Building Blocks
Pediatric Therapy, LLC
2261 Deer Pointe Drive - Clarkston, WA 99403
Phone: (509) 202-0966 / Fax: (208) 906-8599

Occupational Therapy Referral Questionnaire

Patient Name: What concerns do you have that led you to seek an OT referral?

A. Do you have concerns regarding fine motor skills/delays?
   Fine motor:
   Delays:

B. How does your child's fine motor limitations and/or sensory processing impact their self-care, daily routines or play skills?
   fine motor limitations:
   Self care:
   Daily routines:
   Play skills:
   fine motor limitations:

1. Sensory processing impacts their self-care, daily routines or play skills:
   Self care:
   Daily routines:
   Play skills:
   Do you have any other concerns?

2. Is your child **currently** receiving services for these concerns?
   If so Where?

3. If your child has received Occupational Therapy services in the past, how long ago did they receive services?

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A. School Based Services?

B. Has an Occupational Therapy Evaluation been completed **in the last year**?

C.

4. What time would you be available for therapy visits?
5. Are you seeking Occupational Therapy services on a continual basis or just seeking an evaluation? Please Circle:

Evaluation Only/ Evaluation with continuous Treatment

Is it ok to leave a Detailed Message on Voice Message – Yes

Ok to Text for Appts – Yes

No Show policy Advised – If the therapist sets up an appt time with you and she comes to the home or schedules a Telehealth appt. And you do not answer that is considered a no show. If you No Show 3 times you may be discharged from services. Advised

Are you OK to do Telehealth services? Zoom log in ----------- Yes or No