TO THE STARS
Occupational Therapy & Wellness Centre

#3 5623 Wolf Creek Drive
Lacombe, AB T4L 2H8
p: 403.786.0006 f: 403.786.0252
e: admin@tothestars.ca
www.tothestars.ca

CONSENT FOR OCCUPATIONAL THERAPY SERVICES

Please have parents/legal guardians complete this form

Student Name:		☐ Male ☐ Female
Date of Birth: YYYY/MM/DD		
Parents/Legal Guardian		
Phone Numbers	Name: Name:	☐ Cell ☐ Home ☐ Cell ☐ Home
Full Mailing Address		
Email Address		

Preferred method of Communication:	☐ Email ☐ Phone ( ) home ( ) cell ☐ Text

Occupational Therapists can support children in a variety of ways. Our focus is to provide strategies, suggestions and education to support the child to participate more actively within their home, classroom or community environments. We may help with:

- ✓ Self Regulation - May include:
  - Sensory Processing - how children respond to various stimulation (sight, sound, touch, movement, smell, taste)
  - Emotional Regulation
  - Executive Functioning - attention & focus
  - Social Participation
- ✓ Motor development - This includes managing fasteners, using scissors, coloring, drawing, grasp development and printing or pre-printing skills. We look at imitation through movement games, drawing tasks and play to ensure that children are developing this important area for eye hand coordination, visual attention and perception. This area is related to success with reading and printing as well.
- ✓ Self care - Dressing, Feeding, Toileting & Sleep. This can also include early ways to support organization and responsibility for belongings.

**Signing this consent form will allow our team to receive and exchange information (assessment information, individualized education plans, background information) with other members on the educational team as well as other agencies.

**Please include copies of all pertinent assessments and reports with the referral.

	Name & Agency	Current	Previous Involvement
Name of School			
Previous Schools Attended			
Speech Language Pathologist			
Physical Therapist			
Occupational Therapist			
Family Physician			
Pediatrician			
Psychologist			
Others (Glenrose, AB Children's Hospital, FSCD, Aspire)			

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MEDICAL/BIRTH HISTORY

Please have parents/legal guardians complete this form

Medical History

Diagnosis:	Date:	Who gave diagnosis:
Surgeries or significant illnesses		
Allergies (list with reaction)		
Medications		

Early Years History

Birth Weight			
Were there any concerns with your child's early years?			
At approximately what age did your child reach these milestones?	Crawled:_____ Walked: _____ Toilet trained: _____ daytime _____ nighttime		
Does your child have bowel irregularities?	☐ constipation	☐ diarrhea	☐ fluctuates
Has your child had their vision tested?	Date:	Results:	
Has your child had their hearing tested?	Date:	Results:	

Are there any areas you would like more information or have questions about regarding your child's behaviour or development?

_____

_____

My child's favorite activities, toys and playmates: _____

_____

Please check or initial each box to indicate that you have read and consent to each of the following statements. Please check only the boxes you are consenting to:

☐ I provide consent for my child, _____ to receive occupational therapy services from the To the Stars Occupational Therapy and Wellness Centre. I understand that this consent includes both formal and informal assessment, consultation and support.

☐ I give my consent for photographs and video to be taken of my child for the purposes of assessment or consultation services. This information will be kept in confidence.

☐ I give consent to receive email communication from the therapist directly related to child.

☐ I give consent to receive email communication including newsletters from To the Stars OT and Wellness Centre.

_____ _____

Signature of Parent/Guardian Date

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Please check off any items that you feel describe your child:

Self Regulation

- ☐ My child prefers sedentary types of play (TV, computer, books)
- ☐ My child has difficulty sitting or standing still (is in constant motion)
- ☐ My child dislikes messy play (playdough, paint, glue).
- ☐ My child is bothered or distracted by:
  - ☐ Loud noises
  - ☐ Bright lights
  - ☐ Touch (flinches with touch or may be "too rough")
  - ☐ Bothered by certain smells
  - ☐ Shows discomfort during hygiene tasks (brushing teeth, cutting hair, nails)
- ☐ My child has trouble with transitions (gets upset in new environments or with unexpected changes in routines). **Describe:**
- ☐ My child seems anxious. **Describe**:

Motor Development

- ☐ My child has used scissors at home.
- ☐ My child has difficulty recognizing colors or shapes.
- ☐ My child complains of their eyes hurting or rubs their eyes often.
- ☐ My child enjoys playgrounds and outdoor activities.
- ☐ My child seems clumsy.
- ☐ My child seems to have weak muscles and may tire easily.

Self Care

- ☐ My child is able to dress themselves. Coat____ Shoes/Boots _____ Clothing_____
- ☐ My child has difficulty with fasteners ___zippers, ___buttons, ___shoes
- ☐ My child is a picky eater: **Describe:**
- ☐ My child uses utensils
- ☐ My child drinks from
  - ☐ Cup
  - ☐ Bottle
  - ☐ Straw
- ☐ My child has difficulty sleeping : Describe (trouble falling asleep, trouble staying asleep, restless, snoring, history of night terrors.)

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SCHOOL QUESTIONNAIRE

Please have Teacher/Educational Assistant complete this form

Student Name		School	
Teacher		Teacher Email	
Education Assistant			
Days and Times at school			Grade

☐ PUF ☐ Mild Moderate ☐ Pending Approval Assessment ONLY

Describe this child's participation in your classroom:

_____

_____

_____

Please identify **key questions or areas you would like to address during this Occupational Therapy consultation. This helps to ensure that the focus of the visit meets your expectations.

_____

_____

Self Regulation:

- ☐ Has trouble focusing attention
- ☐ Is fidgety in class
- ☐ Seems lethargic or difficult to engage
- ☐ Seems anxious
- ☐ Has trouble with transitions
- ☐ Can be aggressive at times

Fine Motor / Visual Motor:

- ☐ Difficulty learning to use scissors, coloring
- ☐ Difficulty with printing, drawing
- ☐ Difficulty with fasteners, opening containers
- ☐ Considering assistive technology

Gross Motor

- ☐ Seems clumsy, bumps into things, trips
- ☐ Has trouble keeping up in gym, tires easily
- ☐ Requires adaptations for seating or mobility (walker, wheelchair, chairs)
- ☐ Considering adapted equipment for school

Self Care

- ☐ Feeding (picky eater, using utensils, messy)
- ☐ Dressing (fasteners, organization)
- ☐ Toileting

You are always welcome to call or email our team at admin@tothestars.ca or call 403.786.0006 . We look forward to working with your team this year.

Sincerely,

To the Stars OT and Wellness Team