**REGION 10 EDUCATION SERVICE CENTER Page 1**

**400 E. Spring Valley Road**

**Richardson, Texas 75081-5101**

**PLEASE EMAIL TO:** [**directservices@region10.org**](mailto:directservices@region10.org) **Logged**

# DISTRICT INPUT FORM FOR OT/PT/APE EVALUATION/RE-EVALUATION

Special education students referred to Region 10 for education based OT and/or PT and or APE related services should evidence difficulties impacting educational performance and/or participation as identified through some of the following questions. Please carefully observe this student and respond to all items below. This information will assist in the selection of materials and assessment instruments most appropriate to this student’s needs. Thank you.

**Student Name: District/Charter: Campus:**

**Eligibility: Class Setting - *choose one:* ( )-Gen Ed. ( )-Resource ( )-Self Contained**

**PE Class Time:**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **YES** |  | **NO** |  | **DOES THIS STUDENT** | | | | | | | |
|  |  |  |  | Use any of the following aids? If yes, please check: | | | | | | | |
|  |  |  |  |  | wheelchair | |  | walker |  | crutches |  |
|  |  |  |  |  | braces |  |  | adaptive seating/positioning equipment | | | |
|  |  |  |  |  | hearing aids | |  | glasses |  | oxygen |  |
|  |  |  |  |  | GI tube | |  | communication device | | |  |
|  |  |  |  |  | other |  | | | | | |
|  |  |  |  |  |  |  | | | | | |
|  |  |  |  | Experience frequent health problems? Comment | | | | | |  |  |
|  |  |  |  |  | | | | | | | |
|  |  |  |  | Assume and maintain sitting without support? | | | | | | | |
|  |  |  |  | Assume and maintain standing without support? | | | | | | | |
|  |  |  |  | Walk independently? | | | | | | | |
|  |  |  |  | Move independently around the school environment? | | | | | | | |
|  |  |  |  | Have difficulty participating in the P.E. program? | | | | | | | |
|  |  |  |  | Manipulate objects appropriate for classroom participation? | | | | | | | |
|  |  |  |  | Perform paper/pencil tasks appropriate for classroom participation? | | | | | | | |
|  |  |  |  | Evidence problems with chewing/swallowing? | | | | | | | |
|  |  |  |  | Demonstrate independence in the cafeteria? | | | | | | | |
|  |  |  |  | Handle self independently in the bathroom? | | | | | | | |

What are your areas of concern?

What is the location and best time to observe student relative to your areas of concern?

Desired educational outcomes:

Additional comments:

COMPLETED BY RELATIONSHIP TO STUDENT