OTKimWiggins LLC

OT EVALUATION/IEP TO-DO LIST

Child's Name:_____ **Meeting Date:_____**

Consent received ☐**yes** Date:_____

Administer Assessments: ☐ **DONE** Date:_____

- ☐ The Developmental Test of Visual Perception 2nd Edition (DTVP-3)
- ☐ The Bruininks-Oseretsky Test of Motor Proficiency-2nd Edition (BOT-2)
- ☐ The Wide Range Assessment of Visual Motor Abilities (WRAVMA)
- ☐ The Motor-Free Visual Perception Test, Third Edition (MVPT-3)
- ☐ Sensory Profile – School Companion 2nd edition
- ☐ Sensory Processing Measure
- ☐ Handwriting screening
- ☐ Other _____

Score the Assessment ☐ **DONE** Date:_____

- ☐ The Developmental Test of Visual Perception 2nd Edition (DTVP-3)
- ☐ The Bruininks-Oseretsky Test of Motor Proficiency-2nd Edition (BOT-2)
- ☐ The Wide Range Assessment of Visual Motor Abilities (WRAVMA)
- ☐ The Motor-Free Visual Perception Test, Third Edition (MVPT-3)
- ☐ Sensory Profile – School Companion 2nd edition
- ☐ Sensory Processing Measure
- ☐ Handwriting screening

Other _____

Input Scores into IEP program ☐ **DONE** Date:_____

- ☐ The Developmental Test of Visual Perception 2nd Edition (DTVP-3)
- ☐ The Bruininks-Oseretsky Test of Motor Proficiency-2nd Edition (BOT-2)
- ☐ The Wide Range Assessment of Visual Motor Abilities (WRAVMA)
- ☐ The Motor-Free Visual Perception Test, Third Edition (MVPT-3)
- ☐ Sensory Profile – School Companion 2nd edition
- ☐ Sensory Processing Measure
- ☐ Handwriting screening

Other _____

Teacher completes CERT Student Profile ☐ **DONE** Date Sent:_____ Date received:_____

Input into Cleartrack ☐ **DONE** Date:_____

- ☐ PLEPS
- ☐ Program Modifications
- ☐ Test Modifications
- ☐ Goals

Write the Report ☐ **DONE** Date:_____

Print the Report ☐ **DONE** Date:_____

Copy the Report ☐ **DONE** Date:_____

Send to Appropriate People ☐ **DONE**

- ☐ CSE Date:_____
- ☐ School File/Teacher Date:_____
- ☐ OT File Date:_____
- ☐ Parent Date:_____

Prescription Received: Date: _____

504 or CSE Meeting Notes:

Date of meeting: _____ Parent present? Yes/no

Present level of performance:

Services and frequencies recommended:
OT ____ PT ____ SLP _____ Counseling ____ Special Ed services:
Other: _____

Program Modifications recommended:

Testing Modifications recommended:

AT recommended?

Doctor name:

Goals: