Macomb Intermediate School District - Support and Related Services
Auxiliary and Preschool Services Center
37623 Garfield Road • Suite 110 • Clinton Twp. • MI • 48036 •Phone: (586) 412-2600 • Fax: (586) 412-8419

OCCUPATIONAL THERAPY PRE-REFERRAL FORM

Student: _____ Date: _____
District: _____ School: _____
Birthdate: _____ Grade: _____Eligibility: _____
Referring Individual: _____
Teacher:_____Teacher Email: _____

The purpose of the pre-referral form is to initiate the process of collaboration with the IEP team for data collection and strategy development. This process helps to determine any underlying fine, visual, and/or perceptual motor difficulties negatively impact the student's ability to participate in their educational curriculum.

I give permission for the MISD Occupational Therapist to observe, interact with my child and/or IEP team. I am aware that this is not a formal assessment to determine eligibility for Occupational Therapy services.

Parent Name:_____Email/Phone:_____
Parent Signature (Required):_____ Date:_____

To be completed by referring individual:

1. Describe your concerns about this student and the impact on their educational participation.

_____
_____
_____

2. List strategies tried, their duration, and effectiveness (be specific)_____
_____
_____
_____

3. What other information should we know regarding this student? (Are there other areas of concern being addressed by other professionals?)_____
_____
_____
_____

To be completed by occupational therapist:

Date pre-referral form received by OT:_____
Date data form initiated:_____ Tentative review date(s):_____
Date data form reviewed:_____
Student contact date(s):_____
Comments/Observations:_____
_____
_____

MISD OT Signature (Required):_____ Date:_____

- ☐ No further consultation recommended. Provided staff with suggestions for teaching/instructional strategies.
- ☐ Occupational Therapy Assessment Recommended **Complete REED and Form 2**