Riverside County Special Education Local Plan Area (SELPA)

GUIDELINES AND TOOLS FOR EDUCATIONALLY NECESSARY OCCUPATIONAL AND/OR PHYSICAL THERAPY

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Introduction

Each child has unique physical, sensory, neurological, emotional and mental functions, as well as challenges, which enhance or deter successful school performance. The following information is provided as a **guideline** to assist in looking at how to address children's needs for occupational therapy (OT) and/or physical therapy (PT). Individual professionals have different experiences as well as additional areas of training and expertise. Professionals are primarily responsible for development of a program to meet specific individualized family service plan (IFSP) or individualized education program (IEP) goals. However, activities need to be carried out across several environments. This requires a supportive, collaborative team approach.

The role of an occupational or physical therapist as a member of any team is to work collaboratively with other team members, to assist in identifying the student's priorities, strengths, and needs; to plan strategies and goals for educational performance; and to anticipate outcomes for the future. A therapist provides a unique professional expertise by explaining aspects of a medical disability and the relationship of that disability to the student's expected school performance.

Guiding Principles and Assumptions

This document was created from a variety of resources and is based on the following guiding principles and assumptions.

1. Individuals eligible for special education services should be served in the least restrictive environment (LRE) possible. For infants and toddlers, this would mean that educational services are provided in natural environments. For individuals with exceptional needs aged 3-22, the LRE for an individual is determined by the IEP team and can be anywhere along the continuum of special education service options.
2. The educational relevance of an activity is defined by the educational curriculum and needs of the student.
3. The educational environment is the location where a student's curriculum is being implemented (e.g., home, school, community)
4. Motor functioning is an area which may be assessed by various professionals (e.g., teachers, school psychologists, adapted physical education teachers, occupational and/or physical therapists) – each assesses motor functioning from their unique perspective.
5. Even though services may overlap, OT and PT are separate disciplines and different educational related services.
6. Evaluation data in each area of suspected disability helps the IEP/IFSP team members determine the child's present levels of performance, goals, special factors, and the type, frequency and duration of services needed.
7. The IEP/IFSP team documents a clear offer of a free appropriate public education (FAPE) and the plan is then implemented.
8. The IEP/IFSP is reviewed on a regular basis for progress monitoring, progress reports are provided, and the team meets at least annually to determine service needs.

Definitions and Qualifications of Occupational Therapists and Physical Therapists in Public Schools

In school-based practice, OTs and PTs support a child's ability to gain access to and make progress in the school curriculum. OTs are health professionals whose purpose in a public school setting is to support a child's engagement and participation in daily occupations, which include activities of daily living, education, prevocational work, play, rest, leisure, and social participation (American Occupational Therapy Association 2008). PTs are health professionals whose purpose is to correct, facilitate, or adapt the child's functional performance in motor control and coordination, posture and balance, functional mobility, accessibility, and use of assistive devices (see http://www.apta.org). OTs and PTs have unique roles in the educational setting in working both on remediation (e.g., improving sensory and motor foundations of learning and behavior) and compensation (e.g., modifying the environment, tools, or task) to help a child succeed at school.

Definition of Occupational Therapy

California *Business and Professions Code* Section 2570.2 (k) states:

> Practice of occupational therapy "means the therapeutic use of purposeful and meaningful goal-directed activities (occupations) which engage the individual's body and mind in meaningful, organized, and self-directed actions that maximize independence, prevent or minimize disability, and maintain health."

Under IDEA regulations, Title 34, *Code of Federal Regulations,* Section 300.34(c)(6) defines "occupational therapy" as "services provided by a qualified occupational therapist; and includes (a) improving, developing, or restoring functions impaired or lost through illness, injury, or deprivation; (b) improving ability to perform tasks for independent functioning if functions are impaired or lost; and (c) preventing, through early intervention, initial or further impairment or loss of function."

Qualifications of the Occupational Therapist

Occupational therapists must possess the educational background and a license to practice OT in California.

Educational Requirements

Beginning in 2007, the minimum educational requirement to become an OT is a master's degree in OT from an accredited program verified by the Accreditation Council for Occupational Therapy Education (ACOTE). OTs who entered educational programs prior to 2007 may practice with a bachelor's degree. Included in the OT's education are 9 courses in human anatomy and physiology, human development across the life span, kinesiology, neurology, medical diagnoses, physical disabilities, mental health, and activity and skills analysis. Course work includes biometry, qualitative and quantitative analysis, and

occupational science. OTs study the occupation, habits, routines, engagement and participation of children and adults in the context of daily living throughout the life span. An OT must successfully complete appropriate clinical fieldwork requirements (usually six to nine months) as required by the educational program. Advanced training programs are also available to OTs in specialized practice areas (e.g., sensory integration, school-based practice, assistive technology, social skills, feeding, etc.).

Licensure Requirements

Currently, OTs must have graduated from an accredited institution to be licensed to practice OT in the state of California. They are required to pass the National Board for Certification in Occupational Therapy (NBCOT) examination and obtain a license in California through the California Board of Occupational Therapy. OTs must earn the minimum professional development units and meet professional and ethical standards to maintain licensure (BPC §§ 2570-2570.32).

Qualifications of Certified Occupational Therapy Assistants

Certified OT assistants (COTAs) provide OT, under the supervision of a licensed OT, to the child within the regulations and scope of practice as determined by the California Board of Occupational Therapy (BPC § 2570.2(h)).

Educational Requirements

COTA candidates must graduate from an accredited OT educational program at the associate or technical degree level. A COTA must satisfy the appropriate clinical fieldwork requirement (usually six to nine months) as required by the education program.

Certification

A COTA must apply for and attain a passing score on a national certification examination and obtain a certification through the California Board of Occupational Therapy. Minimum continuing education units and maintenance of professional and ethical standards are required to maintain certification (BPC § 2570.3(a)).

Scope of Practice for Occupational Therapy

In the field of OT, the *Business and Professions Code* related to OT is also referred to as the Occupational Therapy Practice Act (OTPA). As outlined in the OTPA, the “practice of occupational therapy” means the therapeutic use of purposeful and meaningful goal-directed activities (occupations) that engage the individual's body and mind in meaningful, organized, and self-directed actions that maximize independence, prevent or minimize disability, and maintain health. Occupational therapy services encompass occupational therapy assessment, treatment, education of, and consultation with, individuals who have been referred for occupational therapy services subsequent to the diagnosis of a disease or disorder (or who are receiving occupational therapy services as part of an individualized

education program (IEP) pursuant to the federal Individuals with Disabilities Education Act (IDEA)). Occupational therapy assessment identifies performance abilities and limitations that are necessary for self-maintenance, learning, work, and other similar meaningful activities. Occupational therapy treatment is focused on developing, improving, or restoring functional daily living skills; compensating for and preventing dysfunction; or minimizing disability. Occupational therapy techniques that are used for treatment involve teaching activities of daily living (excluding speech-language skills); designing or fabricating selective temporary orthotic devices, and applying or providing training in the use of assistive technology or orthotic and prosthetic devices (excluding gait training). Occupational therapy consultation provides expert advice to enhance function and quality of life. Consultation or treatment may involve modification of tasks or environments to allow an individual to achieve maximum independence. Services are provided individually, in groups, or through social groups (BPC § 2570.3(a)).

Documentation Requirements for Occupational Therapy

The OTPA mandates that "An occupational therapist shall document his or her evaluation, goals, treatment plan, and summary of treatment in the patient record. Patient records shall be maintained for a period of no less than seven years following the discharge of the patient, except that the records of unemancipated minors shall be maintained at least one year after the minor has reached the age of 18 years, and not in any case less than seven years" (BPC § 2570.185).

Supervision Requirements for Occupational Therapy Assistants

State laws and regulations set forth the requirements for supervision of therapy assistants and aides. COTAs must work under the supervision of a licensed OT. Appropriate supervision of a COTA includes, at a minimum, the weekly review and inspection of the supervising occupational therapist. Weekly review should occur once each calendar week (16 CCR § 4181(a)(3)) and requires the supervising occupational therapist to provide periodic on-site supervision and observation of the assigned client care rendered by the COTA. Periodic review is defined in Section 4181(e) as at least once "every thirty days" (16 CCR § 4181(e)). The supervision process is aimed at ensuring the safe and effective delivery of OT services and fostering professional competence and development. Supervision may include observation, modeling, co-treatment, discussions, teaching and instruction, and may be provided face to face or by telephone, written correspondence, or electronically. One OT may supervise no more than two COTAs at a time without Board approval (BPC §2570.3(j)). (See 16 CCR § 4181 and § 4183 for regulations that apply to supervision of OT students and interns awaiting licensing, certification, or approval by the California Board of Occupational Therapy). Additional regulations are in place for advanced practice certification in several areas. (See www.bot.ca.gov for all laws and regulations.)

Definition of Physical Therapy

The California Physical Therapy Practice Act, in *Business and Professions Code* Section 2620, states:

> Physical therapy means the art and science of physical or corrective rehabilitation or of physical or corrective treatment of any bodily or mental condition of any person by the use of the physical, chemical, and other properties of heat, light, water, electricity, sound, massage, and active, passive, and resistive exercise, and shall include physical therapy evaluation, treatment planning, instruction and consultative services. The practice of physical therapy includes the promotion and maintenance of physical fitness to enhance the bodily movement related health and wellness of individuals through the use of physical therapy interventions. The use of roentgen rays and radioactive materials, for diagnostic and therapeutic purposes, and the use of electricity for surgical purposes, including cauterization, are not authorized under the term "physical therapy" as used in this chapter, and a license issued pursuant to this chapter does not authorize the diagnosis of disease.

Under IDEA regulations, Title 34 of the *Code of Federal Regulations,* Section 300.34(c)(9) states, “Physical therapy means services provided by a qualified physical therapist.”

Qualifications of the Physical Therapist

A physical therapist must possess the educational background and a license to practice in California.

Educational Requirements

Beginning in 2002, the minimum educational requirement to become a PT is a master’s degree from an accredited program verified by the Council for Accreditation in Physical Therapy Education (CAPTE). PTs who entered educational programs prior to 2002 may practice with a bachelor’s degree or professional certificate. PTs are health professionals with specific training in kinesiology, human development, and the remediation of posture and movement dysfunction. Included in the PT’s education are courses in human anatomy and physiology; physical pathophysiology; joint and whole-body kinesiology; gait and posture analysis; human development, especially gross motor development and physical growth; motor control and motor learning; physical treatment modalities; and cardiopulmonary, orthopedic, and neurological rehabilitation. Advanced training and/or certification programs are also available to PTs in specialized practice areas. In addition, advanced training and postgraduate certification is available for various specialized areas (e.g., pediatrics, orthopedics, geriatrics, sports, etc.).

Licensure Requirements

Currently, to be licensed to practice PT in the state of California, individuals must have graduated from an accredited institution and passed national and state licensure

examinations. Minimum continuing education units and maintenance of professional and ethical standards are required to maintain licensure (BPC §§ 2650–2655.93).

Qualifications of the Physical Therapist Assistant

Physical therapist assistants (PTAs) provide PT, under the supervision of a licensed PT, to the child within the regulations and scope of practice as determined by the Physical Therapy Board of California (BPC §2655(b)).

Educational Requirements

PTA candidates must graduate from an accredited PT assistant education program approved by the Board or have training or experience or a combination of training and experience that, in the opinion of the Board, is equivalent to that obtained in an approved PT assistant education program (BPC § 2655.9).

Licensure Requirements

A PTA must apply for and attain a passing score on a national examination and state license examination and obtain a license through the California Physical Therapy Board. Minimum continuing education units and maintenance of professional and ethical standards are required to maintain licensure (BPC § 2655(b)).

Scope of Practice for Physical Therapy

California *Business and Professions Code* § 2620(a) defines PT as:

> The art and science of physical or corrective rehabilitation or of physical or corrective treatment of any bodily or mental condition of any person by the use of the physical, chemical, and other properties of heat, light, water, electricity, sound, massage, and active, passive, and resistive exercise, and shall include physical therapy evaluation, treatment planning, instruction and consultative services. The practice of physical therapy includes the promotion and maintenance of physical fitness to enhance the bodily movement related health and wellness of individuals through the use of physical therapy interventions. The use of roentgen rays and radioactive materials, for diagnostic and therapeutic purposes, and the use of electricity for surgical purposes, including cauterization, are not authorized under the term "physical therapy" as used in this chapter, and a license issued pursuant to this chapter does not authorize the diagnosis of disease."

Direct Access to Physical Therapy and Diagnosis

A PT may conduct an assessment in accordance with the referral without a specific medical diagnosis. However, based on state Attorney General Opinion No. 65-21 and the Physical Therapy Board of California's response to Direct Access and Senate Board 1485 Article (see www.ptb.ca.gov), although a referral for PT may come from any source (including an IEP team), a PT may not perform treatment intervention without a diagnosis

(for the condition being treated) from a physician or other duly licensed practitioner (unless the service is for “the purpose of general fitness and health services”).

Documentation Requirements for Physical Therapy

A PT must document a patient's examination and re-examination, evaluation, and when a patient is to be re-evaluated as well as diagnosis, prognosis, and intervention, treatment plan, and modifications, each treatment provided, and discharge summary (16 CCR § 1399.85).

According to the *Business and Professions Code* § 2620.7:

(a) A physical therapist shall document his or her evaluation, goals, treatment plan, and summary of treatment in the patient record.

(b) A physical therapist shall document the care actually provided to a patient in the patient record.

(c) A physical therapist shall sign the patient record legibly.

(d) Patient records shall be maintained for a period of no less than seven years following the discharge of the patient, except that the records of unemancipated minors shall be maintained at least one year after the minor has reached the age of 18 years, and not in any case less than seven years.

Supervision Requirements for Physical Therapy Assistants

The law states that no more than two PTAs may be supervised by one PT, without Board approval (BPC § 2655.2). The supervision of PTAs is defined in regulations. Adequate supervision is defined as the PT always being available in person or by telecommunication and conducting periodic site reviews. In addition the PT must co-sign all documentation weekly and hold case reviews at least every 30 days (16 CCR § 1398.44). Regulations that apply to supervision of PT students and interns who are waiting for licensing or approval by the Physical Therapy Board of California, as well as regulations for advanced practice certification, can be found at www.ptb.ca.gov.

Differentiation between Adapted Physical Education, Occupational Therapy, and Physical Therapy

The state and federal laws and regulations pertaining to individuals with exceptional needs incorporate a wide range of disabilities and a continuum of service options to meet the unique needs of each identified child. When a child exhibits deficits in motor skills, his or her educational needs may require the support a person with specialized training in adapted physical education (APE), occupational therapy (OT), and/or physical therapy (PT).

Areas Addressed by APE: Basic concepts of movement, speed, force, pre-positions, rhythm, tempo, and object control; complex motor skills and sequences, such as aquatics, dance, games, sports, and leisure activities; physical and motor fitness, especially related to health and well-being.

Areas Addressed by PT: Bracing; pre-gait and gait training; muscle re-education, especially for lower extremities following trauma or surgery; prevention and management of orthopedic problems in trunk and lower extremities (i.e., range of motion, positioning, bracing, casting, splinting).

Areas Addressed by OT: Visual perception, integration and motor skills; fine motor skills and dexterity; self-help skills beyond foundational components; pre-vocational skills; communication systems (i.e., switch control, computers, and assistive technology tools).

Areas Addressed by APE / OT / PT: Developmental motor and locomotor patterns; movement exploration activities; balance; refining motor skills (especially gross motor); generalized strength and endurance; environmental adaptations; accommodations and adaptive techniques.

Areas Addressed by APE & OT: Body awareness; spatial relations, laterality, directionality; social group and interaction skills; play and leisure skills; social/emotional development; peer interactions; sportsmanship.

Areas Addressed by APE & PT: Functional gross motor skills training in relation to mobility and play; endurance and conditioning programs for physical fitness.

Areas Addressed by OT & PT: Assessment and treatment of muscle tone, range of motion, sensation, specific muscle strength and endurance, joint stability; use of prostheses, orthotics, splints, walkers, wheelchair and seating modifications; oral-motor and feeding sensory processing.

Medical versus Educational Models

There are primarily four ways a child can receive occupational and/or physical therapy once a need has been identified.

- a hospital; served by medical model
- outpatient clinic; served by medical model
- home based services; served by medical model
- school based services; served by educational model only when occupational and/or physical therapy is required to meet educational needs

The factors determining need for intervention may be very different in these two models. This can sometimes be very confusing.

In The Medical Model

- Referral is initiated by the physician based on a particular diagnosis or observed delay in one or more areas of development.
- The parent is then referred to a hospital or clinic for an evaluation and/or treatment by the appropriate professional.
- Need for service is primarily based on testing and clinical observations. The assessment would take all settings into consideration.
- Children with mild, moderate and severe deficits may qualify for services.
- The parent is responsible for obtaining the needed services as well as payment for those services.
- Health insurance may frequently assist with payment, but not always.

In The Educational Model

- Occupational and physical therapy are provided by schools as service **only** when it is related to educational needs.
- Related services are possible only when they are “required to assist a child with a disability to benefit from special education".
- The child is assessed for needs associated with his or her educational program. Need for service is primarily based on testing, classroom observations and input from the student’s IEP/IFSP team.
- The school district must establish whether the service is needed for the child to benefit from his or her education. In other words, it is deemed that the student’s educational program would be inappropriate without the service.
- A child who does not perform to what may be his/her full potential but does function adequately, would not qualify for school based OT or PT services.
- Related services are provided only when they support an educational need. They are not provided when there is a transportation problem or other obstacle in getting medical model outpatient or home based OT and/or PT.

Determining Educationally Versus Medically Necessary Therapy

Educationally necessary therapy is provided in the school to help the child access educational services and benefit from his educational program. In the school, educational goals hold a primary position, while occupational therapy goals are undertaken to support the educational goals. The school therapist delivers a wide range of services. These services cover individual therapy, as well as therapy within small groups, and consultation with school staff, and with the child’s family. Thus, the school therapist is expected to share his/her knowledge and skills with others by demonstrating and monitoring activities that are educationally appropriate.

Medically necessary therapy is usually undertaken as an adjunct to medical treatment for acute and chronic conditions to ameliorate an underlying disability. The goal of medically necessary therapy is to improve global functioning through the use of a variety of modalities. Medically necessary therapy conducted in the school is not the same as therapy conducted in the clinic. Therapy differs in these two settings in terms of its intent, the role of the therapist, and the type of support available to the therapist. The significant ways in which clinical therapy and school therapy differ from one another are summarized below.

Educationally Necessary Therapy	Medically Necessary Therapy
Educational goals are primary.	Therapy goals are primary.
Intervention is directed toward facilitating educational progress.	Intervention is directed toward alleviation of a specific medical problem.
Services are collaborative. Much time must be given to communicating with other service providers.	Services tend to be delivered individually in a clinic or hospital setting.
Focus is on functional skills and adaptations that promote the attainment of educational objectives.	Focus is based on developmental milestones and components of movement. The focus is on functional outcomes.
More responsibilities are delegated to parents and other educational professionals.	Few responsibilities are delegated except to parents.

The therapist works in the school setting.	Clients generally come to the clinics to see the therapist.

Adapted from: "The Role of the Physical Therapist and the Occupational Therapist in the School Setting," by Judith Hylton, Penny Reed, Sandra Hall, and Nancy Cicirello. TIES: Therapy in Educational Settings. A collaborative project conducted by Crippled Children's Division--University Affiliated Program, the Oregon Health Sciences University and the Oregon Department of Education, Regional Services for Childs with Orthopedic Impairment. Funded by the U.S. Department of Education.

Some children will receive services through both educational and medical models. For some children the frequency or intensity of OT and/or PT received at school through the educational model will not meet all of the child's OT or PT needs. There may be goals that are not addressed by school-based therapy that would require home or community based services from the medical model. In each setting, the child should be assessed individually to determine the best way to meet his or her needs.

	EDUCATIONAL MODEL	**MEDICAL MODEL**
WHO DECIDES?	Educational team, including parents, student (if appropriate), educators, administrators and school based therapists determine the student's educational needs and what support is required by related services.	Medical team determines focus, frequency and duration of therapy. Insurance coverage may be determining factor.
WHAT?	Therapy focuses on adaptation and intervention to allow the student to participate, access their special education and school environment.	Therapy addresses medical conditions; works to get full potential realized.
SAMPLE ACTIVITIES	Cutting, drawing, writing, identify shapes and sizes, sequencing.	Hair and teeth brushing, feeding, dressing, food preparation ambulation.
WHERE?	On school grounds, bus, halls, playground, classroom, lunchroom, …	In the clinic, hospital or home.
	EDUCATIONAL MODEL	**MEDICAL MODEL**
HOW?	The student's educational needs are met individually. Services may include direct one on one treatments, staff training, program development, collaboration with staff, integrated therapy, inclusive therapy (with peers) or by consultation for the student's daily program.	Direct one on one or small group treatment to accomplish set goals.
ELIGIBILITY	Educational need as determined by the IEP team.	Medical need as determined by medical professionals.
COST	No cost to student or family.	Fee for service payment by family, insurance or governmental assistance.
DOCUMENTATION	Related to IEP with accessible, readable language guided by the setting and best practice.	Dictated by insurance requirements and guidelines of the setting. Emphasis on medical terminology.

Educationally Necessary Therapy Services

Public schools are not required to provide a service to a child with a disability just because the child will benefit from the service or even if the child requires the service for other than educational reasons. A student might benefit from OT or PT if s/he is having significant difficulties in classroom performance as impacted by curriculum, educational environment, and abilities. Simply having needs in the areas of gross or fine motor skills does not mean that a child needs OT or PT. Special education teachers can assess and assist children who have special needs in fine or gross motor skills. Most special education children with needs in these areas can and should be served by their teachers. There are a few children whose needs are so significant and unique that the child's special education teacher cannot serve them. These children may need the services of an OT or PT.

A key factor the IEP/IFSP team must remember is that a related service such as OT or PT is warranted only if it is necessary for the child to benefit from their educational instruction. Therefore, if the IEP/IFSP team should determine if all other strategies, activities, or resources available have been exhausted and it has been determined that OT or PT is necessary for the child to benefit from his/her instructional program. OT and PT should not be viewed as a part of the curriculum but as a resource to allow the student to function within the school routine. The amount and intensity of services should increase or decrease according to the changes in educational demands and in a student's performance.

As a related service, OT and PT serve a supportive role in helping the student to participate in and benefit from special education. Educationally-related OT and PT services are provided within the context of the student's educational program, with service delivery occurring in the school environment where the need occurs. The goal of intervention is to assist the student to function in the school setting by adapting the environment, revising the functional tasks, and by promoting elements of sensorimotor development.

While physical therapists assist with muscle development, occupational therapists assist with the functional use of these muscles. In the educational setting, OT and PT services focus on "improvement of functioning" and not serving goals beyond the capacities of the individual. Services may include assessment, direct therapy, and several types of consultation. These intervention activities are not mutually exclusive and may occur at the same time.

Determination of Educational Need for Therapy

According to the CA Ed Code and IDEA 2004, the IEP/IFSP team is addressing the question, "Is occupational therapy (OT) or physical therapy (PT) necessary for the child to benefit from his/her special educational instruction?" While "educationally necessary" is difficult to define precisely, determining the need for educationally necessary OT and/or PT may best be approached by the IEP team addressing a series of questions about the developmental issues involved in the student's progress toward goals.

Indicators for Occupational Therapy Referral

- Poor hand use including illegible handwriting or poor pencil grasp. (OT is ***not*** appropriate if the child has not been taught correct handwriting or if the child uses a

non-standardized pencil grasp yet writes legibly. If the student is unable to learn correct letter formation strategies despite repeated individual instruction and remedial programs like *Handwriting without Tears*, then an OT referral may be appropriate.)

- Extreme difficulty completing classroom activities requiring cutting, gluing, manipulating small objects without adaptive equipment, environmental modifications, or assistive technology.
- Deficits in adaptive self-help skills necessary in the educational setting, for example toileting, fastening clothing, feeding.
- Excessive difficulty learning new motor tasks.
- Modulation of sensory information in the areas of vestibular, proprioceptive, tactile, auditory, visual, olfactory and taste substantially impeding ability to access the educational plan.

Indicators for Physical Therapy Referral

- Difficulty navigating school grounds, including areas with uneven terrain, obstacles, congestion, etc.
- Difficulty climbing stairs, curbs, and bus steps with or without rails
- Difficulty transitioning in and out of desks/chairs and to and from the floor independently
- Difficulty keeping up with classmates while walking in line
- Difficulty remaining stable in a seated position in order to do classroom work
- Difficulty carrying books, backpack, lunch tray, and other school materials
- Difficulty opening and closing school doors
- Difficulty accessing playground equipment
- Difficulty accessing areas of the school using a wheelchair, walker, or other assistive device
- Difficulty safe transport to and from school

Response to Instruction and Intervention (RtI^2)

In some areas,RTI^2 is being utilized prior to referral for assessment in the area of OT and PT. For more information on RtI^2, please refer to page 75 in the Guidelines for Occupational Therapy and Physical Therapy in California Public Schools, Second Edition (California Department of Education, 2010)

Referral for OT or PT Evaluation

A child with a suspected but not yet identified disability is initially referred to a problem solving team (i.e., Student Success Team [SST] or Educational Monitoring Team [EMT]). Once identified, every year an IEP or IFSP team will be responsible for monitoring student progress and identifying any additional areas of needed assessment. As special education instruction frequently can overlap OT and PT activities in many skill areas, such teams need to thoroughly consider the level of professional expertise needed to assess in all areas of suspected disability and address educational goals. Going through this process helps to assure that general and special education resources have been explored before determining that OT and/or PT services are required for a student to benefit from their special education program.

The referral process should follow the local education agency's standard referral procedures. As the assessment should always focus on the problem(s) identified, team members may want the teacher to complete the *"Therapy Needs Survey"* (see Appendix B), "*Review of Existing Data Related to OT*" (see Appendix C), and/or for the team to complete the *"Team Discussion Points about Need for OT Referral for Evaluation"* (see Appendix D) prior to making a referral for educational based therapy assessment. It is recommended that the referral team utilize these forms to address the questions about the student's developmental levels, current performance and needs for services from a specialist.

Public schools are not required to provide a related service to a student with disabilities simply because the student will benefit from the service. The IEP team must determine that a related service is warranted only if it is necessary for the student to benefit from the special education instruction. When the team has explored the strategies, activities and resources available within the instructional program, and has determined that the student is not likely to benefit from this program's opportunities without additional professional services from an OT or PT, then the case should be referred for a specialized evaluation. The IEP team may want to review the "*Fine and Visual Motor Development Milestones*" (see Appendix E) and/or "OT Problems and Strategies Chart" (see Appendix F) when reviewing the students educational program.

Assessment Guidelines for School Based OT and PT

Assessment, as defined in these guidelines, refers to a systematic process of gathering and interpreting information when it is believed that an individual may require special education services. This information is used to both determine eligibility for special education services, to guide the IEP/IFSP team in the development of goals, and to identify appropriate services.

In conducting an evaluation, a school district must use a variety of tools and strategies to gather relevant information about the child's functional, developmental, and academic abilities, including information provided by the parent that will assist in determining whether the child has a disability and the extent to which the child is able to gain access to and make progress in the general education curriculum (20 USC § 1414(b)(2)(A); 34 CFR § 300.304(c)(6); EC § 56320).

The use of standardized tests to determine special education eligibility and programming needs is being questioned by many professionals. Even tests with good reliability and validity measures often lack usefulness in developing specific student interventions. Occupational and physical therapists have frequently found that standardized assessment can incorrectly identify children. Performance on a standardized test can sometimes indicate below-average skills. However, the teacher may report that in the natural or educational setting, the child is functioning with minimal or no modifications and is not displaying any signs of stress. Rather than spending the time required for standardized assessments, it may be more effective for a therapist to use teacher interviews and to observe the child's performance within the classroom and school settings.

- *Standardized scores* are frequently used as the *standard* or comparison. Many other standards can be used within the natural environments, including local norms such

as curriculum-based measurements, classroom and teacher expectations, criteria for the next environment, peer standards, and professional expectations or judgment.

- *Curriculum-based measurement* (CBM) is based on the academic performance of the students within their curriculum. CBM can be used to determine a student's strengths and weaknesses, as well as to provide information for design of instructional programs. Written communication (handwriting) standards developed through CBM can also be used by occupational therapists to assess children for difficulties with handwriting.
- *Classroom and teacher expectations* vary. For instance, a practitioner may find the expectations different in each of the three first-grade classes in one school, but the performance within a given student's classroom sets the standard. The practitioner must be aware of that classroom and that teacher's expectations. To enhance the person-activity environment fit, the practitioner should observe the activity, the tools used, the time of day, the seating arrangement, the motivation and attention of the student, the teacher's expectations, and the performance of the student's peers.

The Ecological Model of Student Performance (EMSP) was developed as a philosophical framework for both OT and PT assessment of student functioning and service provision within the educational environment. The *"Assessment Questions Using the Ecological Model"* (see Appendix H) is provided as a resource in conducting the evaluation and writing the report. The primary assumption within the EMSP is that the ecology of student performance (or the interaction between a student, the curriculum, and the environment) affects student performance and that performance cannot be understood out of context. Therefore one cannot do an evaluation of need for educationally based OT or PT in a clinic without first seeing the student in their classroom environment.

The evaluation process for OT and PT practitioners working in school and early intervention settings offers many unique opportunities. Because the therapist is able to observe the child functioning in his or her natural environment and to observe products of the child's performance (the child's written work, amount of lunch eaten, pulling self into standing position at the couch), reliance on criterion-referenced (standardized) tools has declined in favor of functional assessments. When therapists use functional assessment tools, the procedures depend on the questions asked or the decisions to be made. Therapists must immediately define the problem, collect baseline data related to the problem, determine the expected performance, and decide if a significant discrepancy exists.

By collecting information within the natural setting, rather than by pulling the child out to be tested, the occupational and/or physical therapist provides a more natural approach to evaluation, intervention, and programming needs. It is important to anticipate the needs of the child for future environments. Will there be a computer, stairs, narrow hallways, and different expectations? Sometimes the skills needed to be successful in the next environment must be addressed now. Many home-based early intervention personnel begin to prepare the toddler for preschool, while preschool teachers and related service personnel work to prepare the child for kindergarten. This approach also assists in program termination because it allows the therapist to compare the child's performance with the prevalent classroom or developmental standards (judgments by teacher, peer, district, or families) and to determine if ongoing services are necessary. For sample data

collection forms and Educational Assessment Methods, Procedures, and Tools, see Appendix I, Appendix J, and Appendix Q.

For additional information on OT an PT assessments, please refer to page 82 in the Guidelines for Occupational Therapy and Physical Therapy in California Public Schools, Second Edition (California Department of Education, 2010)

Report of the Assessment

Once the assessment has been completed, information is synthesized for presentation to the IEP team. Assessment findings and results and the implications for the child's ability to gain access to and make progress in the curriculum must be conveyed in a way that can be clearly understood by all members of the IEP team: parents, teachers, and other related services providers and professionals. Use of technical terms and jargon should be well defined.

California *Education Code* Section 56327 requires that, after an assessment has been made a report be written and include, but not be limited to, all of the following information, as appropriate to the discipline:

- Whether the pupil may need special education and related services
- The basis of such a determination
- The relevant behavior noted during observation of the pupil in an appropriate setting
- The relationship of that behavior to the pupil's academic and social functioning
- The educationally relevant health and development, and medical findings, if any
- For pupils with learning disabilities, whether there is such a discrepancy between achievement and ability that it cannot be corrected without special education and related services
- A determination concerning the effects of environmental, cultural, or economic disadvantage, where appropriate
- The need for specialized services, materials, and equipment for pupils with low-incidence disabilities, consistent with guidelines established pursuant to Section 56136 of the *Education Code.*

In addition to the inclusion of the legally required elements of the assessment report noted above, the following sections are typically included in most OT and PT evaluation reports:

- **Reason for referral**: Reason for referral, purpose of the assessment, and concerns of the IEP team (e.g., child, parents, and educational staff).
- **Background:** Educational and therapeutic history; relevant health and developmental history; current program and services and supports.
- **Evaluation procedures:** Methods and dates (e.g., observations, interviews, questionnaires, non-standardized or standardized tests in pertinent areas related to child's suspected disability with an explanation of purpose and rationale for methods used). Review of existing evaluation data is mandated (Public Law 108-446).
- **Validity of findings:** Assessments must be completed within the parameters of *Education Code* Section 56320 (e.g., "testing procedures . . . are selected and administered so as not to be racially, culturally, or sexually discriminatory . . . materials and procedures shall be provided in the pupil's native language or mode of communication, unless it is clearly not feasible to do so") and in such a manner that

the child's behavior during testing is an accurate reflection of performance. In addition, assessments must be administered by trained and knowledgeable personnel in a valid and reliable manner and in accordance with instructions provided by the publisher of the assessment (20 USC §§ 1412(a) (6)(B) and 1414 (b)(2)).

- **Findings:** Findings include all suspected areas of dysfunction related to the OT and PT domains of practice, an interpretation of the educational relevance of these findings, the discrepancies between test scores (prior and current), and the need for specialized services, materials, and equipment.
- **Summary and implications for education**: The significance of the supports and barriers revealed by the assessment results. Sufficient evidence from the assessment results is required to support clinical reasoning and final recommendations regarding child needs.

Writing IEP Goals

An occupational or physical therapist should contribute to the IEP/IFSP process by cooperating with staff to establish educationally relevant annual goals, with short term objectives as needed. The goals included in the IEP/IFSP should be the consensus of the team and not represent only one profession. When the level of expertise of an occupational or physical therapist is required in order to work on a specific goal, the specialist should be listed as one of the person's responsible for implementing and monitoring progress on the goals.

Since teachers are responsible for their students' overall development, and because OT and PT are considered a related service to help the student to succeed in the classroom, there should not be any "*OT Only*", "*OT Specific*", "*PT Only*", or "*PT Specific*" goals. The IEP team should be responsible for writing OT or PT goals just as they write academic, language and social/emotional goals. Goals should be written in ways that are measurable and quantifiable so that outcomes can be demonstrated. The method of documentation should be agreed upon, as well as persons responsible for data collection. For more information on goal writing, please refer to the Riverside County SELPA IEP Manual and Forms, page 34. http://www.rcselpa.org/Home/Policies

The purpose or objective of providing school based OT and PT is to have a child participate and function as independently as possible in the classroom and school setting. Once a child has been found to be eligible for special education, a listing of the student's needs which cannot be met by the regular education program must be made. This list becomes the basis for identifying the student's special education needs and specific goal areas. Needs in the areas of gross and/or fine motor, special physical adaptations or similar areas, which cannot be met by the regular or special education teacher, then raise the possibility of a therapist's involvement via consultation or direct service. The following chart delineates the relationship to education for each service provided within the functional skill areas.

FUNCTIONAL AREA	SERVICES PROVIDED	RELATIONSHIP TO EDUCATION
Self-help	Mobility and transfer skills, feeding, toileting, adaptive equipment	To permit the child to manage personal needs in the classroom and school

Functional Mobility	Equilibrium and balance reactions, transfer skills	To permit the child freedom of movement within the educational setting
Environmental	Recommend modifications of school's or child's equipment	To help the child access the educational environment
FUNCTIONAL AREA	**SERVICES PROVIDED**	**RELATIONSHIP TO EDUCATION**
Positioning	Positioning with wheelchairs and/or adaptive equipment & handling methods	To maintain the child in the best position for learning and functional use of hands
Neuromuscular and Musculoskeletal Systems	Activities which promote muscle endurance, strength, motor coordination and planning, and integration of developmental reflexes	To enable the child to participate maximally in school activities. To increase speed, accuracy, and strength in manipulative skills in pre-academic and academic tasks
Sensory Processing	Activities which promote muscle tone and integration of tactile, visual, auditory, proprioceptive, and vestibular input	To process information that will enhance the child's ability to perform learning and motor tasks in school
Adaptive Equipment	Recommend and fabricate devices to facilitate fine motor and self-help tasks	Provide the child with alternative means to accomplish functional activities
Fine Motor/Visual Motor	Evaluate and improve functions such as reach, grasp, object manipulation, and dexterity	To facilitate the child's ability to manipulate classroom tools (such as writing implements, puzzles, and art materials)
Communication	In coordination with speech therapists & augmentative communication professionals, evaluate and recommend adaptive equipment, and communication devices necessary for functional communication	To enable the child to communicate in school, at home and in the community
Adapted from: "School Administrator's Guide to Physical Therapy and Occupational Therapy in California Public Schools," California Alliance of Pediatric Physical and Occupational Therapists		

Service Delivery Considerations

Neither state nor federal law sets aside distinct eligibility criteria for occupational therapy services. The Individuals with Disabilities Education Act (IDEA 2004) mandates that public schools offer occupational therapy (OT) and physical therapy (PT) services for children ages 3-21 that are needed for educationally-related difficulties. For a student to receive OT or PT services in the schools the student must be eligible for special education and OT or PT must be necessary to assist the child to benefit from special educational instruction.

Best practice dictates that occupational and physical therapists work collaboratively with special education team members to address the needs of individual children. Collaborative teaming entails an exchange of information, teaching techniques and therapeutic strategies among IEP/IFSP team members. Parents need to be part of this collaborative IEP/IFSP team process. Collaborative teaming enables therapy to be integrated into the child's educational program to address individual student needs through the school day and across all educational environments. Some of the issues to consider are:

- Is therapy likely to improve the student's ability to function in his or her educational environment?
- Is there a significant discrepancy in the student's fine motor, sensory motor, visual motor, or oral motor ability compared to his or her ability level in the areas of cognition, communication, social and or self-help skills?
- Are the instructional strategies and interventions designed at the appropriate level for the student, i.e. task analyzed into small enough steps with appropriate cues?
- Does the student need training in the use of environmental adaptations?
- Does the student need an assistive device in order to participate in an educational program?
- Who has the expertise to determine the need? Who has the expertise to train the student in the use of the device?
- Does the teacher know what activities, interventions, or procedures to provide to address the student's areas of assessed need? If not, who has the expertise to assist her/him?

No one service delivery method is exclusively better than another.

Consultation means sharing of expert knowledge by one team member with another or other team members depending on the currently identified problem. Rather than being in an authoritarian position, consultation reflects the collegial nature of the team. This service is provided directly and indirectly to the student consisting of regular review of student progress, student observation, accommodations and modifications of core material, developing and modeling of instructional practices through communication between the general education teacher, the special education teacher, parent and/or related service provider.

Collaboration (Supplemental aides and services) is a service by which general education teachers, special education teachers, and/or related service providers work together to teach a student with and without disabilities in the classroom. All are responsible for direct instruction planning and delivery of instruction, student achievement, progress monitoring and discipline to support the student goals and objectives and access to curriculum.

Direct service delivery is the role in which occupational and physical therapists have most commonly been engaged. Teachers and parents may feel that only direct services are acceptable, although consultative services have proven equally effective for some students and have increased teachers' appreciation of therapy's contributions to education. Direct service or instruction is by a single special education provider designed to support, bridge, and strengthen student skills. It is an opportunity to provide specific skill instruction, re-teach, pre-teach, and scaffold instruction to support student goals and objectives and access to curriculum.

OT or PT services may be provided directly to students, as a consultative model, or as an integrated model incorporating both of these approaches. The service delivery models differ in who is the therapist's primary contact, the service delivery environment, the methods of intervention, and who the implementer of the activities as delineated below.

	Direct	Integrated/Collaborative	Consultative
Therapist's Primary Contact	Student	Student, teacher, parent	Teacher, parent, student
Service Delivery Environment	Distraction free environment (e.g., separate from regular learning environment); specialized equipment needed	Learning environment with support of others within that setting; may include a separate environment at times	Learning environment with support of others within that setting
Methods Of Intervention	Specific therapeutic techniques which cannot be safely delegated; emphasis on acquisition of new motor patterns	Educationally related functional activities; emphasis on practice of newly acquired motor skills in the daily routine	Educationally related activities; assistive technology; adaptive materials; emphasis on accommodations to learning environment
	Direct	**Integrated/Collaborative**	**Consultative**
Implementer Of Activities	Physical Therapist (PT) or Physical Therapist Assistant (PTA)	PT or PTA; teacher, parent, other school personnel	Teacher, parent, other school personnel
Adapted From "Iowa Guidelines for Educationally Related Physical Therapy Services" by Kathy David (1996)			

Research has shown that interventions that are set in natural environments and embedded in class routines that use functional life skills increase the efficacy of intervention, the achievement of IEP/IFSP goals, and the motivation to participate. This research has provided an impetus to move from isolated therapy provision to integrated therapy services. Along with this shift come changes in (a) the site of service delivery from the therapy room to the community site or school campus; (b) the focus of therapy outcomes, from improving postural and balance responses to improving sitting during dining; and (c) the personnel involved, from only the practitioner and child to several team members and the child.

By bringing the interventions into the classroom, lunchroom, gym, and home or community site, integrated services increase the opportunities for collaboration and skill building among team members, along with practice opportunities for the student or young child. Integrated and cooperative interventions in educational and therapy provide essential practice opportunities for students with severe disabilities and enhance the effectiveness of therapy.

Progress Monitoring and Termination of OT or PT Services

It is important that data be collected in order to reflect progress toward the functional outcome being worked on. This is necessary before any discussion of termination of services; whether for lack of progress or adequate progress toward goals. A student may be ready to be discharged from OT or PT services when s/he has evidenced one or more of the following:

- As reported by the teacher, the student is now able to function within average range as compared to the other children in the classroom.
- Deficits are not interfering with child's ability to function adequately within the school environment.

- Therapy is no longer affecting change in child's level of function.
- Child's needs are better served by an alternative program and/or service, as determined by IEP team
- Formal reassessment indicates the child no longer requires the previous level of service and the IEP/IFSP team concurs.
- The child has learned appropriate strategies to compensate for deficits.
- The student is meeting and/or exceeding all goals supported by the therapist and is performing successfully within the educational environment.
- Strategies can be effectively implemented by current educational team and do not require the training and expertise of a specialized therapist.
- Equipment and environmental modifications are in place and are effective.
- The child no longer shows potential for progress or performance remains unchanged despite multiple efforts by the therapist to remediate the concerns or to assist student in compensating.
- Therapy is contra indicated due to change in medical or physical status.

Discharging a child from intervention can be emotional for all parties. Children and practitioners become attached to each other, and practitioners can easily lose perspective on what goals have been reached and what goals are still to be met. Additionally, parents generally see intervention as important to the child's growth. Continued intervention frequently indicates to them that the child has potential for growth and change. Therefore, the decision to discontinue a child's services may not be well received. The occupational therapist must have an appropriate rationale for the change in service and be able to back up the decision with data, either through testing, observation, or both. Information from the teacher and other professionals working with the child should contribute to the decision to discontinue services.

Educationally Necessary Occupational Therapy

School based occupational therapy (OT) is designed to support the student's successful participation in the school curriculum and environment – not in treating the disability. When considering evaluation to determine need for OT services, the IEP team may want to utilize the *"Occupational Therapy Referral for Assessment Form"* (see Appendix G). The OT evaluation should follow the guidelines previously provided. When discussing possible services, OT should not be viewed as a separate curriculum, but as a support in accessing the existing curriculum.

In general, occupational therapists concentrate on postural background mechanisms, sensory impairments or motor impairments effecting function. For instance, support from an occupational therapist can include activities such as adapting the classroom environment, introducing adaptive equipment, using assistive technology, and participating as collaborative team members. There is, however, some overlap between the things teachers and therapists do in the course of helping children learn and become independent. The following chart shows some examples of who does what and how the roles/responsibilities complement one another.

AREAS OF NEED	WHAT THE TEACHER DOES	WHAT THE OT DOES
Fine Motor Function	Teaches monitors and reinforces normal pencil grasp. Teaches and provides practice opportunities in form reproduction (lines, circles, squares etc.). Teaches letter reproduction, use of lines and spaces. Offers drill and practice opportunities in visual motor and visual perceptual activities. Offers opportunities and assistance to work with motor materials such as puzzles, peg boards, beads, and scissors. Monitors student progress.	Evaluates accommodations and assistive devices necessary for improved grip, grip strengthening activities, postural supports, fatigue minimization, kinesthetic cues. Provides activities which promote muscle endurance and motor planning. Monitors student progress.
Self-Help Skills	Encourages independent attitude. Teaches organizational systems for dealing with instructional materials. Teaches and monitors organizational systems for dealing with class work completion. Teaches dressing, toileting, self-feeding specific to individual developmental level, using known adaptations. Develops structure and processes necessary for independence in the cafeteria, restroom, and moving between classes. Defines necessary mobility and transfer skills, and minimizes obstacles in the classroom.	Assists with management of instructional materials by providing exercises to improve visual tracking, scanning, vestibular or tactile issues. Provides adaptations for dressing. Provides postural support/adaptations for toileting. Provides support for utensil usage in feeding, and helps resolve sensory based food resistance. Promotes independence in cafeteria and other school locations by developing adaptations and training the student and staff in their use.
Behavior/Attention	Addresses issues of oppositional behavior, immature social skills, different learning styles, decreased attention, impulsiveness and self - stimulatory behavior using behavioral/instructional strategies. These strategies include: posted schedules, transition supports, adapted curriculum, social skills training, self-monitoring programs, and systematic reinforcement of functionally equivalent replacement behaviors.	Addresses issues of increased or decreased arousal level based upon vestibular responsiveness, tactile irregularity, or kinesthetic sensation seeking. Addresses issues related to activity shift through work on vestibular/somatosensory regulation and modulation systems. Addresses self-stimulation behavior by assisting to design sensory activities that can be used in the classroom.
Keyboarding	Teaches keyboarding skills.	Provides adaptations, positioning assistance.

For example, in the area of visual attention wherein a child does not maintain eye contact on his work, interventions may focus on verbally cuing the child to keep looking at his paper, providing a physical prompt to position his head, decreasing external distractions to help the child focus on his work, and providing reinforcement when the child does look at what he is cutting. As another example, this time in the area of hand manipulation skills wherein the child does not position her scissors correctly in her hand, staff can assist the

child in putting her right thumb through the upper handle of the scissor, with her pointer and middle finger through the bottom; reinforce that her fingers are flexed (bent) and not extended (straight) within the handles; provide physical assistance to curl the ring and pinky finger into the palm; provide hand over hand assistance to guide the child through rhythmic opening and closing of scissors; and saying “open-close” in correspondence to scissor movement. A third example applies to bilateral hand use, wherein the child does not stabilize or rotate his paper efficiently with his left hand while cutting with his right hand. Some strategies could include providing hand over hand assistance to help him stabilize the paper, providing verbal cues, teach child to rotate his paper in a systematic way after finishing cutting a side.

Additional examples of Occupational Therapy in the Educational Setting can be found in Appendix K.

Methodology Discussion Points

It is important that IEP/IFSP team members understand the difference between a “related service” under IDEA and methodology approaches such as sensory integration and neuro-developmental treatment. The IEP team must document all related services that an individual with exceptional needs requires in order to receive a free appropriate public education. The team is not required to include methodology approaches.

Sensory Integration.

A typically developing child’s central nervous system is designed to receive, interpret, and use sensory input from the environment and his own body. A child may have the ability to see, hear, taste, etc., but may have difficulty making sense of the information. Children who have difficulty processing and integrating sensory input may experience challenges in engaging in their environment. This may result in difficulties with behavior, attention, communication, learning, socialization, and/or motor skills.

The term “sensory integration” is used in California by different people to refer to different types of treatment strategies. Other terms, such as “sensory motor training,” “sensory integrative therapy” and “sensory processing,” are often used as synonyms. For our purposes, sensory integration is a methodology used by the therapists at their discretion. A teacher (regular class, special education, art, music, dance, etc.) may include perceptual motor or sensory motor activities or instruction in his/her curriculum. Specific techniques individualized to a child, which are identified by the OT, can be utilized by the teaching staff with direct supervision and/or training by the OT.

Sensory therapy is defined as the process of organizing sensory information in the brain to make an adaptive response to changes in the environment. In general, sensory integration therapy attempts to elicit appropriate behavioral responses from the child to sensory input. It attempts to enhance the brain’s ability to process and integrate sensory and motor information. Sensory integration therapy may result in improvement in the child’s ability to organize sensory information and adapt responses so that they are appropriate to the environment. This technique focuses on ameliorating the underlying problem, rather than on teaching specific skills or utilizing accommodations.

An IEP/IFSP team cannot indicate sensory integration therapy treatment as a related service on the IEP or indicate that a therapist use this methodology. It is not a related

service under IDEA 2004; but, rather, a technique or instructional method which may be used in providing special education or related services. The decision to use, or not use, sensory integration therapy as a method should be made by the person responsible for the service or instruction specified in the IEP/IFSP, based on the professional judgment of the service provider and the needs of the child. This decision should be made only after the child is identified through assessment as an individual with exceptional needs.

The local school district is under no obligation to include sensory integration therapy in the IEP/IFSP since it is a method, not a related service. After the IEP/IFSP team has identified the child as an individual with exceptional needs and included, for example, therapy in the plan, the therapist may decide to use whatever method(s) is most effective for carrying out the goals and objectives for that child. For example, a "sensory diet" may be embedded into the daily classroom program design to assist a student in satisfying their sensory needs in a proactive manner to minimize maladaptive sensory seeking behaviors.

Neuro-Developmental Treatment (NDT).

Neuro-developmental treatment (NDT) is a treatment approach that can be used by occupational or physical therapists, speech/language therapists, and teachers trained in its use. The aim of NDT is to provide a sense of normal movement, to assist the individual to use movement patterns to improve function. This is done by using techniques to inhibit abnormal patterns and facilitate normal movement. The goals of NDT are:

- To carefully analyze problems of posture and movement in all possible positions;
- To facilitate movement in order to allow the child to move more functionally;
- To teach parents and teachers the necessary procedures to ensure consistent management of motor deficits;
- To use equipment to aide in enabling more normal patterns of movement and to help in functional skills; and
- To prevent a cycle of abnormal sensory-motor development including secondary changes such as contractures and deformities from occurring.

Again, a team should <u>not</u> indicate NDT as a related service on the IEP/IFSP or indicate that a therapist use this methodology. It is not a related service; it is a technique to be used or not as determined by the current therapist. Typically, an evaluation that determines the need for NDT will result in a referral to a medically based service provider.

Educationally Necessary Physical Therapy

Although some students demonstrate what appear to be delays they may actually be within the norms of child development as listed in "*Gross Motor Milestones*" (see Appendix M). Prior to considering an assessment, it is recommended the IEP team review "*Gross Motor Problems and Strategies*" (see Appendix N) for possible accommodations, modifications, and/or interventions.

Motor functioning assessment should not be considered the sole responsibility of the physical therapist and other professionals may also be involved in these assessments. The therapist is responsible for selecting appropriate assessment procedures that are designed to document developmental levels, physical status, and motor function as they affect educational performance. Developmental level assessments typically look at gross and

fine motor skills, typically, but not always, with a standardized test. Neuromuscular-skeletal components may include any of the following: muscle tone, developmental reflexes, joint range of motion and joint mobility, static postural alignment, dynamic postural alignment, movement quality and movement patterns, strength and endurance, static and dynamic balance, motor learning and planning, general coordination, visual-motor integration, and oral-motor control.

It is recommended that the IEP team use the "*Review of Existing Data Related to PT*" (see Appendix L) and/or the *"Physical Therapy Referral for Evaluation Checklist"* (see Appendix P) to assist team members in making a decision about the need for PT services in the school setting. The assessment will focus on the following area(s):

- Functional movement skills: Assesses the student's ability to move within and around the educationally related school, home, and/or community environment (i.e., rolling, crawling, assisted or independent walking, wheelchair mobility).
- Architectural accessibility: Assesses architectural barriers within the student's educational environment (including the home, school and/or community) that prevent the student from benefiting from the educational program (i.e., ramps, stairs, curbs, heavy doors, rough ground).
- Utilizing appropriate assistive devices: Assesses the student's need for and use of assistive devices (i.e., walkers, wheelchairs, prosthetic and orthotic devices).
- Transfers: Assesses the student's ability to perform educationally related transfers (i.e., to/from desk, chair, toilet, floor, bus, cafeteria bench, car).
- Independent sitting, standing, etc.: Assesses the student's ability to achieve and maintain these positions independently as required to benefit from his/her educational program.
- Assisted alternative positions: Assesses the student's need for alternative positions and/or alternative positioning devices within the educational environment (i.e., prone standers, side lyers, adapted tables and chairs).
- Transportation: Assesses the student's need for specialized and/or adaptive positioning during transportation.

After the evaluation is completed and needs identified, the IEP team then needs to determine the amount of PT services needed. Some factors to consider when deciding on amount of PT service are available in the *"Rubric to Determine Physical Therapy Needs"* (see Appendix O). Various service delivery models and progress monitoring were previously addressed. For "*Examples of Physical Therapy in the Educational Setting*" (see Appendix R). Transition planning is an important aspect of therapy intervention. Typical transitions occur between programs (i.e., early intervention to preschool, elementary to middle school, secondary to graduation). It is important for the therapist to be involved at these critical transition periods as the student's needs may change, it may be necessary to alter the model or amount of service to meet the student's needs, or perhaps even discontinue services in the need setting. The *"Physical Therapy Exit Criteria Checklist"* (see Appendix S) is designed to assist IEP team members in making a decision about a child's readiness to exit PT services in the school setting after a complete PT reevaluation has been conducted. [The preceding information and appendices were adapted from "Iowa Guidelines for Educationally Related Physical Therapy Services" by Kathy David (1996).]

Medically Related Therapy Services

This section describes the referral to California Children's Services (CCS), assessment for medically related therapy services, Medical Therapy Program (MTP) definitions, and CCS IEP procedures.

Referral to California Children's Services

If a parent provides a medical doctor's prescription or recommendation for OT to school team members, any relevant input from a medical practitioner would be considered by an IEP team along with other health information. However, there is no educational requirement or authority to fill a physician's prescription for OT.

While the local education agency (LEA) provides OT or PT services to students based on educational need, there are other children who may exhibit a medical necessity for therapy. In such cases, the LEA may refer the case to CCS for determination of medical needs. A decision to refer to CCS depends on the information contained in the referral and the student's documented physical deficit.

If the student is referred to CCS by the LEA, the referral must be accompanied by:

- The student's medical diagnosis;
- Current medical records;
- Parental permission for exchange of information between agencies; and
- Application for the CCS program if the student is unknown to CCS.

If medical eligibility cannot be determined by medical records submitted, CCS shall:

- Notify the parent and LEA within 15 days of the receipt of the referral;
- Seek additional medical information; and
- If the additional medical information sought does not establish medical eligibility, and if the student's diagnosis is cerebral palsy, then the student shall be referred to a CCS panel physician for a neurological examination.

If CCS determines that the student is ineligible because the student's medical condition is not a MTP eligible condition, CCS shall notify the parent and LEA within five days of the determination of eligibility status for the MTP.

Assessment for Medically-Related Therapy

If CCS determines the student has a MTP eligible condition, CCS shall propose a therapy assessment to the parents and obtain written consent for the assessment of the need for medically necessary occupational therapy or physical therapy. This assessment for therapy shall be implemented not more than 15 days following the determination of whether the student has a medical therapy program eligible condition.

Upon receipt of the parent's written consent for an assessment, the CCS agency shall send a copy of the parent's consent to the LEA, which shall establish the date of the IEP team meeting. The LEA shall schedule an IEP team meeting to be held within 60 days from the date parental consent is received by CCS.

When CCS determines a student needs medically necessary occupational therapy or physical therapy, CCS shall provide the LEA and the parent a copy of the completed

assessment report for therapy or a proposed therapy plan prior to the scheduled IEP meeting.

When CCS determines a student does not need medically-necessary physical therapy or occupational therapy, the LEA and the parent shall be provided with the completed assessment report for therapy and a statement that delineates the basis for the determination.

Medical Therapy Program Definitions

"Assessment for medically necessary occupational therapy and physical therapy" means the comprehensive evaluation of the physical and functional status of a student who has a MTP eligible condition

"Assessment plan" for the CCS MTP for students with a disability who have an IEP means a written statement describing proposed:

(1) Procedures necessary for determination of medical eligibility for the CCS MTP; or

(2) Procedures necessary for the re-determination of need for medically necessary physical therapy or occupational therapy for a student known to be eligible for the CCS MTP.

"Assessment report for therapy" means a written document of the results of a student's assessment for medically necessary occupational therapy or physical therapy.

"CCS Panel" means that group of physicians and other medical providers of services who have applied to and been approved by CCS.

"Documented physical deficit" refers to a student's motor dysfunction recorded on the referral for special education and related services by the Local Education Agency and documented in the student's CCS medical record.

"Independent county agency" means the CCS administrative organization in a county that administers the CCS program independently.

"Medical therapy conference (MTC)" means a team meeting held in the Medical Therapy Unit (MTU) where medical case management for the student's MTP eligible condition is provided by the MTC team as described below.

"Medical Therapy Conference team" means a team composed of the student, parent, physician and occupational therapist and/or physical therapist, or both. The team may include, with the consent of the student's parent(s), an education representative who is present for the purpose of coordination with medical services.

"Medical Therapy Program (MTP) eligible conditions" are those diagnoses that make a student eligible for medical therapy services and include the following diagnosed neuromuscular, musculoskeletal, or muscular diseases.

(1) Cerebral palsy, a non-progressive motor disorder with onset in early childhood resulting from a lesion in the brain and manifested by the presence of one or more of the following findings:

(A) Rigidity or spasticity;

(B) Hypotonia, with normal or increased deep tendon reflexes and exaggeration or persistence of primitive reflexes beyond the normal age;

(C) Involuntary movements, athetoid, choreoid, or dystonic; or
(D) Ataxia, incoordination of voluntary movement, dysdiadochokinesia, intention tremor, reeling or shaking of trunk and head, staggering or stumbling, and broad-based gait.

(2) Other neuromuscular diseases that produce muscle weakness and atrophy, such as poliomyelitis, myasthenias, muscular dystrophies;

(3) Chronic musculoskeletal diseases, deformities or injuries, such as osteogenesis imperfecta, arthrogryposis, rheumatoid arthritis, amputation, and contractures resulting from burns.

"Medical therapy services" are occupational therapy or physical therapy services that require a medical prescription and are determined to be medically necessary by CCS. Medical therapy services include:

(1) ***"Treatment"***, an intervention to individuals or groups of students in which there are occupational therapy or physical therapy services.

(2) ***"Consultation"***, an occupational therapy or physical therapy activity that provides information and instruction to parents, care givers or LEA staff, and other medical services providers;

(3) ***"Monitoring"***, a regularly scheduled therapy activity in which the therapist reevaluates the student's physical status, reviews those activities in the therapy plan which are provided by parents, care givers or LEA staff, and updates the therapy plan as necessary; and (4) ***"Medical Therapy Conference"*** as defined above.

"Medical Therapy Unit (MTU)" means a CCS and LEA approved public school location where medical therapy services, including comprehensive evaluations and medical therapy conferences, are provided by CCS.

"Medical Therapy Unit – Satellite (MTU-S)" means a CCS and LEA approved extension of an established MTU where medical therapy services may be provided by CCS. Comprehensive evaluations and medical therapy conferences are not a part of medical therapy unit satellite services.

"Medically necessary occupational therapy or physical therapy services" are those services directed at achieving or preventing further loss of functional skills, or reducing the incidence and severity of physical disability.

"Necessary equipment" means that equipment, provided by the LEA, which is required by the MTU staff to provide medically necessary occupational therapy and/or physical therapy services to a student with a MTP eligible condition.

"Necessary space" means the facilities, which are provided by the LEA for a MTU or MTU-S, and enable the MTU staff to provide medically necessary therapy services to a student with a MTP eligible condition.

"Occupational therapy and physical therapy" mean services provided by or under the supervision of occupational therapists and physical therapists.

"Therapy plan" means the written recommendations for medically necessary occupational therapy or physical therapy services based on the results of the therapy assessment

and evaluation. The therapy plan is to be included in the individualized education program (IEP) or individualized family service plan (IFSP).

California Children's Services IEP Procedures

A "Related Service" is defined in the California Education Code as "…services that are *necessary* for the pupil to benefit educationally from his or her instructional program." The Education Code further states that California Children's Services (CCS) OT or PT, when defined as a "related service" by the IEP team, must include goals corresponding to that service written into the IEP. CCS therapists may share information and participate in a child's IEP when it is requested and notification of the IEP is provided.

Documentation of CCS services should be clearly listed in the IEP. Use the Other Agency Services section of the Education Setting page to identify CCS as a provider. Services provided by CCS should be documented in the IEP team meeting comments.

California Education Code requirements regarding notification to/from the IEP team:

a. When the student is a CCS client, CCS is required to notify the IEP team educational liaison in writing within 5 days of a decision to increase, decrease, change the intervention, or discontinue services. An addendum IEP must be held to make the changes to the IEP (telephone addendum procedures may be utilized).

b. The District is required to notify CCS in writing 10 days prior to an IEP team meeting if the student is a CCS client. If the student receives CCS as a related service, the OT or PT provider is an IEP team member and must be excused by the parent if unable to attend.

The *"Flow Chart to Determine Need for OT/PT Documentation in IEP"* (see Appendix T) describes the decision-making process to assist IEP teams regarding the inclusion of CCS OT and/or PT on the IEP.

Provision of Medically Necessary Services

CCS medical therapy services are available to all eligible children who require them and are available at no cost to the parents of those children. The frequency of CCS therapy services (monitoring or direct service) is based on physician prescription and is determined by the physician, parent, and therapy team. Services may increase or decrease based on the child's medical condition and progress towards therapy goals. If the parent or legal guardian is not in agreement with the frequency of prescribed occupational or physical therapy he/she may appeal this decision by contacting the CCS administrative office.

Medically based occupational and physical therapy levels of therapy service may include:

1. Weekly therapy for children who are changing rapidly or have acute needs (e.g. after surgery)
2. Frequent monitoring (up to two times per month)for children who need to be followed closely
3. Periodic monitoring 1 to 6 times a year for students who are stable, have met their goals, or who will continue to improve/maintain skills without therapeutic intervention

Approved October 15, 2010
Revised May 18, 2012; January 20, 2017

Appendices

Appendix A

Glossary

Access is the opportunity to engage in educational curriculum, programs, and activities.

Adaptive Development means the acquisition of skills that are required to meet environmental demands. Adaptive development includes, but is not limited to, activities of self-care, such as dressing, eating, toileting, self-direction, environmental problem solving, and attention arousal (17 CCR 52000(34).

Plan Review is a yearly review, for a child with an IEP, to determine progress made on past IEP goals, the child's present needs, and goals, placement, and services for the next year.

Bilateral Coordination Skills The ability to use both sides of the body in a smooth, coordinated manner. Some activities that may be affected by difficulties with upper body bilateral coordination are stabilizing the paper while writing and using a ruler and stencils.

California Children's Services (CCS) is a division of California Medical Services, (CMS), an agency of the State Department of Health. CCS provides OT and PT services as part of the medical services provided to children who qualify based on medical diagnosis and functional need.

Certified Occupational Therapy Assistant (COTA) is a person who is certified by the California Board of Occupational Therapy (CBOT) and provides OT services under the supervision of a licensed occupational therapist.

Cognitive Development Construction of thought processes, including remembering, problem solving, and decision-making.

Complaint Procedures are initiated by a written signed statement alleging that a local public agency has violated a federal or state law or regulation.

Confidentiality is maintaining a person's right to privacy as stated by law.

Consent is voluntary permission expressed in writing for a certain activity to be carried out and is given after a parent or guardian is fully informed of all relevant information related to the activity being sought consent for.

County Office of Education (COE) means the office of the county superintendent of schools.

Criterion-referenced Assessment is an assessment that has established standards of performance (often related to age or expectations of a developmental level) that the child is measured against.

Data Collection is written documentation of some action or response, often used to establish a baseline or to measure progress.

Designated Instruction and Services (DIS) means related services.

Documentation is written record of assessments, services, and communications.

Free Appropriate Public Education (FAPE) means special education and related services provided in conformity with the IEP, at public expense, and under public supervision and direction (20 USC 1401(9)).

Figure-Ground Perception The ability to perceive a figure in the foreground from a rival background.

Fine Motor Skills The skilled use of one's hands. It is the ability to move the hands and fingers in a smooth, precise and controlled manner. Fine motor control is essential for efficient handling of classroom tools and materials. It may also be referred to as dexterity.

Educationally Necessary OT and PT Related Services are services specified on an IEP as needed in order for a child to benefit from his or her special education program.

Gross Motor Skills Coordinated body movements involving the large muscle groups. A few activities requiring this skill include running, walking, hopping, climbing, throwing and jumping.

Hypersensitivity Oversensitivity to sensory stimuli, characterized by a tendency to be either fearful and cautious, or negative and defiant.

Hyposensitivity Under sensitivity to sensory stimuli, characterized by a tendency either to crave intense sensations or to withdraw and be difficult to engage.

Independent Education Evaluation (IEE) may be provided at public expense when parents disagree with a school district's evaluation. The parent is entitled to only one IEE each time the district conducts an evaluation. (The school district, however, may choose to defend its own assessment in due process rather than provide an IEE (34 CFR 300.502)).

Individuals with Disabilities Education Act (IDEA) is the federal educational law of 1997 (which amended PL 94-142 and PL 101-476 and included updated regulations) that delineated and governed special education services.

Individuals with Disabilities Education Improvement Act (IDEIA) is the federal educational law (which updated IDEA 1997 and includes updated regulations) that delineates and governs special education services. IDEIA, however, is commonly referred to as IDEA or IDEA 2004.

IEP Team refers to all the members, including the parents, who meet and/or provide services to the special education child as part of a free and appropriate educational program. The IEP meeting is where the IEP is discussed and formulated (34 CFR 300.23).

Individualized Education Program (IEP) is a working document for the special education child that documents eligibility for services, the level of present functioning by the child, appropriate goals, objectives, services, and service providers as well as other

specific details. When the IEP is signed, which signifies acceptance by the parent or legal guardian, the IEP becomes the legal document that satisfies the requirement that special services be provided for the child with special needs (34 CFR 300.22).

Medically Necessary occupational therapy or physical therapy services are those services directed at achieving or preventing further loss of functional skills or reducing the incidence and severity of physical disability (2 CCR 60300(n)).

Motor Planning The ability to have an idea, plan an action and execute the action necessary for completion of a new motor skill.

Multidisciplinary Team means two or more professionals from different disciplines, and the parent, who participate in provision of integrated and coordinated services (17 CCR 52000(34)).

Needing Related Services means that an assessment shows the need for a service related to special education for a child identified as a special education student.

Nonpublic Agency (NPA) or Nonpublic School (NPS) is a nonsectarian agency or school that has applied, met state criteria, and paid fees to be recognized as a provider of special education or related services or both.

Occupational Therapy (OT), as outlined in the Occupational Therapy Practice Act, *Business and Professions Code* Section 2570.2(k), means therapeutic use of purposeful and meaningful goal-directed activities (occupations), which engage the individual's body and mind in meaningful, organized, and self-directed actions that maximize independence, prevent or minimize disability, and maintain health.

Physical Therapy (PT), according to the American Physical Therapy Association, Physical Therapy Scope of Practice, means services provided under the direction and supervision of the PT and includes examining (history, system review, and tests and measures) individuals with impairments, functional limitations, and disability or other health-related conditions for diagnosis, prognosis, and intervention; alleviating impairments and functional limitations and disability, including the maintenance of fitness, health, and quality of life in all populations and engaging in consultation, education, and research.

Physical Therapist Assistant (PTA) is a person who meets the legal qualifications and provides PT services under the supervision of a licensed PT.

Postural Stability Ability to maintain seated position, assume and maintain various positions required at school, strength and range of movement.

PRAXIS Refers to motor planning and is the ability of the brain to conceive, organize and execute unfamiliar actions in a planned action sequence.

Proprioception The proprioceptive sense refers to the sensory input and feedback that tells us about movement and body position. It's "receptors" are located within our

muscles, joints, ligaments, tendons, and connective tissues. It is one of the "deep senses" and could be considered the "position sense"

Regional Center is a diagnostic, counseling, and service coordination center for persons with developmental disabilities and their families. It is a contractor of the Department of Developmental Services (17 CCR 52000(43)).

Related Service is defined as a service that may be required in order for a child to benefit from his/her special education program. OT and PT are defined in both federal regulation and state regulations as related services (34 CFR 300.34).

Response to Instruction and Intervention (RtI2) is a general education approach based on providing scientific, research-based interventions for a child struggling in general education. In RtI2 the child's response is documented before referral to special education.

Screening to determine the appropriate instructional strategies for curriculum implementation is not considered to be an assessment for eligibility for special education and related services. This would be part of early intervening services, which occur, before referral to special education.

Section 504, of the Rehabilitation Act of 1973 and Amendments of 1992, is the civil rights law prohibiting discrimination against handicapped children for the use of public services. The term "504 accommodations" refers to the measures to accommodate the child's disability written into a 504 Plan, which becomes part of the child's general education program.

Sensory Defensiveness A child's behavior in response to sensory input, reflecting severe over-reactions or a low threshold to a specific sensory input.

Sensory Diet A term devised by Patricia Wilbarger in 1971 to describe a therapeutic method to maintain an optimal level of arousal (in the nervous system) by offering the right combination of sensory information. The term diet is a metaphor for the regular "feeding of the nervous system" to change one's state of arousal timed carefully throughout the day. A well-planned "sensory diet" should include comfort touch, pleasurable social experiences, organizing proprioception, varied tactile activities and modulating vestibular input.

Sensory Dormancy A child's behavior in response to sensory input, reflecting under-responsiveness or a high threshold to a specific sensory input.

Sensory Input The constant flow of information from sensory receptors in the body to the brain and spinal cord.

Sensory Integration The ability to receive, process and act upon sensory input for "use". This "use" may be a perception, an adaptive response or a learning process. Through sensory integration many different parts of the nervous system work together so that a person can interact with the environment efficiently.

Sensory Integrative Dysfunction (Now referred to as D.S.I.) A brain irregularity that makes it hard to receive, process and act upon sensory input efficiently. DSI can be observed as a delay or difference in one's motor learning, social/emotional, language, or attention abilities. Two categories of dysfunction in sensory integration include dysfunction in discrimination/praxis or dysfunction in sensory modulation.

Sensory Modulation Increasing or reducing neural activity to keep that activity in harmony with all other functions of the nervous system. Maintenance of the arousal state to generate emotional responses, sustain attention, develop appropriate activity level and move skillfully.

Sensory Orientation Selective attention, supporting our inner drive to engage with the stimulus, respond and learn.

Sensory Processing Skills The ability to receive and process information from one's sensory systems including touch (tactile), visual, auditory (hearing), proprioceptive (body position) and vestibular (balance). Behavior, attention and peer interactions are greatly influenced by the child's ability to process sensory stimuli

Spatial Awareness The perception of one's proximity to, or distance from, an object, as well as the perception of the relationship of one's body parts.

Special Education Local Planning Area (SELPA) provides special educational services to children in the designated area. A SELPA may include more than one local educational agency.

Standardized Assessment (also called norm-referenced assessment) is an assessment that ranks the child's performance based on normative population test results; thus average performance and performance outside the average range can be determined.

Student Success Team (SST) is a part of the general education program. Referral to an SST precedes a referral to special education. A team of different professionals and parents help problem-solve issues and monitor progress of a student struggling in the school environment.

Supplementary Aids and Services are those aids, services, and other supports provided in general education and other education-related settings to enable children with disabilities to be educated with nondisabled children (20 USC 1401 (33)).

Tactile Defensiveness A sensory defensiveness that results in tactile sensations being perceived as negative. Decreased attention, avoidance of a variety of touch experiences and strong emotional reactions are seen consistently in a child exhibiting tactile defensiveness.

Therapeutic Listening A therapy technique; the use of modulated and filtered music during S.I. therapy to promote regulation and praxis, as devised and instructed by Sheila Frick, OTR.

Transition or Transition Services refers to a time period when a child is getting ready to enter a new phase or life role and the services directed toward that period. In the educational system, when a child in the early intervention program is going to turn three or is being discharged from all early intervention services, the IFSP team must create a transition plan (17 CCR 52112). When a special education child is sixteen years old or younger, if appropriate, the term “transition services” refers to a coordinated set of activities for a child with a disability that is designed to be within a results-oriented process, that is focused on improving the academic and functional achievement of the child with a disability to facilitate the child’s movement from school to post-school activities, including postsecondary education, vocational education, integrated employment (including supported employment). The child must have an individualized transition plan (ITP) for entering adulthood when the services provided by the public school are no longer available (20 USC 1401(34)).

Transdisciplinary Team is a team of different professionals who work together in assessing the child and often report findings in one integrated report so that team decisions can be made.

Reevaluation Review is a process conducted every three years to determine whether the child continues to be eligible for special education services.

Vestibular Refers to our sense of movement and the pull of gravity, related to our body.

Vestibular System Our inner gyroscope that detects the sense of movement head movement and our response to gravity to help develop a sense of spatial relationships. Our inner drive is to keep the body in an upright position. Any input to this primitive system can last up to 6 hours in the nervous system, so parents and therapist must use caution when applying this powerful input.

Visual-Motor Skills Often referred to as eye-hand coordination employed in handwriting, reaching and grasping objects.

Visual-Perceptual Skills The ability to distinguish size, distance and shapes.

Appendix B

Therapy Needs Survey

CHILD: _____DOB: _____ SCHOOL: _____

PREVIOUS OT: ❑Yes ❑ No If Yes: ❑ CCS ❑ PRIVATE

Please indicate where there is a problem that influences the child's school performance and describe how the child's ability to gain from his educational program is affected. Your information will help determine an appropriate course of therapy service.

- ❑ Balance and motor coordination appear delayed relative to cognitive level, adversely affecting ability to participate in the educational program (frequent falls, significant clumsiness, bumps into things). Describe on back.
- ❑ Classroom positions are difficult to assume, maintain or tolerate (independent sitting or standing, moving to or from the floor). Describe on back.
- ❑ Fine Motor skills appear delayed relative to cognitive level, limiting ability to reach for, grasp, manipulate or release objects or to use both hands together (difficulty with clothing fasteners, poor scissors use, poor pencil/crayon grasp, hand does not assist with stabilization). Describe on back.
- ❑ Visual-perceptual-motor abilities are delayed not due to vision impairment, developmental readiness or behavior/ emotional disorders (difficulty tracing or coloring within lines, copying from the board, forming and spacing letters). Describe on back.
- ❑ Oral motor dysfunction or problems in self-feeding interfere with intake at meals or present a safety hazard (scoops poorly, loses food/liquids from mouth, gags, takes excessive time to feed or be fed). Describe on back.
- ❑ Self-dressing skills related to managing outerwear and clothing at the toilet are delayed (difficulty taking off/putting on jacket, difficulty pulling pants up/down). Describe on back.
- ❑ Adaptive or assistive equipment to perform educational activities needs to be acquired, fabricated, or adjusted (pencil grips, desk or chair modifications, positioners, built-up spoons). Describe on back.
- ❑ Sensorimotor processing deficits may affect attention to task and performance (overreaction to movement or accidental touch, difficulty with changes in routine, impulsive grabbing). Describe on back.
- ❑ Functional living skills require task analysis and modifications to accomplish successful job performance (decreased strength, coordination, and endurance). Describe on back.
- ❑ Motor planning abilities make it difficult to negotiate the school environment and learn new tasks (difficulty moving within the room or school areas, difficulty imitating movements, understands directions but cannot do task). Describe on back.

SIGNATURE _____DATE _____

Appendix C

Review of Existing Data Related to OT

Name:		Date:	
School:		Birthdate:	
Teacher:		Parent:	
Grade	Address:		
Referred by:		Cell Phone:	
Language Spoken Home:		School:	

Educational Eligibility: _____ ❑ Not Determined

School Status: Reg. Ed. ❑ RSP ❑ Speech ❑ 30-day Transfer ❑
SDC ❑ Child Find ❑ Home School ❑ Hospital ❑

Dates: IEP/IFSP _____ 30-day Review _____ Plan Review _____ Reevaluation _____

Agency Status: CCS _____ Regional Center _____ Mental Health _____ Private OT/PT _____

Contact Information _____

Medical Diagnosis: Medications: _____

Presenting Problem(s):
What is this child not able to do that other children in the classroom are able to do? Summarize concerns.

_____

_____

Who is expressing the most concern?
Parent Teacher Principal Psychologist RSP Speech Nurse Physician

Estimated Ability: Not Tested Above Average Average Suspect Developmental Delay
Estimated Curriculum Level: Lang Arts ____ Math ____ Science ____ History/Soc. Sci. ____ P.E. ____

Functional Ability: Please indicate the child's level of independence and participation.
5 = Independent, 4 = Needs Occasional Assistance, 3 = Requires Some Supervision, 2 = Constant Supervision, 1 = Dependent

						Comments
General education classroom:	1	2	3	4	5	
Special education classroom:	1	2	3	4	5	
Campus:	1	2	3	4	5	
Playground: motor ability:	1	2	3	4	5	
Social Skills:	1	2	3	4	5	
Bathroom:	1	2	3	4	5	
Lunch: Uses utensils	1	2	3	4	5	
Opens containers	1	2	3	4	5	
Transitions:	1	2	3	4	5	
Transportation:	1	2	3	4	5	

Accommodations and modifications: _____

_____

Percentage of expected written work child is able to complete _____
Quality of work: ❑ Excellent ❑ Good ❑ Fair ❑ Poor
Note: Please attach an Educational Assessment, a writing sample, and any medical, OT, PT or APE reports
Source: Anaheim City School District 2009.

Appendix D

Team Discussion Points about Need for OT Referral for Evaluation

CHILD: _____DOB:_____ SCHOOL: _____

This document provides questions to help lead a team to a decision about the need to refer a student for an OT evaluation.

- ❑ Does the student have difficulty accessing school environments?
- ❑ Are the problems interfering with the student's ability to learn?
- ❑ Is the student making progress in his educational program?
- ❑ What are the circumstances leading to the referral?
- ❑ Does the teacher know what activities, interventions or procedures to provide to address the student's needs?
- ❑ If not, who has the expertise to assist her/him?
- ❑ What is the developmental level of the student?
- ❑ Is the student delayed in all areas of development?
- ❑ Does the student seem to have difficulty responding to environmental stimuli?
- ❑ Does the student have educational goals that involve motor skills or sensory functioning?
- ❑ Can these goals be addressed by adaptations or modifications to the classroom environment or curriculum?
- ❑ Can these goals be addressed by classroom instructional staff using typical educational strategies with reasonable expectation of success?
- ❑ Can these goals be addressed by classroom instructional staff with consultation and guidance or monitoring by an Occupational Therapist?
- ❑ Can classroom instructional staff conduct a program of activities designed by an Occupational Therapist specifically for this student, with reasonable expectation of success?
- ❑ Can activities designed to address educational goals be delivered to the student only by a professional Occupational Therapist?

Signature: _____ Date: _____

Appendix E

Fine and Visual Motor Developmental Milestones

Between Ages of Three and Four	• Buttons in less than 30 seconds • Unbuttons (simple fasteners) quickly • Draws a person – 3 body parts • Builds a tower of six cubes • Imitated vertical stroke; copies circle; copies a cross • Traces a line • Grasps a marker with thumb and index finger moving hand as a unit • Cuts 8.5 inch paper in half; cuts on curved line • Laces string into 3 holes/strings beads • Puts together simple 3 piece or inset puzzle • Colors within ¼ inch of line • Drops small object into a jar
Between Ages Four and Five	• Touches finger to thumb quickly • Colors between lines • Draws person with face including mouth, nose, and eyes • Builds steps with blocks, then a pyramid • Copies square • Connects 2 dots • Holds crayon well • Uses scissors • Cuts a large circle, then cuts a square within ¼ inch of line • Completes puzzle to 20 pieces • Colors almost within lines of 4 inch circle • Folds 2 pieces of paper in half lenghwise
Between Ages Five and Six	• Dresses and undresses without assistance, begins to tie shoes • Prints some letters • Draws a person with 6 body parts • Builds 5 block bridge (from model) • Copies a triangle • Prints some letters, copies first name (may have reversals, large letters) • Mature tripod/functional grasp • Cuts out complex pictures following outlines • Cuts cloth and other material • Puts together complex/interlocking puzzle (10 piece inset puzzle) • Folds pieces of paper in half

Between Ages Seven and Ten	• Can tie knots • Puts together intricate construction pieces • Uses hole punches, staplers, glue, scissors • Uses keyboard and mouse (may not use typing technique) • May develop specialized skill (e.g., piano or needlework) • May begin to play musical instrument and build things • Ages 8-9; Writes in cursive (learns in 3rd grade)
Ten Plus	• Increased typing speed and motor skills for computer use • Tool use for science activities and for other projects • May be more clumsy with puberty

Appendix F

OT Problems and Strategies Chart

Type of Problem	Strategies
Motor Planning: Learning new motor skills	• Uses pictures (e.g., stick figures) • Have child repeat steps/directions aloud • Model steps/body movements (e.g., Follow the Leader) • Uses action songs
Organizing/sequencing school (and home) related tasks	• Have child repeat step/directions aloud • Use checklists (e.g., morning routine) • Use schedule • Use pictures for steps of an activity or to illustrate schedule

Type of Problem	Behaviors	Strategies
Hand skills relating to use of tools for eating, coloring, writing, and cutting	Draws or colors too lightly Has trouble feeding self Uses awkward grasp on pencils, crayons	• Plays games with small pieces • Use small/shortened writing tools • Use one hand to pick up coins in a slot • Play games that involve using fingers to twist (e.g., wind up toys) • Tear paper for art projects • Try pencil grips • Write/work/do activities on vertical surfaces by using an easel or taping work onto the wall • Do work or play games while lying in floor on stomach • Do wall push ups; while standing, place hands on wall and push • Do chair push ups; while sitting, hold sides of chair with both hands and push body up • Do animal walks, wheelbarrow walks • Throw a heavy ball overhead • Carry heavy boxes, push classroom furniture • Do classroom jobs, such as put chairs up on desk, open doors, wipe tables
Writing, copying, drawing	Difficulty writing on the lines of notebook paper Has trouble forming letters (e.g., shape, size)	• Play pencil and paper games (e.g., dot to dot, hidden picture) • Color by number activities • Draw letters in sand or shaving cream • Print over bumpy surface such as sand paper • Use pipe cleaners to form letters • Draw rainbow letters-write letter in one color, have student trace letters in different colors • Practice letters in alphabet stencils • Highlight lines on paper • Use graph paper

Writing, copying, drawing (cont.)	Does not leave spaces between words	• Use slandted surface; make a “desktop easel” by placing an empty, large 3 ring binder horizontally on work surface, so that the surface inclines
Poor attention for school or home related tasks	Has trouble finishing assignments Difficulty listening to class discussion Fidgets or appears to be in constant motion	• Give reminders to sit up tall (e.g., make sure feet touch floor) • Allow movement breaks during activity for 2 to 3 minutes • Use timer to let the children know how long they are expected to work • Allow child to work in different positions (e.g., stand at table or lie on stomach to complete desk work)
Over or under reaction to different textures	Likes getting messy or avoids doing messy activities Hits others when they get close	• Activities that involve the sense of touch (e.g., play-doh, shave cream; involve the child in some simple steps of cooking) • Avoid unwanted touch by allowing child to be first or last in the line

Appendix G

Occupational Therapy Referral for Assessment Form

CHILD: _____DOB:_____ SCHOOL: _____

Please help us by indicating specific areas of concern so our follow-up will be more appropriate and accurate. Check if the child has difficulties in any of the following areas:

DESKTOP ACTIVITIES

- ❑ Writing/Pre-writing
- ❑ Use of age-appropriate supplies and tools
- ❑ Organization of materials
- ❑ Coloring
- ❑ Cutting/pasting
- ❑ Copies assignments from board/books
- ❑ Maintains upright posture in chair

FLOOR/CIRCLE TIME

- ❑ Navigates classroom smoothly
- ❑ Maintains upright posture on floor

PLAYGROUND/SCHOOL CAMPUS

- ❑ Navigates playground smoothly
- ❑ Learns new motor acts within reasonable time frame
- ❑ Tactile (*overreacts to touch, trouble standing in line, touches people and objects frequently*)
- ❑ Auditory (*sensitive to noise*)
- ❑ Body space awareness (falls, bumps into people and objects, invades space of others)

SELF-HELP

- ❑ Dressing (*for bathroom use, recess, P. E*.)
- ❑ Fasteners
- ❑ Utensil/container use (*for lunch/snack*)
- ❑ Use of backpack, locker, binder

COMMENTS:

_____

_____

_____

Signature: _____ Date: _____

Appendix H

Assessment Questions Using the Ecological Model

CHILD: _____DOB:_____ SCHOOL: _____

RECORD REVIEW/CHECKLIST

- ✓ What is the medical diagnosis?
- ✓ What is the eligibility for special education?
- ✓ Establish profile of strengths and areas of concern (assess in these areas)
- ✓ What are the IEP goals?
- ✓ What goals are related to OT's areas of expertise?
- ✓ What is the program placement and classroom setting?
- ✓ Who are the educational personnel addressing educational areas of concern or IEP goals?

PARENT/TEACHER INTERVIEW

- ✓ Does the student have the ability to participate in the ongoing structure/routine of the class?
- ✓ What does the teacher/parent see as the student's strengths and weakness?
- ✓ What are the parent's concerns regarding their child's functioning in his/her educational program?
- ✓ What type of curriculum is being used?
- ✓ In which areas of the instructional program is the student having the greatest difficulty (assess in these instructional areas)?
- ✓ What are the teachers' expectations for students in the classroom?
- ✓ What are the methods of instruction and methods of behavior management?
- ✓ In which setting is the student having the greatest difficulty (assess in these settings)?
- ✓ How does the student interact and work with peers in the classroom?
- ✓ What other staff might contribute information about this student's performance in areas of concern?
- ✓ Is the student using any special adaptations of special equipment?
- ✓ What is the student's daily school schedule?

STUDENT OBSERVATION

- ✓ To what extent is the student able to participate in the environment?
- ✓ Focus observation on OTs and PTs areas of expertise relevant to the educational program.
- ✓ Do the curriculum demands match or accommodate the student abilities?
- ✓ Is the student sufficiently challenged within his or her educational environment?
- ✓ Is the physical environment (student's desk, educational technology, lighting, acoustics, instructional materials, and classroom/campus design) suitable or does it present an obstacle to the student?
- ✓ Do the organization, structure, and routine meet the student's needs?
- ✓ Is the student able to follow the social rules, and interact with classroom members?

Appendix H

STANDARDIZED NONSTANDARDIZED ASSESSMENT

✓ Targeting areas of concern focus assessment on occupational therapy and physical therapy areas of expertise to discern additional relevant factors and underlying skills which impact student performance.

SUMMARY

- What does the assessment information reveal about the student's abilities?
- What is the student's potential for improvement, maintenance or regression?
- Would therapeutic interventions likely result in improved functional changes in the classroom?
- Within the curriculum what is specifically expected of the student that he/she is not accomplishing/inefficient/slow?
- Are there modifications, which could enable the student to participate more successfully?
- Would modifications or classroom adaptations alone suffice as an intervention?
- What environmental accommodations could assist the student in functioning?
- Would changes in structure, routine or the social environment assist the child in participating in the educational program?
- Are there other educational personnel who can address student's area of concern?

From Guideline for *Occupational Therapy and Physical Therapy in the California Public Schools*, page 37, California Department of Education, (1999) and *Occupational Therapy Services for Children and Youth under the Individual with Disabilities Education Act (IDEA)*, 2nd edition, pages 81,116, 117. Bethesda, MD: American Occupational Therapy Association, Inc. (1996).

Appendix I

Educational Assessment Methods, Procedures, and Tools

Method of Analysis	Record Review/Checklist	Parent & Teacher Interview	Observation of the Child	Nonstandardized & Standardized Assessment	Summary
Environmental Factors Participation To what extent is the child included in or restricted from participating in the educational environment?	• What is the program placement & classroom setting? • Who are the educational personnel addressing educational areas of concern or IEP goals?	• In which setting(s) is the child having the greatest difficulty? (Assess in all settings, but pay close attention to those settings that challenge the child) • How does the child interact and work with peers in the classroom? • Which other staff members might contribute information about this child's performance in the areas of concern?	• Does the physical environment (child's desk, educational technology, lighting, acoustics, instructional materials, classroom design, etc.) support or limit child performance and/or access to the curriculum? • Do the organization, structure, and routine meet the child's needs? • Is the child able to follow the social rules and interact with classroom personnel and peers? • What is the overall pattern of engagement and participation?	• Physical, social, and functional participation in multiple contexts: classroom, playground, cafeteria/lunch area, bathroom, etc. • Pattern of engagement and participation	• Would modifications or classroom adaptations alone suffice as an intervention? • What environmental accommodations would assist the child in functioning? • Would changes in structure, routine, or the social environment assist the child in participating in the educational program? • Are there other educational personnel who can address the child's areas of need?
Curriculum To what extent is the child currently meeting expectations for the performance of important tasks	• Which IEP goals are related to OT's and PT's areas of expertise? • What strategies, accommodations, modifications,	• What type of curriculum is being used? • In which areas of the instructional program is the child having the greatest difficulty?	• Do the curriculum demands match or accommodate the child's abilities? • Is the child sufficiently challenged within	• Important tasks typically expected in each of the above contexts or settings in which the child performs the classroom	• Within the curriculum, what does the child do well? What is specifically expected of the child that he/she is not accomplishing?

Appendix I

Method of Analysis	Record Review/Checklist	Parent & Teacher Interview	Observation of the Child	Nonstandardized & Standardized Assessment	Summary
expected of his/her same age peers to gain access to the curriculum?	adaptations, and interventions have been tried or are currently in place?	(Assess in these instructional areas) • What are the teacher's expectations for the child in the classroom? • What are the methods of behavior management?	his/her educational environment?	tasks, playground tasks, etc. and the nature of these tasks (e.g., physical, cognitive, social) • Measure of the supports (i.e., adaptations, assistance) needed by the child to perform each major task	• Are there modifications that could enable the child to participate more successfully?
Child Factors What are the child's current strengths and limitations in performance of specific activities required to accomplish the major education and school related tasks expected or desired by him or her? What is the status of the basic performance skills and processes necessary for the performance of daily education and school related activities?	• What makes the child eligible for special education? • What is the medical diagnosis (if any)? • What previous assessments have been conducted?	• Does the child have the ability to participate in the ongoing structure / routine of the class? • What does the teacher/parent see as the child's strengths and weaknesses? • What are the parents / teachers priorities and concerns regarding this child's functioning in his/her educational program?	• Establish a profile of child strengths and needs based on available information and identified areas of concern and assess in these areas. • Focus observation on OT and PT areas of expertise relevant to the educational program. • Do the OT's and PT's classroom observations match the expressed concerns and reason for referral?	• Essential activities in the task area during the school day; activity demands. • Extent of child's contribution to performance of the activity (versus extent of limitation), and performance patterns • Targeting areas of concern, focus assessment on OT's and PT's areas of expertise to discern additional relevant factors & underlying skills that impact child performance	• What does the assessment reveal about the child's abilities? What is his/her profile of strengths and needs compared with the areas of concern? • What is the child's potential for improvement, maintenance, or regression? • Would therapeutic interventions likely result in improved functional performance in the classroom?

Appendix J

Sample OT Data Collection Measure

Name: _____ Date: _____

School: _____ Teacher: _____

Grade: _____ Room: _____

N-Not observed
1- 0%-30% of the time
2- 30%-60% of the time
3- 60%-90% of the time
4- 90%-100% of the time

Academic Readiness	
1. Copy letters, numbers, and shapes accurately	N 1 2 3 4
2. Identify letters, numbers, and shapes accurately	N 1 2 3 4
3. Write in assigned spaces and on the writing line	N 1 2 3 4
4. Write/copy without omitting letters or words	N 1 2 3 4
5. Identify single letter/word from a field of many	N 1 2 3 4
6. Maintain functional body positions during daily school activities	N 1 2 3 4
7. Maintain endurance to engage in activities for the duration of the school day and keep pace with peers	N 1 2 3 4
8. Maintain required body movements and activities for the required amount of time without difficulty	N 1 2 3 4
9. Learn new motor tasks within a reasonable time frame (such as games in PE/recess)	N 1 2 3 4
10. Perform required school-based motor activities with sufficient skill on verbal command or demonstration	N 1 2 3 4
11. Navigate the school environment efficiently and safely	N 1 2 3 4
12. Demonstrated consistent hand dominance for required motor tasks	N 1 2 3 4
13. Learn new motor tasks and perform motor tasks required by the child's daily routines	N 1 2 3 4
14. Appropriately attend to classroom instruction	N 1 2 3 4
15. Organize personal belongings	N 1 2 3 4
16. Independently find required materials	N 1 2 3 4
17. Tolerate ambient noise of the learning environment	N 1 2 3 4
Self-Care	
1. Manage clothing and clothing fasteners	N 1 2 3 4
2. Feed self with appropriate utensils, including opening food containers	N 1 2 3 4
3. Use utensils appropriately (fork/spoon)	N 1 2 3 4
4. Complete dressing and hygiene habits and routines	N 1 2 3 4
5. Develop understanding of basic safety precautions	N 1 2 3 4
Vocation/Pre-Vocation	
1. Complete required tasks with minimal adult prompting	N 1 2 3 4
2. Complete activities with multiple steps	N 1 2 3 4
3. Organize desk/backpack/cubby so items can be retrieved upon request	N 1 2 3 4
Social Participation	
1. Maintain attention/stable emotional state during school activities and during transition between activities	N 1 2 3 4
2. Identify situations that may cause stress and utilize strategies to minimize environmental stressors	N 1 2 3 4
3. Tolerate a variety of sensory experiences without emotional disability	N 1 2 3 4
4. Ask for help when needed	N 1 2 3 4
5. Share materials with peers	N 1 2 3 4
6. Settle disputes without aggression	N 1 2 3 4
7. Engage in appropriate play and leisure activities	N 1 2 3 4
8. Engage peers cooperatively in class, play and during games	N 1 2 3 4
9. Follow rules such as taking turns	N 1 2 3 4
10. Win and lose games graciously	N 1 2 3 4
11. Comply with requests from peers and adults	N 1 2 3 4
Recreation/Leisure	
1. Engages in sports, games, hobbies, or other structured activities during child's free time	N 1 2 3 4
2. Participates in leisure activities individually or socially	N 1 2 3 4

Source: San Diego Unified School District 2008.

Appendix K

Examples of Occupational Therapy in the Educational Setting

Possible concerns related to curriculum and participation in the educational context	Examples of participation goals and outcomes related to the child's needs within the educational context	Examples of body functions and structures and performance skills and/or environmental modifications
Completion of written work and organization of materials in the classroom	• Use classroom tools appropriately (scissors, pencils, crayons, keyboard). • Holds materials steadily when working (stabilize paper, stabilize container for opening). • Follow classroom routines. • Tolerate sensory demands of the educational environment. • Appropriately attend to classroom instruction. • Organize personal belongings. • Independently find required materials. • Complete activities with multiple steps. • Copy letters, numbers, and shapes accurately. • Identify letters, numbers, and shapes accurately. • Write in assigned spaces and on the writing line. • Identify single letter/word from a field of many.	• Strength • Grasp/prehension • Skills, precision, and dexterity • Hand dominance • Bilateral coordination • Eye-hand coordination • Postural stability • Sensory modulation and sensory perception (e.g., tactile, visual, proprioceptive, vestibular, etc.) • Ability to motor plan sequenced steps of activity • Ocular control • Visual motor integration
Participation in leisure and playground activities	• Maintain required body movements and activities for the required amount of time without difficulty. • Share materials with peers. • Learn new motor tasks within a reasonable time frame (such as games in PE/recess). • Perform playground activities with sufficient skill. • Navigate the school environment efficiently and safely. • Learn new motor tasks and perform motor tasks required by the child's daily routines. • Engage peers cooperatively in class, play, and games. • Follow rules, such as taking turns. • Win and lose games graciously. • Identify own interests and goals. • Comply with requests from peers and adults. • Engage in sports, games, hobbies, or other structured activities.	• Strength and endurance • Balance • Bilateral coordination • Eye-hand coordination • Quality of movement • Proximal joint and trunk stability • Imitation of body positions • Sensory modulation and sensory perception (e.g., tactile, visual, proprioceptive, vestibular, etc.) • Ability to act upon verbal commands and/or sequence movements • Ability to initiate, organize, and execute motor plans • Ability to engage in cooperative relationships • Maintenance of personal space • Ability to transition

Appendix K

Possible concerns related to curriculum and participation in the educational context	Examples of participation goals and outcomes related to the child's needs within the educational context	Examples of body functions and structures and performance skills and/or environmental modifications
Self-care activities during the school day	• Manage clothing and clothing fasteners for activities, such as toileting. • Feed self with appropriate utensils, including opening food containers. • Self-help skills, such as washing hands, using the drinking fountain, etc.	• Postural stability • Fine motor manipulation • Sensory modulation and sensory perception (e.g., tactile, visual, proprioceptive, vestibular, etc.) • Motor planning and coordination • Visual-motor and visual perceptual abilities • Ability to analyze, organize, and complete self-help task (motor plan)
Prevocational skills and secondary transition	• Maintain attention/stable emotional state during school activities and during transitions between activities. • Identify situations that may cause stress and utilize strategies to minimize environmental stressors. • Ask for help when needed. • Use communication devices (e.g., telephone, computer, communication boards). • Engage in community mobility when appropriate. • Develop understanding of basic safety precautions. • Participates in leisure activities individually or socially. • Freely get access to and participate in all campus activities. • Gain access to community transportation system. • Navigate the entire campus safely. • Use map to navigate school grounds. • Use map to navigate unfamiliar community locations.	• Sensory modulation and sensory perception (e.g., tactile, visual, proprioceptive, vestibular, etc.) • Postural stability • Fine motor manipulation • Motor planning and coordination • Visual-motor and visual perceptual abilities • Motor planning/praxis • Self-regulation • Ability to analyze, organize, and complete tasks • Self-determination

Appendix L

Review of Existing Data Related to PT

Name:		Date:	
School:		Birthdate:	
Teacher:		Parent:	
Grade	Address:		
Referred by:		Cell Phone:	
Language Spoken Home:		School:	

Educational Eligibility: _____ ❑ Not Determined

School Status: Reg. Ed. ❑ RSP ❑ Speech ❑ 30-day Transfer ❑
SDC ❑ Child Find ❑ Home School ❑ Hospital ❑

Dates: IEP/IFSP _____ 30-day Review _____ Plan Review _____ Reevaluation _____

Agency Status: CCS _____ Regional Center _____ Mental Health _____ Private OT/PT _____

Contact Information _____

Medical Diagnosis: Medications: _____

Presenting Problem(s):
What is this child not able to do that other children in the classroom are able to do? Summarize concerns.

_____

_____

Who is expressing the most concern?
Parent Teacher Principal Psychologist RSP Speech Nurse Physician

Estimated Ability: Not Tested Above Average Average Suspect Developmental Delay
Estimated Curriculum Level: Lang Arts ____ Math ____ Science ____ History/Soc. Sci. ____ P.E. ____

Functional Ability: Please indicate the child's level of independence and participation.
5 = Independent, 4 = Needs Occasional Assistance, 3 = Requires Some Supervision, 2 = Constant Supervision, 1 = Dependent

						Comments
General education classroom:	1	2	3	4	5	
Special education classroom:	1	2	3	4	5	
Campus:	1	2	3	4	5	
Playground: motor ability:	1	2	3	4	5	
Social Skills:	1	2	3	4	5	
Bathroom:	1	2	3	4	5	
Lunch: Uses utensils	1	2	3	4	5	
Opens containers	1	2	3	4	5	
Transitions:	1	2	3	4	5	
Transportation:	1	2	3	4	5	

Accommodations and modifications: _____

_____

Percentage of expected written work child is able to complete _____
Quality of work: ❑ Excellent ❑ Good ❑ Fair ❑ Poor
Note: Please attach an Educational Assessment, a writing sample, and any medical, OT, PT or APE reports
Source: Anaheim City School District 2009.

Appendix M

Gross Motor Milestones

Between Ages of Three and Four	• Runs around obstacles • Walks on tiptoes, 1-2 feet • Balances on one foot for one to two seconds • Hops on one foot unsupported • Jumps over two inch high object and lands on both feet together • Kicks a stationary ball • Catches (traps) a bounced ball • Throws ball overhead • Walks up and downstairs alternating feet with assistance • Jumps from bottom step (12 inces), feet together • Walks 20-foot diameter circle staying on path • Runs and changes direction without stopping • Performs a somersault
Between Ages Four and Five	• Gallops 6-10 patterns • Walks backward toe-heel • Balances on one foot for six to eight seconds • Hops in place five times • Jumps forward 10 times without falling • Kicks a rolled ball in any direction • Catches (traps) a thrown ball from three feet • Throws a ball in an intended direction • Walks up and down stairs independently, alternating feet • Maintains momentum on a swing • Walks 10 feet carrying an object blocking view of floor • Hangs from bar using overhead grip • Walks 4 feet on 4 inch wide beam without stepping off
Between Ages Five and Six	• Skips on alternate feet • Walks with a mature pattern • Walks on balance beam • Can hop 6 to 8 feet • Jumps rope with others turning • Kicks a rolled ball in an intended direction • Catches (traps) a thrown ball from five feet • Throws a ball to target from 5 feet • Runs through obstacle course avoiding objects

Dixon, S.D. & Stein, M.T. (2000). University of Michigan Health Systems (Retrieved on May 23, 2007); Child development institute (1998-2007); California Department of Education: Content Standards (Retrieved on June 4, 2007)

Appendix N

Gross Motor Problems and Strategies

Type of Problem	Behaviors	Strategies
Motor Planning: Difficulty learning new motor skills	May require frequent verbal and manual cues to learning novel gross motor skills	• Modeling body movement ✓Simon Says, "Follow the leader". • With music or clapping ✓*Head, shoulder, knees & toes (4)* ✓*Hokey-pokey (5)* ✓*Obstacle course I and II (6,7)* • Give one direction at a time, break down the skill into parts
Difficulty in moving or moving unsafely in the school	Frequent falling and bumping into obstacles and peers Poor safety awareness	• Create clear pathways and decreased obstacles ✓Push in chairs, avoid floor mats, check for clutter in classroom environment • Decrease visual/auditory distractions and crowded environments ✓Allow child to be line leader ✓Classroom holding onto a rope • Practice agility skills ✓Relay races through narrow cones ✓Obstacle course
Difficulty in maintaining an appropriate sitting posture	Improper sitting alignment Inability to access materials at desk due to desk or chair height	• Sitting upright ✓Feet on the floor or phone book foot rest ✓Appropriate chair and desk height ✓Activities on a vertical surface (on an easel and wall) ✓Lumbar roll
Balance and Coordination: Poor balance or frequent falling	Difficulty picking objects off floor in sitting and standing position Difficulty walking on various surfaces such as cracked pavement and grass Difficulty accessing classroom and/or campus such as stepping up a curb, ascending/ descending stairs or ramps	• Practice activities or allow for reaching or placing objects overhead • Dressing skills encourage standing on one foot ✓*Dress Up Relay (8)* • Clean up time – picking up toys or scraps of paper off floor • Encourage walking on uneven surfaces ✓Cracked pavement within the school ✓Grass at the park ✓Sand on the beach • Balance activities: ✓*Tug of War (9)* ✓*Tug Boat Game (10)* ✓*Towel Pull (11)* ✓*Walking on Clouds (12)* ✓*Puzzle Squat (13)* ✓*Bean Bag Pick-up (14)* ✓*Balloon Volley (15)*
Endurance and Strength: Reduced endurance and fatigue	Difficulty keeping up with classroom peers Tires quickly	• Endurance and strengthening activities: ✓Wheelbarrow walking ✓*Animal Walks (16)* ✓*Red Light, Green Light (17)* ✓*Crabwalk Soccer (18)*

Appendix O

Rubric to Determine Physical Therapy Needs

1. Potential to benefit with therapeutic intervention
   - 1.1. Student demonstrates minimal potential for change
   - 1.2. Student appears to have potential for change but at a slower rate
   - 1.3. Student appears to have a significant potential for change
   - 1.4. Student appears to have a high potential to improve skills

2. Critical period of skill acquisition or regression related to development or disability
   - 2.1. Not a critical period
   - 2.2. Minimally critical period
   - 2.3. Critical period
   - 2.4. Extremely critical period

3. Amount of motor program that can be performed by others in addition to therapist intervention
   - 3.1. Motor program can be safely carried out by others with periodic intervention by therapist
   - 3.2. Many activities from the motor program can be safely performed by others in addition to intervention by therapist
   - 3.3. Some activities from the motor program can be safely performed by others in addition to intervention by therapist
   - 3.4. A few activities can be safely performed by others but most of the motor program requires the expertise of the therapist

4. Amount of training provided by therapist to others carrying out the program
   - 4.1. Teacher, staff and/or parents highly trained to meet student's needs; no additional training needed
   - 4.2. Teacher, staff and/or parents trained but some follow-up needed
   - 4.3. Teacher, staff and/or parents could be trained to carry out some activities
   - 4.4. Teacher, staff and/or parents could carry out some activities with extensive training

5. Amount motor problem plus environment interferes with education program
   - 5.1. Environment is accommodating and motor difficulties are minimal
   - 5.2. Environment is accommodating and motor difficulties are moderately interfering
   - 5.3. Environment is accommodating but motor difficulties are significant
   - 5.4. Environment is not accommodating or environment is accommodating but motor difficulties are significant

Appendix P

Physical Therapy Referral for Evaluation Checklist

CHILD: _____DOB:_____ SCHOOL: _____

Following a PT evaluation, the student's educational problem(s) should be identified in the categories listed. Indicate educational relevance for every problem area by marking each column with a "yes", "no" or "NA" (not applicable). If all five entrance criteria are marked with a "yes", then PT should be considered as a related service to meet the student's IEP or IFSP goal(s).

Entrance Criteria	Problem interferes with student's ability to benefit from his/her educational program	Problem appears to be primarily motor or sensori-motor based	As documented, previous attempts to alleviate problems have not been successful	Therapist's unique expertise is required to meet the student's identified needs	Potential for change in student's problem through intervention appears likely
Mobility					
Functional Movement Skills					
Ability to Handle Arch Requirements					
Utilizing Assistive Devices					
Transfers					
Other (specify)					
Positioning					
Independent sitting/standing					
Assisted Alternative Positions					
Transportation					
Other (specify)					

COMMENTS:

_____

_____

_____

Signature: _____ Date: _____

Appendix Q

Sample PT Data Collection Measure

Name: _____ Date: _____

School: _____ Teacher: _____

Grade: _____ Room: _____

N-Not observed
1- 0%-30% of the time
2- 30%-60% of the time
3- 60%-90% of the time
4- 90%-100% of the time

Academic Readiness	
1. Independently transfers to/from chair and/or floor (when appropriate)	N 1 2 3 4
2. Navigates classroom with functional classroom mobility	N 1 2 3 4
3. Opens/closes classroom door	N 1 2 3 4
4. Maintains functional/dynamic postures for educational activities	N 1 2 3 4
5. Responds to balance demands when occupied by school activities	N 1 2 3 4
6. Utilizes effective manipulation and reaching skills	N 1 2 3 4
Self-Care	
1. Independently walks or uses alternative mobility on flat surfaces	N 1 2 3 4
2. Independently walks on ramps, grass, sand, mats, curbs	N 1 2 3 4
3. Transitions between varied surfaces	N 1 2 3 4
4. Independently ascends/descends school or bus stairs	N 1 2 3 4
5. Independently transfers/climbs in/out of car or bus seat	N 1 2 3 4
6. Plans and navigates destination/course around campus	N 1 2 3 4
7. Independently transfers on/off toilet	N 1 2 3 4
8. Mobilizes around restroom and sink for hygiene activities	N 1 2 3 4
9. Mobilizes while carrying items (lunchbox, book, backpack)	N 1 2 3 4
10. Uses adequate mobility skills for mealtime preparation/eating	N 1 2 3 4
11. Independently uses mobility skills for dressing and grooming at school	N 1 2 3 4
12. Demonstrates adequate safety awareness for school activities	N 1 2 3 4
13. As needed, manages own orthotics, equipment, or supportive devices to participate at school	N 1 2 3 4
Vocation/Pre-Vocation	
1. Maintains endurance during required tasks	N 1 2 3 4
2. Participates in classroom chores that require mobility	N 1 2 3 4
3. Uses different types of equipment required by the work/school environment	N 1 2 3 4
4. Gains new motor skills within a reasonable time frame	N 1 2 3 4
5. Improves speed and accuracy of new motor skills	N 1 2 3 4
6. Maintains body stability/mobility to use classroom/work materials, tools, toys, utensils, and AT devices	N 1 2 3 4
7. Participates in community mobility	N 1 2 3 4
Physical Participation	
1. Participates physically, gaining access to school activities with peers for the duration of the day	N 1 2 3 4
2. Keeps pace with peers, maintains endurance	N 1 2 3 4
3. Has physical access to play games	N 1 2 3 4
Recreation/Sports	
1. Uses playground structures (steps, slide, ladders, swings)	N 1 2 3 4
2. Rides tricycle (on/off, pushes with feet, pedals, steers)	N 1 2 3 4
3. Hangs/crosses monkey bars	N 1 2 3 4
4. Runs, jumps, hops, gallops	N 1 2 3 4
5. Throws, catches, kicks ball, including bouncing, dribbling	N 1 2 3 4
6. Imitates simple/complex motor movements (dance)	N 1 2 3 4
7. Engages in sports, games, or other structured activities during free time	N 1 2 3 4
8. Has physical access to leisure activities	N 1 2 3 4
Accessibility and Extra-curricular Activities	
1. Has access to the same instructional materials and areas as nondisabled peers	N 1 2 3 4
2. Has access to and participates in campus activities	N 1 2 3 4
3. Navigates the school campus	N 1 2 3 4
4. Navigates the classroom/campus by using modifications and accommodations	N 1 2 3 4
5. Navigates obstacles (various doors, potholes, people)	N 1 2 3 4

Source: San Diego Unified School District 2008.

Appendix R

Examples of Physical Therapy in the Educational Setting

Possible concerns related to curriculum and participation in the educational context	Examples of activities, goals, and outcomes related to the child's needs within the educational context	Examples of body functions and structures and performance skills and/or environmental modifications
Participation in classroom, educational and/or academic activities	• Sits with good posture for designated time periods in classroom environments • Transfers to/from chair and floor • Navigates classroom with functional mobility • Opens/closes classroom door • Maintains functional/dynamic postures for educational activities • Responds to balance demands in classroom • Utilizes effective manipulation and reaching skills • Has access to the same instructional materials and areas as nondisabled peers	• Balance • Environmental barriers • Ergonomics and body mechanics • Motor function • Muscle performance (strength, power, force, etc.) • Neuromuscular development • Orthotic, protective, and supportive devices • Posture • Postural stability and control • Sensory integrity (proprioception and kinesthesia)
Functional mobility in the classroom and on campus	• Walk or use alternative method of mobility • Walk on ramps, grass, sand mats, and curbs • Make the transition between varied surfaces • Ascend/descend school stairs or bus steps • Enjoy mobility around campus • Climb in/out of a car or bus seat • Develop understanding of basic safety precautions • Maintain endurance during required tasks • Perform classroom chores that require mobility • Lift and carry objects • Use different types of equipment required by the work/school environment • Show speed and accuracy of new motor skill • Manipulate classroom/work materials, tools, utensils, and assistive devices • Navigate/mobilize to access work location • Manage shopping materials (push cart, carry bags, obtain items) • Engage in community mobility	• Aerobic capacity • Balance • Body mechanics • Efficiency of movement • Endurance • Environmental barriers • Ergonomics and body mechanics • Gait • Joint integrity • Locomotion • Mobility • Motor function • Muscle performance (strength, power, force, etc.) • Nerve and reflex integration • Pain • Postural stability and control • Range of motion • Sensory integrity (proprioception and kinesthesia) • Strength
Leisure and recreational activities, including playground environments	• Get access to playground structures (steps, slide, ladders) • Get access to swings (on/off, balance, pumps, gains momentum) • Ride tricycle (on/off, pushes with feet, pedals, steers)	• Aerobic capacity • Balance • Endurance • Environmental barriers • Gait • Joint integrity

Appendix R

Possible concerns related to curriculum and participation in the educational context	Examples of activities, goals, and outcomes related to the child's needs within the educational context	Examples of body functions and structures and performance skills and/or environmental modifications
	• Run, jump, hop, and gallop • Throw, catch, and kick a ball • Use a variety of ball skills (throw, bounce, dribble, toss/catch) • Imitate simple to complex motor movements (dance) • Engage in sports, games, hobbies, or other structured activities • Participate in individual or social leisure activities	• Locomotion • Mobility • Motor function • Muscle performance (strength, power, force, etc.) • Pain • Range of motion • Sensory integrity (including proprioception and kinesthesia)
Self-care activities during the school day	• Transfer on/off toilet • Mobilize around restroom and sink for hygiene activities • Mobilize while carrying items (meal tray, book, backpack) • Mobility skills for mealtime preparation and/ or eating • Mobility skills for dressing and grooming activities • Manage personal orthotic devices, equipment, or supportive device(s)	• Balance • Endurance • Gait • Locomotion • Motor function • Muscle performance (strength, power, force, etc.) • Pain • Postural stability and control • Sensory integrity (including proprioception and kinesthesia)

Appendix S

Physical Therapy Exit Criteria Form

CHILD: _____DOB:_____ SCHOOL: _____

Following student re-evaluation to determine continued need for PT services in school, the IEP team should complete the following: Check any exit criteria items that apply to previously identified problem areas. When one or more of the exit criteria have been met, the PT services should no longer be considered as a needed related service to meet the student's IEP or IFSP goal(s). If new problems are identified during this process, complete a new entrance criteria checklist updating the problem area(s).

	Goals/objectives requiring PT have been met and no additional goals requiring PT are appropriate	Potential for further change as a result of PT intervention appears unlikely	Problem ceases to be educationally relevant	Therapy is contradicted due to change in medical or physical status
Mobility				
Functional Movement Skills				
Ability to Handle Arch Requirements				
Utilizing Assistive Devices				
Transfers				
Other (specify)				
Positioning				
Independent sitting/standing				
Assisted Alternative Positions				
Transportation				
Other (specify)				

COMMENTS:

_____
_____
_____
_____

Signature: _____ Date: _____

Appendix T

Flow Chart to Determine Need for OT/PT Documentation in IEP