Dear Parents,

An Occupational Therapy evaluation is competed to determine a child's functional abilities in the areas of fine motor skills, gross motor skills, oral motor skills, self care, sensory processing, motor planning, visual perception, and visual motor control. If you have pursued this evaluation, you will need to have a referral or a prescription from your physician. If your physician has recommended an assessment, he will provide you with a prescription.

The following forms assist the therapist to have a more complete understanding of your child, their needs, and your concerns. Please print out the forms, complete them, and fax them in their entirety, including the physician's prescription to our office: (916) 726-7624. They may also be mailed. The physician's referral must be signed and returned as it is required for the evaluation and any follow up therapy if recommended. To comply with HIPPA and maintain confidentiality, these forms are not completed on line.

When all paperwork has been received you will be placed on a waiting list and you will be called to set up an evaluation appointment. Payment for the evaluation is due at the time of service.

The evaluation process may take up to 3 hours to complete. The evaluation may include the Sensory Integration and Praxis Test (SIPT) which assesses visual perception, somatosensory functioning: tactile (touch), vestibular (body's response to movement), proprioceptive (awareness of muscles and joints), hand accuracy, praxis (motor planning), and bilateral coordination. Standardized tests to assess visual perception with and without fine motor control, hand writing, and clinical observations of reflexes, antigravity postures, and postural control may also be completed. The results are incorporated with the background history which you have provided.

Upon scoring, and interpretation of results, which factors the clustering of scores, the findings are reviewed with you and goals are established. Therapy may be recommended utilizing sensory integration techniques, neuro-developmental treatment, and/or traditional Occupational Therapy. Individual therapy sessions are then scheduled, and are billed monthly.

Progress reports are scheduled once every 6 months. Reassessments are completed, goals reviewed, and a written report is completed and reviewed with you during a half hour parent conference. Discussions with your child's therapist are available and your child's therapist may make ongoing recommendations to assist your child's progress.

Please contact us with any questions at (916) 726-0155.

Bev Bruce, OTR/L, CHT
Occupational Therapist, Registered/Licensed
Certified Hand Therapist

Checklist for required paperwork:

_____ (1 page) Physician's referral

_____ (1 page) Signed Schedule Policy Agreement

_____ (1 page) Signed Payment Policy Agreement

_____ (9 pages) Completed Histories: Birth - Developmental - Sensory

Fax: (916) 726-6724

Mail: Vista Child Therapy
7579 Old Auburn Road
Citrus Heights, California 95610

OCCUPATIONAL THERAPY & THE SENSORY INTEGRATIVE APPROACH TO LEARNING DISORDERS

Information for Parents & Teachers

The brain receives vast amounts of information from each of our senses. As a child learns to move is body, balance himself and relate to the objects and people around him, his brain organizes the incoming sensory information. this organization - which is called - “sensory integration” - enables us to direct our attention, to produce useful and well coordinated behavior, and to feel good about ourselves.

‘In a child’s early life the brain organization which will be the foundation for his later learning and behavior develops. In theses early years, the spontaneous movements of play involving the entire body are most effective in developing the nervous system.

The human brain has frequently been compared to a computer. The brain is dependent upon the information it receives from the environment through the sensory systems. It is dependent upon visual, auditory and tactile input, as well as information about gravity and movement. the grain is able to put theses various sensations together and organize them into a meaningful plan of action. A breakdown of dysfunction in one area of the brain will affect performance in other areas,.. The child may not be receiving and organization important information from the senses in a clear, adequate, concise manner - he may not be getting the input upon which his brain depends for the process of learning.

In general, the child has difficulty both in lay and in work. He may not succeed in getting along with his peers, or he has to use so much effort that he doesn’t enjoy himself.

The child’s brain can function more efficiently once it has developed certain processes which are necessary for learning. These processes can be developed if the child receives the proper types of sensory stimulation in a well organized environment.

A. Jean Ayres, PhD, OTR, combined studies of the nervous system with years of experience with children. She found that by directing and controlling the incoming sensory stimuli through sensory integrative therapy, children are able to learn more effectively at home, school and play.

Sensory integration therapy does not involve drugs, psychotherapy, or medical treatment, but relies on the natural sensory experience which occurs in body activities.

Sensory integration therapy is given by an Occupational Therapist who has had additional training in nervous system function and sensory integration. since the brain develops in an orderly sequence, the therapist must follow that sequence, starting with the child’t most basic difficulty. Each child is unique and therapy is structured for he child’s individual needs. Depending upon the child progress, therapy may last from 6 months to 2 years or more.

Specific activities have been identified which produce improvement at each level of nervous system development, usually involving the entire body and many senses at once. they require skillful yet spontaneous body responses, since sensory integration occurs without deliberate concentration. It may appear that a child engaged in Occupational Therapy is merely playing or doing exercises. However, the therapist has organized the environment and the child’s activities so that his sensory network is stimulated in the most effective way. Because of therapy, the child’s nervous system begins allowing him to learn.

A child may display some of the following problems as a result of sensory integration dysfunction:
1. Lack of strength and tone in the muscles which may result in poor posture and fatigue.
2. Poor spatial awareness and internal position sense resulting in insecurity while moving.
3. Lack of coordination between the two sides of the body. The child may be clumsy and confused when he has to use both hands and feet together.
4. Lack of coordination between the eyes and body so that the child does not effectively use the visual information to assist him in his actions.
5. Poor attention span. The child often has difficulty focusing on a task.
6. Threatened by unfamiliar motor tasks, showing great difficulty in the execution, a child handles a new task by thinking about each movement.
7. Overactive behavior and restlessness - sometimes referred to as hyperactivity.
8. A poorly developed sense of touch, and sometimes discomfort when touched, a child may have difficulty learning the shape and texture of items.
9. Difficulty using the understanding language. Problems speaking, reading and writing.

Treatment:
1. Changes the way the brain functions so learning becomes easier.
2. Supplements, but does not duplicate an educational approach.
3. Relies on neuro-developmental concepts known to be basic to the acquisition of motor and academic skills.
4. Provides a specific program for a child based on his sensory integrative profile.
5. Recognizes the need to provide the child with the opportunity and mens to organize his own nervous system through purposeful movements.

The therapist does not “teach” the child how to perform specific skills, Instead, the child learns spontaneously as he bends, turn, rides, rolls, and swings on the simple equipment provided by the therapist. Gradually, he becomes more relaxed and alert in any situation. He is more aware of his environment and responds more appropriately to it.

This information was adapted from the Bay area association for Sensory Integration pamphlet on Sensory Integration and from the Center for the Study of Sensory Integrative Dysfunction.

For further information contact: The American Occupational Therapy Association.

PHYSICIAN'S REFERRAL FORM

Child's Name: _____ Date of Birth: _____

Dear Doctor:

An Occupational Therapy Evaluation has been suggested for this patient to assess sensory-motor development. Testing includes a battery of standardized tests designed to assess visual, tactile, proprioceptive, and vestibular processing. Clinical observations are also utilized to assess developmental reflexes, and neuro-developmental functions which are building blocks in establishing motor skills, laterality, and postural-ocular mechanisms. Performance provides foundational information influencing a child's motor planning ability, bilateral integration, and gross, fine, and oral motor skills.

As this child is a patient of yours we would like to request a referral from you for a screening/evaluation and follow-up therapy if indicated. If you are in agreement, a copy of the report with recommendations will be sent to you. If therapy is recommended, and you concur, progress reports are sent every 6 months of therapy. Questions, comments, suggestions, and discussion are welcome. Thank you for your assistance.

OCCUPATIONAL THERAPY REFERRAL

Child's Name: _____

Diagnosis: _____

_____ Screening/Evaluation of Sensory Motor Development

_____ Therapy as indicated

_____ Splinting

_____ _____

Physician's Signature:_____ Date:_____

Physician's Printed Name: _____

Address: _____

_____

Phone: _____

SCHEDULE POLICY AGREEMENT

Child's Name:_____ Date: _____

Date of Birth: _____

Parent Names: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Child's School: _____ Teacher: _____

If Occupational Therapy services are recommended and approved for your child at Vista Child Therapy, the following are policies that you will need to be aware of:

1. Appointments will be scheduled on a regular basis. Your child will receive services at the same time on the same day each week
2. It is the parent's responsibility to see that the child attends their appointment each week.
3. If the child's therapy appointment must be cancelled, it is the parent's responsibility to call Vista Child Therapy at (916) 726-0155 and cancel the appointment, **with 24 hour notice**. If you do not call and do not show for the appointment, it will be considered a "fail to cancel" and you will be billed for the missed appointment.
4. If your child is transported by a school bus, it is the parent's responsibility to cancel the bus **and** the appointment if your child is unable to attend at their regularly scheduled time. You will be billed unless **24 hour notice** is provided.
5. If you must cancel an appointment on your regularly scheduled day or regularly scheduled time, please call the office to reschedule another day and/or time for the week.
6. The evaluating therapist is not necessarily the therapist who will be providing therapy.
7. Every effort is made to schedule your appointment at a time which is convenient for you. Families who have been with us the longest, are given first option for a preferred time. All attempts are made to place older children in time slots after school hours, if preferred, as academic content is more consolidated and more difficult to make-up.

I HAVE READ AND UNDERSTAND THE ABOVE POLICIES.

Parent's Signature: _____ Date: _____

PAYMENT POLICY AGREEMENT

Child's Name:_____ Date: _____

Date of Birth: _____

Child:	Parent:	Spouse:
Address:	Address:	Address:
Home phone:	Home phone:	Home phone:
School:	Cell phone:	Cell phone:
Teacher:	Employer:	Employer:
	Work phone:	Work phone:
Referring M.D.		Referring M.D. phone

In an effort to be clear regarding our payment policy, we request that you read and sign below, indicating that you have read and understand all of our policies.

1. Payment on your account is due monthly.
2. You will be billed for EACH scheduled visit, regardless of cancellations. Should you find it absolutely necessary to cancel an appointment, you may reschedule at an available therapy time.
3. Failure to show for appointments will be billed and can be made up or rescheduled.
4. You are entitled to two weeks vacation leave with no charge each year. If more than two weeks a year are taken, those sessions must be paid for in order to hold that particular time slot and day.
5. There will be no charges for days that vista Child Therapy is closed for national holidays, including two weeks for winter break and one week at spring break.
6. Bills will be mailed by the fifth of the month. to keep our accounts up to date, we would appreciate payment in full by the 15th of the month. Please make your checks payable to Vista Child Therapy.
7. We regret that therapy will need to suspended on any unpaid account until payment is received. A 1.5% service charge will be added monthly to unpaid accounts.
8. If collection attempts are necessary, you are responsible for fees and any attorney and/or court costs.
9. Insurance billing is your responsibility.

If you have any questions or problems, please feel free to talk with us in the office at any time or call us at (916) 726-0155.

I HAVE READ AND UNDERSTAND THE ABOVE PAYMENT POLICY.

Parent's Signature: _____ Date: _____

CHILD HISTORY & DEVELOPMENTAL INFORMATION

		Date:_____
Child's Name:	Birthdate:	__Male __Female
Child's Address:	School:	Grade:
	Teacher:	_Regular Classroom
	Teacher:	__Special Ed. Class
	Teacher:	__Resource
		__1:1 Aide
Parent's Name:	Spouse's Name:	
Address:	Address:	
Phone:	Phone:	
Alternate Phone:	Alternate Phone:	
Occupation:	Occupation:	
Siblings and ages:		

Primary Physician:	Phone:
Address:	
Additional Physicians:	Phone:
Address:	
Specialists:	Phone:
Address:	
Child referred by:	

What do you expect from this evaluation?

DEVELOPMENTAL HISTORY

Pregnancy	
Mother's age at delivery: Father's Age: Due Date:	Number of previous miscarriages:
Describe any infections/illnesses during pregnancy:	
Describe any shocks or unusual stress during pregnancy:	
List medications taken during pregnancy:	
List alcohol/drugs used during pregnancy:	
When did you develop toxemia:	High blood pressure:
Describe complications during labor and/or delivery:	

Child's Birth		
Birth weight:	Child's weight at discharge:	Apgar scores:1min.__ 5min.__
Was Child: Breech (feet first): ___	Face Presentation: ___	Transverse (sideways): __
Require forceps/suction: ___	Have cord wrapped around neck:___	Cesarean: ___
Require fetal monitor: No__Yes__	Need Oxygen: No___ Yes___	How long: _____
Need a respirator: No___ Yes___How long: _____		Cry right away: No___ Yes___
Require additional hospitalization: No___ Yes___ How long:		
Require NICU: No___ Yes___ How long:		
Have heart defect: No___ Yes__ Describe:		
Have blood/exchange transfusion: No___ Yes___ Describe treatment:		
Hypotonic: No___ Yes___ Describe treatment:		
Jaundiced: No___ Yes___Describe treatment:		
Have seizures: No___ Yes___Describe treatment:		
Infection at birth: No___ Yes___Describe treatment:		
Surgery as newborn: No___ Yes___Describe:		
Newborn feeding problems (sucking/swallowing): No__ Yes__Describe:		
Require supplemental nutrition: List:_____		Tube feeding: No__ Yes__
List any birth injuries:		
List any congenital abnormalities:		

Adopted
Age at time of adoption:
Country/Placement prior to adoption:
Additional information prior to adoption:

Motor Development	
List if diagnosed muscle pathology:	
Describe child's demeanor as an infant:	
Child resisted placement on stomach: No__ Yes__	Infancy to 2 years, child enjoyed being held: No__Yes_
At what age did child:	
Lift head when lying on stomach:	Roll stomach to back:
Roll back to stomach:	Sit independently:

Motor Development	
Crawl:	Describe how:
Walk independently:	Walk on toes: No___ Yes___
Ages siblings walked: _____ _____ _____	Confuses right and left No___ Yes___
Toilet trained:	Does child have night accidents: No___ Yes___
Learn to tie shoes:	Learn to ride a bike:
Which hand does child prefer for: Eating: _____ Writing: _____ Throwing: _____	
Parent's preferred hand: _____ Spouse's preferred hand: _____ Siblings: _____ _____ _____	

Speech Development		
At what age did child:	Begin early words:	Begin using sentences:
Speech seemed reasonably normal: No___ Yes___		Difficult to understand: No__ Yes__
Little early speech: No ___ Yes__	Ages siblings began early words: _____ _____ _____ _____	

Medical History		
List allergies:		Allergy Medications:
Age of first seizure:		Seizure Medications:
Types of seizures:		How often does child have seizures now:
Age of first ear infection:	PE tubes now: No__ Yes__	Have PE tubes now: No__ Yes __
List all diagnosis:	Age of diagnosis:	Diagnosis given by whom:
Child receives immunizations on a regular basis: No___ Yes___		
List all childhood diseases:		
List any accidents/injuries and age at which they occurred:		
List any eating problems:		
List any diet restrictions:		
Describe bedtime or sleep problems:		Night bedwetting accidents: No__ Yes__

Academic	Check items that your child considered to be having difficulty with at school.			
Reading: Grade level:	Math: Grade level:	Following directions:	Remembering information:	
Finishing tasks:	Attentiveness:	Handwriting:	Spelling:	Playground:

History of Therapy Services		Start Date	End Date	Frequency
List prior/current Occupational Therapy Providers:				
List prior/current Physical Therapy Providers:				
List prior/current Speech Therapy Providers				
List counseling/ behavior programs and hrs./week:				

Social - Behavioral
List your child's favorite activities:
List your child's favorite school subjects:
List your child's favorite sports and hobbies:
If alone how does your child spend time?
What things does your child tend to fear or avoid?
Number of hours/day your child watches TV _____plays video games/_____plays on computer_____

SENSORY HISTORY

Answer by checking items that apply to your child.

Now	Visual	In the Past
	Has a diagnosed visual defect. Describe: _____	
	Tends to draw some letters or numbers backward	
	Blinks at bright lights or seem irritated by them	
	Has trouble following with eyes	
	Difficulty discriminating colors, shapes, doing puzzles	
	Avoids eye contact	
	Has difficulty with eye-hand coordination	
	Makes reversals when copying or reading	
	Becomes excited or overly active if surrounded by too much visual stimuli	

Now	Vestibular	In the Past
	Enjoys swings, slides, jumping on bed	
	Has good balance	
	Enjoys merry-go-rounds, fast carnival rides	
	Jumps a lot	
	Likes to spin or whirl more than most children	
	Loses balance easily	
	Dislikes being tossed or whirled about by an adult	
	Hesitates, or has difficulty going down stairs	
	Hesitates or avoids climbing/playing on equipment which may make him feel insecure	
	Ever becomes carsick	

Now	Olfactory-Gustatory	In the Past
	Tends to explore with smell, deliberately smells objects	
	Reacts defensively or seems overly sensitive to odors	
	Has/had feeding problems	
	Has/had trouble changing to textured foods	
	Chews on non food items.List:_____	
	Seems to taste flavors as well as most people	
	Has unusual cravings for certain foods. List: _____	

Now	Auditory and Language	In the Past
	Has a diagnosed hearing loss. Describe: _____	

Now	Auditory and Language	In the Past
	Has/had speech or articulation difficulties	
	PE tubes	
	Frequent ear infections	
	Seems generally to understand what is said to him	
	Seems overly sensitive to sound	
	Fears of any particular sounds. LIst: _____	
	Becomes excited, distractible with lots of noise	
	Distracted by sounds such as fans, refrigerator, fluorescent light bulbs, heaters	
	Seems to have trouble remembering information	
	Seems at times to not understand you	
	Fails to listen or pay attention to what is said to them	
	Difficulty copying rhythmic sounds	
	Trouble expressing what he/she wants to say	
	Talking interferes with listening	
	Enjoys making loud noise	
	Talks excessively	
	Unable to function if 2 or 3 steps of instructions are given at once	

Now	Tactile	In the Past
	Tends to examine objects by touching thoroughly with hands	
	Seems to crave being held, cuddled or touched	
	Often seems overly active or wiggly	
	Likes to play in water, sand, mud, clay	
	Excessively ticklish	
	Prefers to touch rather than be touched	
	Dislikes being touched unexpectedly	
	Dislikes being held or cuddled	
	Tends to be more sensitive to pain than others	
	Seems overly sensitive to food or water temperature	
	Seems overly sensitive to rough food textures	
	Tends to over or under dress for the weather	
	Dislikes cloth of certain texture, irritated by some clothing	
	Avoids getting hands into paste, finger paint or messy things	
	Dislikes food of certain textures, resisted solid foods as infant	

Now	Tactile	In the Past
	Tends to not feel pain as much as others	
	Prefers tub baths over showers	

Now	Proprioceptive	In the Past
	Frequently grasps objects too tightly	
	Breaks pencil often	
	Has a weak grasp, drop things easily	
	Bangs head on purpose	
	Tends to bump, hit or push other children	
	Tends to pinch, bite, or hurt himself or others	
	Seems unaware of cuts, bruises, etc., until brought to their attention	
	Tends to deliberately tumble and fall, or bump head	
	Prefers playground activities to table activities or crafts	

Now	Social	In the Past
	Enjoys being with other children, makes friends easily	
	Tends to prefer to play alone	
	Has a strong desire for sameness and routine	
	Adaptable, flexible	
	Rigid, set in their ways	
	Tends to crave attention	
	Short attention span	
	Seems sensitive to criticism, lacking in self-confidence	
	Has strong outbursts of anger or rage	
	Demonstrates self stimulating behaviors. Describe: _____	
	Tends to have trouble getting along with other children	
	Tends to be active or aggressive	
	Tends to be heedless, lack carefulness, be impulsive	
	Expresses feelings of failure and frustration. Describe: _____	
	Seems discouraged or depressed. Describe:_____	
	Able to play alone for a reasonable amount of time (not TV, videos, computer)	

Check all that apply	Muscle Tone - Coordination - Motor Skills
	Creeping and crawling phase was unusually prolonged

Check all that apply	Muscle Tone - Coordination - Motor Skills
	Creeping and crawling phase was almost entirely omitted
	Seems weaker or stronger than others his age
	Has flat feet
	Slumps when sitting
	Tires easily with physical activity
	Movements are slow, plodding, deliberate
	Tends to eat in a sloppy manner
	Difficulty learning sequential tasks such as dressing, buttoning, zipping, shoe tying
	Find small manipulative activities difficult
	Difficulty learning to hold a pencil/crayon in a 3-point position
	Tends to prefer table activities to more active play
	Walks on toes, or did so when younger
	Trips and falls alot
	Seems clumsy/awkward
	Prefers to lie on back rather than stomach
	Seems reluctant to learn to ride a bike or when young tended to avoid wheel toys
	Appears reluctant to participate in sports and games
	Has difficulty trying to jump, hop or skip
	Has difficulty with throwing and catching ball

Completes Independently	Self Care: Feeding	Needs Verbal Cues or Assistance
	Eats finger foods	
	Picks up food and feed self	
	Eats a sandwich	
	Eats with a fork	
	Eats with a spoon	
	Uses a spoon to eat soup	
	Spreads butter with a knife	
	Cuts soft food	
	Cuts meat	
	Drinks from an open cup	
	Drinks through a straw	
	Eats with adult utensils	
	Eats in normal time	

Completes Independently	**Self Care: Undressing / Dressing**	Needs Verbal Cues or Assistance
	Removes socks	
	Removes shoes	
	Removes underwear	
	Unfastens and removes pants	
	Removes T-shirt	
	Unbuttons and removes buttoned shirt	
	Unbuttons and removes sweater	
	Unzips and removes jacket	
	Puts on shoes	
	Puts on underwear	
	Puts on and fastens pants	
	Puts on T-shirt	
	Puts on and fastens shirt	
	Puts on and fastens sweater	
	Puts on and fastens jacket	
	Opens/closes buttons	
	Opens/closes snaps	
	Opens/closes zippers	
	Opens/closes buckles	
	Ties/unties shoelaces	

Completes Independently	**Self Care: Hygiene/Grooming -Toileting -Bathing**	Needs Verbal Cues or Assistance
	Operates water faucet	
	Thoroughly washes and dries hands	
	Wrings washcloth	
	Applies toothpaste and brushes teeth	
	Combs and styles hair (places hair band if needed)	
	Adjusts clothing for toileting	
	Effectively uses toilet paper	
	Remembers to flush toilet	
	Thoroughly bathes/showers and dries	
	Applies deodorant	
	Effectively uses tissue	
	Cleans, trims nails	