Occupational Therapy Consultation

Student Name: Date:

Teacher: Therapist:

Teacher: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_ Primary Concerns to be addressed

Fine Motor:

Sensory:

Other:

Occupational Therapist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_ Observations/ Thoughts

Fine Motor:

Sensory:

Other:

Occupational Therapist and Teacher Future Plan:

Fine Motor:

Sensory:

Other:

Progress with Recommendations and Plan: