Government of **Western Australia**
Child and Adolescent Health Service

Child Development Service

Occupational therapy referral information for children 6 years+

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

Do not write in margin

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
- [ ] Much more difficulty remaining seated at mat time compared to peers the same age
- [ ] 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

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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 (20 line limit):

Do not write in margin

Name: ______________________________

Agency/School: ______________________________

Agency/School address: ______________________________

Agency/School phone number: ______________________________

Email: ______________________________

Please submit as an attachment to the online CDS referral form at cahs.health.wa.gov.au/CDSreferrals or via email as directed by the child's clinician.

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