T.O.T.S OCCUPATIONAL THERAPY

Child:_____ Date:_____

Dear Parent/Guardian,

My name is Heidi Tringali and I am a licensed and registered Occupational Therapist. Occupational Therapy is a wonderful profession that allows me the opportunity to develop children's skills and abilities through therapeutic strategies. I look forward to working with your child and developing his/her individual skills and abilities.

For therapy to be successful, a team approach is important. I plan to gather information from your child's teacher. Please have your child's teacher complete the **Classroom Assessment** form. I will also routinely send updates to you regarding treatment and progress. On occasion, I will send home suggestions for you and your family that may help with your child's treatment goals. It is important for your child's physician to be aware of and approve of his/her involvement in therapy. Please have your child's physician sign the attached **Prescription Form** and return it to me prior to the evaluation.

I have also included a **Child History Form** for you to complete and return to me prior to the evaluation. This form provides valuable information for the assessment process.

Your signature on this **Release of Information** form allows me to talk with your child's school about his/her Occupational Therapy services. Please return all 4 forms to me prior to the evaluation.

I look forward to working with you and your child. If you have any questions, please contact me at ***704.577.4094*** or ***heidi@charlotteot.com***.

Sincerely,

Heidi Tringali, MS, OTR/L
Occupational Therapist

Release of Information

I approve the release of academic records, test results, assessments, and class work from my child's school to Tringali Occupational Therapy Services.
I also approve the release of OT documentation and all child-related information from Tringali Occupational Therapy Services to the necessary faculty at my child's school.

_____

Parent/Guardian Signature Date

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Classroom Assessment

Student:_____ Date:_____

Dear _____

_____ will be participating in an Occupational Therapy Evaluation on _____ at _____. I would like to gather some valuable information from you regarding his/her classroom performance. Please fill out this form and return to me prior to the evaluation.

From your observations and experience, please indicate your level of concern about the following areas/skills.

		N/A	Mild	Moderate	Significant
	Fine Motor Skills (Handwriting, cutting)				
	Attention (Distractibility, inability to focus)				
	Bilateral Coordination (Using both hands simultaneously)				
	Visual Motor Skills (Eye Hand Coordination, copying from the board, reading, writing)				
	Defensiveness/Sensitivity to touch, sounds, foods, sights, smells, etc				
	Gross Motor Skills (Poor balance, coordination, stability, strength)				
	Difficulty Transitioning from one task to another				

Is there any skill that you would like the student to be able to do that he/she can not do at the present time?

_____
_____
_____
_____

Thank you for your time and assistance.

Heidi Tringali, MS, OTR/L

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Child History Form

Date: _____

Child's Name: _____School: _____
Parent's Name(s): _____ E-mail: _____
Mailing Address: _____
Phone: _____ Cell Phone: _____
Child's Physician:_____ Phone: _____
Physician's Fax #: _____
Date of birth: Child's Chronological age: Siblings Names/Ages:
Length of Pregnancy: Type of Delivery:

Complications during Pregnancy/Delivery:

Number of days child was in the hospital after birth:

Did your child achieve the developmental milestones from age 1-4? If no, explain.

Current Medications:

Medical History:

At what age did your child crawl? How long did he/she crawl prior to walking?

Does your child have any sleeping difficulty? If so, explain.

Does he/she have any food intolerances, allergies, preferences, difficulties? If so, explain.

Does he/she seek or avoid loud noises or sounds? If so, explain.

Does he/she seek or avoid touch or textures on his/her skin? If so, explain.

Does your child have difficulty transitioning from activity to activity? If so, explain.

At home, when your child misbehaves, what are the consequences that you use or that are most effective?

As a result of therapy, what would you like your child to be able to do, that he/she is unable to do at the present time?

Please feel free to use the back of the page for additional space. Thank you.

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Physician Prescription

Date: _____

Child: _____

Date of Birth: _____

Occupational Therapy services recommended to evaluate and treat as needed for the 2021-2022 summer and school year.

Treatment may include Fine and Gross Motor Coordination Training, Therapeutic Exercises, Therapeutic Activities, Self Care Training, Sensory Integration Training, Visual Motor Training, Neuromuscular Re-education, Cognitive Therapy, Adaptive Equipment Training, Child/Caregiver Education.

Physician's comments for activity limitations:
_____
_____
_____

_____
Physician Signature

_____
Print Name of Physician

Physician's Address and Phone Number

_____
_____
_____
_____
Thank you.

Please contact Heidi Tringali, MS, OTR/L at 704.577.4094 or heidi@charlotteot.com with any questions.
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