Motor Therapy Referral

Student:_____ School:_____

Teachers: Special Ed_____ Regular Ed_____

Date of Birth:_____ Age:_____ Grade:_____

Classification:_____

Services currently receiving:_____

Date of Referral:_____

1. What aspect of the students classroom performance is interfering with his/her ability to benefit from the educational program?

   _____
   _____
   _____

2. Describe the student's individual strengths and interests.

   _____
   _____
   _____

3. What does the student need to do to be more successful in your classroom?

   _____
   _____
   _____

4. What strategies or interventions have you tried thus far?

   _____
   _____
   _____

5. Provide any background information, medical diagnosis, and/or available assessment data directly relevant to this request.

   _____
   _____
   _____

   I have obtained permission to evaluate from the parent/guardian.

   _____ _____

   Resource Teacher Signature Principal Signature