



**Assistive Technology Referral Form**  
**Physical/Motor Abilities**

Student's Name: \_\_\_\_\_ Completed by: \_\_\_\_\_

(PT/OT)

Date of last physical therapy evaluation: \_\_\_\_\_ Re-eval Date: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Prognosis: \_\_\_\_\_

Date of last occupational therapy evaluation: \_\_\_\_\_ Re-eval Date: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Prognosis: \_\_\_\_\_

A. Seating and positioning of student. (Check all that apply)

- Sits in regular chair
- Sits in regular chair with pelvic belt
- Sits comfortably in wheelchair most of the day
- Sits comfortably in wheelchair part of the day
- Does not sit comfortably in wheelchair
- Wheelchair has been adapted to fit
- Wheelchair NEEDS to be adapted to fit
- Wheelchair being adapted to fit
- Uses adaptive equipment for optional positions
- Has limited variety of functional positions
- Other (related to work surface) \_\_\_\_\_

- Uses regular desk
- Uses tray on wheelchair for "desktop"
- Uses adapted table
- Has difficulty using table or desk
- Other (related to work surface) \_\_\_\_\_

B. Movement inventory - Observe the student using a switch, paper and pencil, typewriter, computer, etc. Check any of the following that demonstrate reliable, voluntary, controlled movement.

	R	L		
Hand	<input type="checkbox"/>	<input type="checkbox"/>	Eyes	<input type="checkbox"/>
Arm	<input type="checkbox"/>	<input type="checkbox"/>	Mouth	<input type="checkbox"/>
Foot	<input type="checkbox"/>	<input type="checkbox"/>	Finger	<input type="checkbox"/>
Leg	<input type="checkbox"/>	<input type="checkbox"/>	Head	<input type="checkbox"/>

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Range of motion - Describe specific limitations.

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D. Reflexes, abnormal muscle tone, and strength. Check and briefly describe any of the following which are exhibited by the student and which may interfere with voluntary control.

- ATNR \_\_\_\_\_
- STNR \_\_\_\_\_
- High Guard \_\_\_\_\_
- Extensor Thrust \_\_\_\_\_
- Bite Reflex \_\_\_\_\_
- Startle Reflex \_\_\_\_\_
- Low Muscle Tone \_\_\_\_\_
- High Muscle Tone \_\_\_\_\_

Strength  Poor  Fair  Good

E. Accuracy and fatigue - Check the following in regard to the student's performance of a motor task - i.e. switch use, typing, self-feeding, writing.

	Poor	Fair	Good
<u>Accuracy</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Reliability</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Consistency</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The student performs a fine motor task for approximately \_\_\_\_\_ minutes prior to becoming fatigued.

F. Time - Describe in minutes, if excessive time is required to complete the following motor tasks.

Activate switch \_\_\_\_\_ Type name \_\_\_\_\_  
Write name \_\_\_\_\_ Eat meal \_\_\_\_\_

G. Mobility Inventory - Check all that apply.

- Walks independently  Operates powered chair
- Has difficulty walking  Learning to operate powered chair
- Walks with adult assistance  Self-propels manual wheelchair
- Walks with appliance  Learning to propel manual wheelchair
- Has floor mobility, crawls,  Can transfer into and out of chair  
rolls, scoots, etc. independently
- Has had no opportunity to try \_\_\_\_\_  Needs assistance to push chair and help  
a powered chair with transfers

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## H. Feeding

Type of food:    Solid    Mashed    Chopped    Pureed

Feeds:                    Independently                    Minimal assistance  
                                 Moderate assistance           Total assistance

Drinks:            Independently                    Minimal assistance  
                         Moderate assistance           Total assistance

Adaptive feeding devices:

Scoop dish            Adapted Cup            Adapted spoon  
Straw                    Dycem                    Plateguard

Other: \_\_\_\_\_