Occupational Therapy referral information for children 6 years+
Child Development Service

Child's Name: ___________________________  Child's Date of Birth: ______________________

Date completed: _______________________

This checklist is designed to provide additional information to support a referral to Occupational Therapy at the metropolitan Child Development Service (CDS). It should be completed by a health or education professional with knowledge of a child obtained through direct observation over a period of time. This checklist should be accompanied by a CDS referral form containing a description of how the child functions in everyday activities.

1) Fine Motor/Handwriting
   - Poor posture when seated at a desk e.g. rests head on hand, slouches in chair, holds head close to paper
   - Does not demonstrate a hand preference
   - Does not use helper hand to assist and stabilise paper e.g. when writing or ruling up
   - Immature pencil grasp and/or control impacting drawing and handwriting skills
   - Heavy or light pencil pressure on paper
   - Hand tremor
   - Difficulty forming letters/numbers correctly and spacing words
   - Difficulty copying from the board
   - Reverses letters more often than peers
   - Exceptionally slow to complete written work and/or tires quickly
   - Difficulty with construction games/activities e.g. building Lego, folding paper
   - Difficulty learning and/or refining new movement tasks

2) Sensory Processing
   - Sensory preferences impacting on participation in everyday tasks (more than peers)
   - Dislikes being touched, getting hands dirty and/or playing with sand, playdough and paints
   - Difficulty standing in line or beside other people/students
Fearful when feet leave the ground and dislikes ‘moving’ playground equipment e.g. swings/trampoline

Frequently moves around the classroom and has difficulty sitting still on the mat/chair

Can get upset by loud noises and may put hands over ears

Difficulty finding appropriate tools in the classroom when asked e.g. scissors, glue

Puts non-food objects in mouth to suck/chew e.g. toys/pencils

Lacks body awareness e.g. stumbles, bumps into things

3) Independence Skills

Difficulty opening/closing lunchbox, containers and/or school bag

Difficulty managing buttons, zips and other clothing fastenings

Unable to toilet independently

Difficulty putting on socks, shoes and doing shoe fastenings

4) Additional information regarding the child’s strengths or areas of difficulty:

_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Name: _________________________________________________________________________

Agency/School:  _________________________________________________________________

Agency/School address:  __________________________________________________________

Agency/School phone number:  _____________________________________________________

Email:  ________________________________________________________________________

Please return this checklist and CDS referral form to childdevelopmentservice@health.wa.gov.au

This document can be made available in alternative formats on request for a person with a disability.

This publication is provided for general education and information purposes.

Contact a qualified healthcare professional for any medical advice needed.