- Procedures for on-going data-based monitoring and evaluation

Selected (at-risk students)

Classroom & small group strategies interventions (10-25% need)

Tier 2

Targeted Group Interventions:

- Social skills groups, role-play includes all Tier1 interventions in addition to supplemental instruction
- Social stories, role-play cards, visual schedules, Token economy
- BSC/BCBA serves as a consultant on programming and classroom management
- Rapid Response to intervention
- Data Driven decision making

Targeted/high-risk students

Individual interventions (3-5% need)

Tier 3

- Formal Functional Behavior Assessment
  - Requires parent permission

Tier 3

- Individualized behavior interventions and programming
- Individualized data collection
- BCBA consultation·
- Behavior therapy/Wrap around agencies included

Tier 3

Evaluation & movement toward Special Education process

RELATED SERVICES MTSS PROCESS

Process begins after Universal Supports have been provided for all students for 4 weeks

Teacher presents a concern to the Core Team

↓

Core Team requests a therapist observation

↓

- Therapist completes observation
- Therapist makes recommendation for Tiered Intervention
- Therapist documents recommendations on the Observation Request Form

TIER 1
Whole Class
(30 days)

- Super Self Classroom
- Super Self Corner
- Super Self Pathway
- Sensory Systems Activity Guide
- Whole Class Reinforcement System
- Schoolwide PBIS
- Classroom Management Strategies
- Teacher and Staff Training

⇔

TIER 2
Selected At-Risk Students
Small Group
(6-12 Weeks)

- Super Self Self Regulation Group
- Super Self Sensory Motor Group
- Sensory Room
- Social Skills Groups
- Reinforcement Systems targeting specific student behaviors
- Self Management Systems

⇔

TIER 3
Individual
(6-8 Weeks)

- Super Self Corner or Pathway
- Sensory Room Protocol
- Student Specific Sensory Room Protocol

↓

TIER 3
Formal Screening of Skills & Areas of Need

↓

Evaluation & movement toward Special Education process

Request for Behavior Support: New Referral (Class)

School:_____ Grade Level:_____

Teacher:_____ Room:_____

Date of Referral:_____

Please provide a brief description of the problem behaviors including setting and number of students involved (e.g., math activities, work stations, whole class, three individuals, etc.)

_____

_____

_____

_____

_____

Please describe the current strategies/interventions being used::

_____

_____

_____

_____

Please check the approximate frequency in which the behavior occurs:

___<1 times per day

___1-5 times per day

___5-10 times per day

___10-30 times per day

___30+ time per day

How would you rate the intensity of behavior?

1 LOW 2 3 4 5 HIGH

Please Check:

____ One-time observation with recommended strategies (student specific or class-wide)

____ Series of observations and consultation sessions regarding challenging behavior and recommended strategies (student specific or class-wide)

____ On-site training for classroom and/or school staff regarding challenging behavior (student/groups of students, class-wide, school-wide)

____ Behavior Support Plan consultation and training for classroom staff regarding BSP (as determined appropriate by principle/school administrators)

IST Approval:_____ **School Principal:**_____

Request for Functional Behavior Assessment (Individual)

Student:_____
School:_____
Teacher:_____
Room:_____
Date of Referral:_____
Gender:_____

Grade:_____
Phone#_____
Parents:_____
Address:_____
_____
Phone # Home:_____
Cell:_____
Referred by:_____

Have parents been notified of your concerns?_____

Has an FBA been previously conducted? Y/N

Please provide a brief description of the problem behavior:

_____
_____
_____

Please describe the current strategies/interventions being used::

_____
_____
_____

Please describe any potential environmental factors that may be contributing to the student's behavior (i.e., recent divorce, death in the family, relocation, birth of sibling, etc.)

_____
_____
_____

Please check the approximate frequency in which the behavior occurs:

___<1 times per day
___1-5 times per day
___5-10 times per day
___10-30 times per day
___30+ time per day

Please check the average duration of behavior:

___<1 minute
___1-5 minutes
___5-10 minutes
___10-30 minutes
___1/2 -1 hour
___1-2 hours
___2-3 hours
___3+ hours

How would you rate the intensity of behavior? 1 LOW 2 3 4 5 HIGH

Please Check:

___Initial FBA
___Follow-up FBA (check here when data supports ineffective interventions and/or new interfering behaviors are present).

PLEASE NOTE:
An FBA request should be submitted with a completed FAST (Functional Analysis Screening Tool).

IST Approval:_____School Principal:_____

PTS PEDIATRIC THERAPEUTIC SERVICES

Request for Behavior Support: New Referral (Individual) page 2

Please describe the current strategies/interventions being used::

_____

_____

_____

Please describe any potential environmental factors that may be contributing to the student's behavior (i.e., recent divorce, death in the family, relocation, birth of sibling, etc.)

_____

_____

_____

Does this behavior(s) occur consistently in specific locations/settings or during particular activities? Please describe:

_____

_____

_____

Please check the approximate frequency in which the behavior occurs:

___<1 times per day
___1-5 times per day
___5-10 times per day
___10-30 times per day
___30+ time per day

Please check the average duration of behavior:

___<1 minute
___1-5 minutes
___5-10 minutes
___10-30 minutes
___1/2 -1 hour
___1-2 hours
___2-3 hours
___3+ hours

How would you rate the intensity of behavior? 1 LOW 2 3 4 5 HIGH

Please Check:

___**Request for observation and consultation.** (Initial step in referral process to determine need for further evaluation and structured FBA.) Parent consent required.

___**Request Evaluation. Full Functional Behavior Assessment** (Child is a danger to self or others) Signed Permission to Evaluate or signed NOREP is required

IST Approval: _____School Principal:_____

PTS PEDIATRIC THERAPEUTIC SERVICES

F A S T

Functional Analysis Screening Tool

Client:_____ Date:_____

Informant:_____ Interviewer:_____

To the Interviewer: The FAST identifies factors that may influence problem behaviors. Use it only for screening as part of a comprehensive functional analysis of the behavior. Administer the FAST to several individuals who interact with the client frequently. Then use the results to guide direct observation in several different situations to verify suspected behavioral functions and to identify other factors that may influence the problem behavior.

To the Informant: Complete the sections below. Then read each question carefully and answer it by circling "Yes" or "No." If you are uncertain about an answer, circle "N/A."

Informant-Client Relationship

1.Indicate your relationship to the person: ___Parent ___Instructor ___Therapist/Residential Staff _____ (Other)_____

2.How long have you known the person? ____Years ___Months

3.Do you interact with the person daily? ____Yes ____No

4.In what situations do you usually interact with the person?

___ Meals ___ Academic training

___ Leisure ___ Work or vocational training

___ Self-care _____(Other)

Problem Behavior Information

1.Problem behavior (check and describe):

__ Aggression _____

__ Self-Injury _____

__ Stereotypy _____

__ Property destruction _____

__ Other _____

2.Frequency: __Hourly __Daily __Weekly __Less often

3. Severity: __Mild: Disruptive but little risk to property or health
__Moderate: Property damage or minor injury
__Severe: Significant threat to health or safety

4.Situations in which the problem behavior is most likely to occur: Days/Times_____

Settings/Activities _____

Persons present _____

5.Situations in which the problem behavior is least likely to occur: Days/Times_____

Settings/Activities _____

Persons present _____

6.What is usually happening to the person right before the problem behavior occurs?_____

_____

_____

7.What usually happens to the person right after the problem behavior occurs?_____

_____

_____

8.Current treatments_____

_____

_____

_____

• Does the problem behavior occur when the person is not receiving attention or when care givers are paying attention to someone else?	Yes	No N/A
• Does the problem behavior occur when the person's requests for preferred items or activities are denied or when these are taken away?	Yes	No N/A
• When the problem behavior occurs, do care-givers usually try to calm the person down or involve the person in preferred activities?	Yes	No N/A
• Is the person usually well behaved when (s)he is getting lots of attention or when preferred activities are freely available?	Yes	No N/A
• Does the person usually fuss or resist when (s)he is asked to perform a task or to participate in activities?	Yes	No N/A
• Does the problem behavior occur when the person is asked to perform a task or to participate in activities?	Yes	No N/A
• If the problem behavior occurs while tasks are being presented, is the person usually given a "break" from tasks?	Yes	No N/A
• Is the person usually well behaved when (s)he is not required to do anything?	Yes	No N/A
• Does the problem behavior occur even when no one is nearby or watching?	Yes	No N/A
• Does the person engage in the problem behavior even when leisure activities are available?	Yes	No N/A
• Does the problem behavior appear to be a form of "self-stimulation?"	Yes	No N/A
• Is the problem behavior less likely to occur when sensory stimulating activities are presented?	Yes	No N/A
• Is the problem behavior cyclical, occurring for several days and then stopping?	Yes	No N/A
• Does the person have recurring painful conditions such as ear infections or allergies? If so, list:_____	Yes	No N/A
• Is the problem behavior more likely to occur when the person is ill?	Yes	No N/A
• If the person is experiencing physical problems, and these are treated, does the problem behavior	Yes	No N/A

Scoring Summary

Circle the number of each question that was answered "Yes" and enter the number of items that were circled in the "Total" column.

Items Circled "Yes"				Total	Potential Source of Reinforcement
1	2	3	4	_____	Social (attention/preferred items)
5	6	7	8	_____	Social (escape from tasks/activities)
9	10	11	12	_____	Automatic (sensory stimulation)
13	14	15	16	_____	Automatic (pain attenuation)

Request for Behavior Support: New Referral (Individual)

Student:_____
School:_____
Teacher:_____
Room:_____
Date of Referral:_____
Gender:_____

Grade:_____
Phone#_____
Parents:_____
Address:_____
_____
Phone # Home:_____
Cell:_____
Referred by:_____

Have parents been notified of your concerns?_____
Has an FBA been previously conducted? Y/N
Current related services as listed on IEP: _____ N?A_____

Behavior Checklist:

___Easily frustrated
___Defiant or argumentative
___Destructive of school and/or personal property
___Aggressive towards others
___Fearful & anxious
___Poor personal hygiene
___Appears to "dislike" school
___Frequent vocal/physical outbursts (including tantrum behavior)
___Not accepted by peers
___Distractible
___Absent or truancy
___Teases or provokes others

Academic Checklist: Check only if item is of major concern

___Unable to organize work on paper
___Does not come to class prepared
___Does not work independently
___Does not complete assignments
___Difficulty following classroom routines/directions
___Difficulty competing multiple assignments
___Does not finish work on time or requires multiple reminders to "keep working"

Please provide a brief description of the problem behavior:

_____
_____
_____

ANTECEDENT	1	2	3	4	5	6	7	8	9	10	11
Non-Contingent Attention											
Simple Language during demand											
Break Down multi-step directions into simple/one-step											
Structured Daily Schedule											
Provide Warnings prior to any transitions or changes in schedule											
Use first/then language											
Provide Choices when appropriate											
Daily review of expectations for day											
Behavior Chart/Reinforcement system											
Use of visuals, timers, and reminders to provide structure											
Scheduled Breaks - CONTINGENT											
Scheduled Breaks - NON-CONTINGENT											
Delay Tolerance Training (items not avaliable or delayed)											
Frequent Preference Assessment (for high-level motivators)											
Behavior Specific Praise for engagin in safe/ desirable behaviors											
Home and School Communication											
POSITIVE CONSEQUENCES (desired behavior)											
Utilize Reinforcing activities and systems											
Positive, behavior specific, praise for **functional communication**											
NEGATIVE CONSEQUENCES (undesired)											
Minimal eye contact											
Increase Proximity as appropriate											
Decrease Vocal Prompts											
Propmt Functional Communication											

Functional Behavior Assessment

Name of Student: _____

Date:_____

School: _____

Conducted by: _____

Purpose of Functional Behavior Assessment (FBA):_____

Data Sources_____

Parent Input_____

Teacher Input _____

Direct Observation_____

Antecedent Behavior Consequence (ABC) Data

Background Information _____

_____

Analysis of Data Collection _____

_____

Sample ABC Data:

Setting Events	Antecedent	Behavior	Consequence	Possible Function

The Functional Analysis Screening Tool (FAST). The following are scores for each possible function identified by the FAST. FAST (possible score of 0 to 4 items indicating possible function)

Attention/Preferred Item Escape Sensory Stimulation Pain Attenuation

As evidenced by the results of the FAST Student's behavior functions as

Hypothesis and Recommendations:

BEHAVIOR IN THE IEP MAY INCLUDE

- VB- Mapp Write-up
- FBA
  - Direct and indirect assessment, FAST, interview, ABC data, rating scales
  - Write up- templates
- PBSP
- GOALs
- Behavior, communication, operants, social skills
- Condition, action, mastery, maintenance
- SDI
- Based on plan or ABA classroom
- Related service
- Consultation, direct service delivery,
  - 1:1 schedule
  - Consultation
- Data collection-FBA, Treatment fidelity, training goals, IEP goals,

Interventions Attempted Data

Student:	Date of Referral:

Intervention	Teir Level	Date Began	Date Ended	Successful?

Individuals responsible for implementing intervention: _____

_____

_____

Settings for interventions: _____

_____

_____

Notes on interventions: _____

_____

_____

_____

TREATMENT AND TRAINING

Training: Modeling, Coaching and Consulting

- One training format is “I do, we do, you do”
- In this technique, you would model a strategy or behavior intervention plan, then you will coach as the teacher or staff run the same plan. This may be prompting, reinforcing, or running an error correction procedure with the staff member just as you would with a student. Once you feel confident that the staff member can run the plan independently, you would have the staff member run the plan without coaching and modeling. You would follow up with observations and when possible written feedback.

Training: Behavior Skills Training

- Behavior Skills Training (BST) is a four-step procedure for teaching new skills, involving the following: Instruction, Modeling, Rehearsal, and Feedback (Miltenberger, 2004)
- When training a staff member on a new skill such as IT/DTT, you would first give the instruction for carrying out the skill. You then model the skill and have the staff member imitate your model. Finally, you give feedback on the staff member’s performance. You may need to repeat these steps within a training session or across training sessions

Training: Delivering Feedback

- Supervision Feedback can be informal, delivered verbally during a training session or it can be formal, delivered in written feedback or data collection form.
- Some staff prefer using the feedback model or sandwich model. In this model you start with what the trainee has done well, make suggestions for what can be improved and then finish with another skill that the staff member did well.
- It is important to deliver reinforcement more frequently than correction when training a staff member just as you would with a student.
- Good supervision feedback is important to improving and maintaining staff performance.
- Good supervision will affect student outcomes.

POSITIVE BEHAVIOR SUPPORT PLAN

Purpose:
The following plan was developed based on the information gathered through a Functional Behavior Assessment completed in January 2015. The purpose of this plan is to decrease escape-maintained behaviors listed and defined below.

Behaviors and Operational Definitions(Examples):

- Verbal aggression - Interactions with peers and/or staff in a manner that includes, but is not limited to, verbalizations of a threatening or intimidating nature.
- Physical aggression - attempts to use physical force toward peers in a potentially harmful/dangerous fashion.
- Non-compliance - instances of insubordination or defiance in regards to expected school and classroom behaviors, including not following directions and breaking known school rules.

Hypothesis
(List hypothesis from FBA here)

Goal: (create IEP goal here)
EXAMPLE ONLY: In response to a behavior intervention plan that incorporates positive and negative reinforcement with Chris will attend all classes for the allotted time each day, refrain from disruptive behavior, complete work and participate in discussions for all classes, each day of the week for six consecutive weeks.

Data Collection- Data will be collected on the number of classes per day Chris misses, arrives late, leaves, or disrupts classes.

Baseline- Chris has currently missed, attended partially, arrived late to and from _ classes

Antecedent Strategies

1. Create an environment Chris prefers to be in
2. Teachers will set clear boundaries with Chris, establishing themselves as both authority figures and mentors. This will be done through rapport building and maintain structured routines and clear expectations.
3. Teachers will make statements of empathy and interest to Chris
4. Teachers will refrain from stating or writing negative comments about Chris especially on his behavior monitoring sheets.
5. Teachers will avoid power struggles and unnecessary confrontation. Instead state and clarify expectations with Chris. Use rule reminders and use point system to motivate Chris. Give redirections in businesslike tone.
6. Teachers will ensure all work assigned is at Chris's instructional level and will be conscious of maintaining his attention during instruction.

1. Use a Token economy to reinforce desired behaviors
2. Allow Chris to self-monitor his classroom performance.
3. Teachers should notify the case manager via e-mail before the end of each day if Chris has not earned points because of his behavior. If teachers do not send this e-mail it will be assumed that Chris earned his points.
4. Conduct weekly preference assessments for Chris to rank items he feels will be motivating.
5. Establish times of the day that Chris can cash in points for earned items
6. Praise and compliment Chris when desired behaviors occur.
7. Do not send Chris out of the room as punishment.
8. Chris's guidance counselor will schedule weekly appointments to meet with him. He will not access the guidance office otherwise unless determined by the guidance counselor.

Consequence strategies

1. Reinforcement for desired behaviors
2. Chris will earn points attending class, participating, completing work and demonstrating student behavior (not disrupting others).
3. Following an undesired behavior
4. For disruptive behavior give redirection and rule reminder
5. For not attending class or leaving class send an e-mail to alert office and staff that Chris is not in class. Once he is located an administrator will walk Chris back to class reminding him of expectations and point system.
6. While out of class Chris is not to access games, computer time, the guidance area or adult attention. He is expected to return to class immediately or complete work with ISS teacher.

SAMPLE ABA PROGRAM COMPONENTS AND STRATEGIES

Recommendations/Interim Plan/Positive Behavior Support Plan

1. Pairing Procedure- All staff should spend time pairing themselves with reinforcement and building rapport with Student throughout the day. This can be done by giving praise and attention at high rates non-contingent on behavior. Limit demands during this time and follow Student's lead in play. Give student access to his favorite items during pairing sessions.

2. Gaining Instructional Control-Practice direction following by giving student multiple easy to follow directions or asking known questions throughout the day and following response with praise.

3. Use discrete trial teaching/errorless learning procedures to teach skills. Vary the length of teaching sessions. Intersperse easy and hard tasks. Mix and vary programs throughout teaching sessions. Work on specific targets and use data to determine when an item is mastered. Teach across multiple exemplars of items, across multiple environments and multiple people. Teach for generalization of skills. Program for maintenance of skills over time.

4. Use fast-paced instruction, adjust the speed you deliver directions and include pauses to gain eye contact.

5. To encourage high rates of responding and engagement, use a high-probability sequence starting with easy low effort responses and building to harder responses then intersperse easy and hard tasks throughout teaching.

6. Establish a system for prompting and prompt fading that matches the skill being taught.

7. Use mand training to teach student to make requests for items, activities, attention and/or removal of undesired items, activities or attention. Facilitate manding with peers and other forms of social interactions, allow for multiple opportunities to practice manding across environments.

8. Use functional communication training to teach student to state a feeling/need in place of undesired behavior.

9. Teach toy play, independent play skills, parallel play skills and reciprocal play skills.

10. Teach peer imitation and peer referencing skills.

11. Teach student to follow task analyses and visual schedules to complete multiple steps of a task and a sequence of tasks.

12. Use visual and auditory cues for transitions.

13. Establish a reinforcement system using a VR schedule or token system based on student's needs.

14. Conduct regular preference assessments.

15. Do not remove demands following behavior. Instead, repeat the direction in the same way until student complies.

16. Use differential reinforcement, giving more/better reinforcement for more/better responding.

17. When aggression or other undesired behaviors occur, do not address by labeling the behavior or telling the student not to do it. Instead, using a businesslike tone, give a direction for an alternate, incompatible behavior, followed by a sequence of compliance directions. Once student is calm, prompt a request or replacement phrase.

18. Teach student to wait, accept "no", and give up reinforcers.

PTS PEDIATRIC THERAPEUTIC SERVICES

ABC Data Collection Procedure

"A" refers to the antecedent, or the event or activity that immediately precedes a problem behavior. "B" refers to observed behavior, and "C" refers to the consequence, or the event that immediately follows a response. Use concise, short language, and write objectively only about what you observed.

Date & Initials	**Time, Location**	**Antecedent** ***What happened before the behavior?***	**Behavior** ***Describe the behavior objectively***	**Consequence** ***What happened after the behavior?***
			Aggression Tantrum Throwing Elopement Other: _____	
			Aggression Tantrum Throwing Elopement Other: _____	
			Aggression Tantrum Throwing Elopement Other: _____	
			Aggression Tantrum Throwing Elopement Other: _____	

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