OCCUPATIONAL THERAPY ONSITE PEDIATRIC CLINIC SELF-REFERRAL FORM 2022

The University of Puget Sound, School of Occupational Therapy Student Teaching Clinic provides **FREE** "occupational therapist in training" services to our Puget Sound community. Each treatment session is led by students in our graduate occupational therapy programs, and is supervised and mentored by an experienced Occupational Therapist.

If you are interested in attending the UPS School of OT On-site Teaching clinic please fill out the form below and mail it to the following address: 1500 N. Warner Street #1070, Tacoma, WA 98416-1070

Upon receipt, a clinic manager or staff member will contact you to discuss your child's participation in the clinic. If you have any questions please call the OT Clinic at (253)879-3499 or Sheryl Zylstra OTR, at (253) 879-3497.

CHILD INFORMATION		
Child's Name:		
Date of Birth:	Gender:	
Current Diagnosis (if applicable):		
Current Physician:		
Current Physician's Phone Number:		
Medications:		
Medical History: Are there any contraindications to participating in our onsite therapy teaching clinic?		
PARENT/CAREGIVER INFORMATION		
Name:		
Current address:		
City:	State:	ZIP Code:
Phone (Home / Cell):		
Alternate Phone (Home / Cell / Work):		
Relationship to child:	E-mail:	
EMERGENCY CONTACT		
Name:		
Address:		
City:	State:	ZIP Code:
Phone:	Email:	
Relationship to Child:		
REFERRAL INFORMATION		
Who referred your child to our clinic?		
☐ Self ☐ School ☐ Therapist ☐ Physician ☐ Other:		
If you marked School, Therapist, or Physician above, please indicate the name and/or facility of the person who recommended our clinic:		

Occupational Therapy Onsite Pediatric Clinic Self-Referral Form 2022

CHILD'S STRENGTHS
Please describe your child's strengths:
CHILD'S DEVELOPMENT
Please describe your child's development (include any difficulties in pregnancy, birth, or milestone development):
AREAS OF CONCERN (CIRCLE IF AN AREA OF CONCERN)
ACTIVITIES OF DAILY LIVING
☐ Feeding Self ☐ Eating ☐ Dressing ☐ Toileting ☐ Grooming & Hygiene ☐ Bathing *Please describe any concerns in this area:*
Play/Social Skills
☐ Exploratory Play Skills ☐ Playing with Others ☐ Play Preferences ☐ Needs Adult Help to Play ☐ Ability to Make Friends ☐ Peer Interactions *Please describe any concerns in this area:*
Fine and Gross Motor Skills
☐ Hand Skills ☐ Grasping/Pinching ☐ Use of Both Hands ☐ Coordination ☐ Balance ☐ Walking/Running *Please describe any concerns in this area:*
Sensory Tolerance
☐ Likes/Dislikes Getting Dirty ☐ Likes/Dislikes Noise ☐ Likes/Dislikes Movement ☐ Likes/Dislikes Various Textures in Mouth *Please describe any concerns in this area:*
School Performance
☐ Name of Current School ______________________ Grade: ________ ☐ Attention ☐ Organization Skills ☐ Writing ☐ Keyboarding *Please describe any concerns in this area:*
Mobility Devices
☐ Wheelchair ☐ Assistive Devices *Please describe any mobility difficulties:*

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SPRING CLINIC TIME PREFERENCE

Indicate your preferences for attending Spring Clinic by indicating your first, second and third choice time slots. We will do our best to accommodate you!

This year clinic will be ONE time per week, either on Tuesday OR Thursday*:

Please circle preference of day: TUESDAY or THURSDAY

Rank your first 3 time choices, using 1, 2, 3:

___ 9:00 - 9:50 a.m.

___ 10:00 - 10:50 a.m.

___ 11:00 - 11:50 a.m.

___ 2:00 - 3:00 p.m.

___ 3:00 - 4:00 p.m.

___ 4:00 - 5:00 p.m.

___ 5:00 - 6:00 p.m.

*There may be a small number of slots available for twice weekly visits.

Please indicate HERE _________ if you would like to be considered for attending clinic two days per week. If you are approved for twice weekly visits your child will be working with different students on each day and will be attending at different time slots.