Occupational Therapy Referral Information for Children 3–4 years
Metropolitan Child Development Service

Child’s Name: ________________________________  Child’s Date of Birth: _______________

This checklist should be used to provide additional information in support of a teacher referral to Occupational Therapy at Child Development Services (CDS). It should accompany a standard CDS referral form containing a description of the child’s functional performance within the classroom.

1  Motor
- Difficulties with hand activities.
- Poor sitting posture.
- Difficulty holding pencil with thumb and fingers.
- Difficulties drawing lines, circles and faces.
- Difficulties with using two hands together in play, i.e. screwing lids, threading, folding.
- Does not use non-preferred hand to assist and stabilise.
- Immature hand function (grasp, accuracy, release, reach).
- Hands seem shaky.
- Difficulties placing fingers correctly when using scissors.
- Difficulties with holding scissors and cutting along a line (after instruction and practice).
- Difficulties with hand action songs e.g. twinkle little star.
- Difficulties with activities requiring rhythm and co-ordination e.g. clapping games.
- Difficulties with ball skills e.g. throwing/catching large ball.

2  Sensory Processing
- Is fearful when feet leave the ground and dislikes ‘moving’ playground equipment e.g. swings/trampoline.
- Frequently moves around the room and has difficulty sitting still on the mat/chair.
- Has difficulty moving around the room without banging into things or tripping over themselves.
- Has difficulty keeping hands to self.
- Dislikes being touched, getting hands dirty, and/or playing with sand, play dough and paints.
- Can get upset by loud noises and may put hands over ears.
- Puts non-food objects in mouth and suck/chew on them (toys/pencils).

3  Cognitive/Perceptual
- Difficulty sorting and matching colours/shapes/pictures.
- Difficulty with simple puzzles.
4 Behaviour/Personal Social (if associated with difficulties in areas 1-3)

☐ Difficulty separating from parent/carer.
☐ Dependent on adult company and support.
☐ Highly distractible, short attention span or impulsive behaviour.
☐ Overactive/ underactive or passive.
☐ Does not relate well to other children.
☐ Avoidance of new/novel tasks.
☐ Difficulty following the group routine.
☐ Difficulty transitioning between activities.
☐ Difficulty participating in circle type games.
☐ Lack of age appropriate play skills.

5 Independence Skills

☐ Difficulties in washing and drying hands.
☐ Difficulties opening containers.
☐ Difficulties zipping and un-zipping school bag.
☐ Difficulties in toileting appropriately.
☐ Difficulties with putting on/taking off shoes and socks independently.

6 Any other comments regarding the child’s strengths or areas of difficulty?

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Name: __________________________________________________________

Agency/School: ___________________________________________________

Agency/School Address: _____________________________________________

Agency/School phone number: _______________________________________

Email: ___________________________________________________________

Preferred method and time of contact: ________________________________