OT EVALUATION CHECKLIST

Student Name:	DOB:	School/Grade:
Date of Last IEP:	Case Carrier:	Teacher:
Sped. Criteria:	Phone Number:	Initial / Tri / Other:

Date AP Received:	**Due Date:**	**IEP Date:**
Reason for Referral:		

Task/Assessment	Date Given	Date Completed	Comments/Attempts to Contact
IEP Review			
Psych. Report			
Previous OT Report			
Parent Int./Q			
Teacher Int./Q			
Functional Q.			
Classroom Obs.			
Clinical Obs.			
*SA: _______________			
*SA: _______________			
*SA: _______________			
Report Written			
Report Presented			

Notes:

Follow up to be completed:

*SA = Standardized Assessment Tool

OT EVALUATION CHECKLIST