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: _____ **Birthdate:** _____
District: _____ **School:** _____
Teacher: _____ **Grade:** _____ **Eligibility:** _____
Referring Individual: _____ **Date:** _____

- The purpose of this pre-referral form is to identify if there may be an underlying fine motor, visual motor and/or perceptual motor deficit, which may negatively impact educational performance, and may require Occupational Therapy support.
- School based Occupational Therapy provides services for students to access and participate within the school setting. The Occupational Therapist supports the student with underlying fine motor, visual motor, and/or perceptual motor difficulties, secondary to other factors such as musculo-skeletal or nervous system impairments in order to determine the need for support and/or accommodations related to academic needs.
- Students with attention span or cognitive delays may ***appear*** to have fine motor and/or visual perceptual motor delays, and may or may not be appropriate for pre-referral.

1. Identify the primary educational/academic concern you have for this student:

☐ Spacing/Line Use ☐ Legibility ☐ Cutting
☐ Grasp/Tool Use ☐ Classroom Activities of Daily Living ☐ _____

2. List strategies tried and/or accommodations provided (be specific):
*****Please attach staffing notes/samples that support concerns when available***

Identified Concern(s)	Strategy(ies) Tried & Accommodation(s) Provided	Effectiveness (Duration + Frequency + Results)

3. Describe the specific impact the student's deficits have on their educational performance:

_____

_____

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

Parent Signature (Required) _____ **Date**:_____

MISD OT Signature (Required) _____ **Date**:_____

To be completed by Occupational Therapist following observation:

☐ No further consultation recommended. *Provided staff with suggestions for teaching/instructional strategies*.

☐ Occupational Therapy Assessment Recommended *****Complete REED and Form 2*****

Revised 06-2016