



PARENT INPUT AND CONSENT FORM

Please note: This form must be **completed and signed** by a parent/guardian before services begin for your child. The following information will help us identify your child's needs.

If you have any questions, please contact the SHOS Intake Coordinator at (403) 314-5274

Child's legal name: _____ **Birth Date:** _____
(First Middle Last) (dd - Mon - yyyy)

Alberta Personal Health Card #: _____ - _____

Family Information:

Your Name: _____ Relationship to Child: _____

Other Parent: _____ Relationship to Child: _____

Sibling(s) name(s) and age(s): _____

Who does child live with? _____

Recent changes in family situation (Divorce, Custody, Loss, Etc.): _____

Health Information:

Diagnosis: _____

Diagnosed by Whom: _____ Diagnosed When: _____

Vision checked? _____ Requires glasses? Yes No
(dd - Mon - yyyy)

Hearing checked? _____ Requires hearing aid? Yes No
(dd - Mon - yyyy)

Medication(s)? (please indicate what each medication is for): _____

Recent illness or hospitalization/surgery? _____

Previous significant illness/injury? _____

Allergies? Yes No (If Yes): _____ Seizures? Yes No

CHILD'S HISTORY

The information provided below will help us better understand your child's needs. All information will be kept in strictest confidence and will be shared only with those individuals whom you specify on the consent form.

Note: If you have a medical history document completed within the last year, please feel free to attach that document instead of filling out the questions on this page.

Birth History:

At how many weeks was your child born? _____ Weight at birth? _____

Any complications surrounding the pregnancy or birth? _____

Developmental History:

About how old was your child when he or she: (please indicate year or month)

Sat up on own _____ Started walking _____

Started crawling _____ Said first word _____

Were there any health concerns during your child's first year? _____

Has your child experienced any concerns with toilet training or bed wetting? _____

Has your child experienced any of the following concerns? (If Yes, please describe)

Walking difficulty Yes No _____

Unclear speech Yes No _____

Feeding problem Yes No _____

Weight problem Yes No _____

Sleep problem Yes No _____

Using Hands Yes No _____

Educational History:

Attended preschool? Yes No

Attended kindergarten? Yes No

Repeated a grade? Yes No

Skipped a grade? Yes No

If Yes, which grade? _____

If Yes, which grade? _____

Is your child absent from school regularly? Yes No If Yes, why? _____

Please describe school history (modified programs, outreach, traditional): _____

1. Please list your child's strengths and interests:

2. Please describe your child's behaviour/temperament or feelings:

3. Please describe your child's typical day after school:

4. What do you hope the assessment and consultation with SHOS will accomplish?

5. What are your greatest concerns about your child?

6. Do you have any specific comments or concerns regarding your child's educational program?

7. **Regarding your child's needs and your hopes for this referral ...**

a. What has been tried? What worked? What didn't work?

b. What do you believe to be the cause of your child's needs?

c. Has your child seen or been referred to any other professionals (e.g. Doctors, Occupational Therapists, Speech Language Pathologists, etc.) or accessed any special services to assist with these concerns? Yes No

If Yes, please complete table below:

Name of Professional/Service	Reason	Where	Date Last Seen
<hr/>	<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>	<hr/>

(dd - Mon - yyyy)

Please complete all sections of the following checklist.

Even if your child is not being referred for all disciplines, the additional information may be helpful for the therapist(s) who will be providing services.

(Please feel free to attach a note with additional concerns or information)

OCCUPATIONAL THERAPY

Fine Motor:

- Weak or awkward pencil grasp
- Pencil lines are shaky, too faint or too dark
- Difficulty using scissors
- Frequently changes hands when coloring/printing
- Erases excessively
- Fatigues during printing, coloring or cutting
- Difficulty with two-handed tasks (e.g. tying shoes, opening lunch containers, stabilizing paper)
- Difficulty typing; using computer mouse
- Difficulty grasping and manipulating small objects
- Poor desk posture (slumps, head too close to work, leans)

Visual Motor/Perceptual:

- Unable to recognize and match colors, shapes, sizes, letters, etc.
- Difficulty forming printed letters/numbers
- Difficulty forming cursive letters
- Letter and/or number reversals (e.g. *b* for *d*) or inversions (e.g. *u* for *n*)
- Difficulty with spacing, sizing, or letter placement
- Difficulty copying work from books (e.g. excessive errors, slow)
- Difficulty copying work from the board (e.g. excessive errors, slow)
- Difficulty with visual tasks (e.g., puzzles or finding objects in a desk/cluttered shelf)
- Squints, rubs eyes, or complains of eyes hurting

Sensory:

- Distractible, or poor attention span
- Dislikes standing in lines; pushes or shoves others
- Avoids putting hands in messy substances (e.g. clay, finger paint, paste)
- Stands at desk while doing work; leaves seat often
- Difficulty transitioning between activities
- Becomes upset with unexpected changes in routine
- Appears tired or lacking in energy
- Difficulty sitting/standing or keeping hands still (e.g. is in constant motion)
- Bothered or distracted by noise, lights, smells, clothing tags, touch
- Avoids specific food textures (e.g. crunchy, mushy, chewy, mixed textures, or meat)
- Chews on fingers or clothing

Self Care:

- Difficulty toileting independently
- Gags, coughs, or chokes while eating or drinking
- Drools
- Cannot independently use utensils or a regular cup
- Difficulty sleeping
- Difficulty organizing his/her space (e.g., work space, locker/desk, or bedroom)
- Difficulty putting on clothes (including buttons, zippers, and other fasteners)
- Unable to follow directions; difficulty following classroom routine

My child may require special equipment to communicate such as a computer or communication board

1. Please indicate what strategies have already been tried. What worked/did not work?

2. Additional Comments:

PHYSICAL THERAPY

- Tends to slouch when sitting or standing; leans on wall or furniture
 - Difficulty balancing (e.g. standing still, in crowded hallway, on one foot, on tiptoes)
 - Falls often; does not get arms out in time to stop fall
 - Knocks over objects; runs into walls/doors/people by accident
 - Walks awkwardly (e.g. arms out to side, leans, feet wide apart)
 - Walks on toes; not able to walk on heels
 - Difficulty running
 - Difficulty with activities such as jumping, swimming, riding a bike
 - Difficulty going up and/or down stairs
 - Difficulty throwing, catching or kicking a ball
 - I would like to have further game / activity strategies to work with my child
 - I am concerned about my child's physical development. Please explain further:

- Switches between left and right sides when kicking or throwing
 - Difficulty playing on playground equipment (e.g. slide, swing, jungle gym, balance beam)
 - Difficulty standing up from the floor
 - Appears to have weak muscles
 - Is not able to keep up with peers in physical education class
 - Becomes tired easily
 - Prefers sitting and indoor activities after school and on weekends (e.g. TV, computer/video games)
 - Difficulty naming his/her own body parts and/or left from right
 - Complains of pain

1. If there were one thing I wish could be physically easier for my child to do, it would be:

2. Please indicate what strategies have already been tried. What worked/did not work?

3. Additional Comments:

PSYCHOLOGY

Memory - Compared to others of the same age my child has difficulty remembering:

- Past events or experiences
- Ideas and concepts
- Expectations, rules or routines
- Rote facts or figures
- Instructions

Academics – My child has trouble with the following school-related skills:

- Reading
- Arithmetic
- Spelling
- Expressing ideas in writing

Organized, Flexible and Persistent Thinking – Compared to others of the same age my child has difficulty :

- Participating in daily routines
- Organizing materials (desk, locker, clothes, toys)
- Getting started on something new
- Persevering with schoolwork or homework
- Gathering the right materials for a task or class
- Staying focused when noise or other activities are happening
- Making progress on tasks without constant reminders or attention from an adult
- Recognizing mistakes in school or other tasks
- Planning ahead; predicting consequences of actions
- Shifting from one topic or activity to the next one
- Completing whole tasks or following instructions without "drifting" to other things
- Due to missed days of school
- Listening to directions right to the end; attending to teacher's instruction

Emotions – The following emotions are severe enough to interfere with life at home or school:

- Worry or fears
- Anger, resentment, or rage
- Wide or sudden changes of mood
- Sadness, discouragement or depression
- Dislike of school

Social Interactions, Behaviour, and Communication – Compared to others of the same age my child has difficulty:

- Understanding social expectations
- Interacting with other children
- Complying with general rules or requirements
- Controlling activity level to fit the situation (classroom, restaurant etc.)
- With stealing
- With lying to impress others
- With threats, bullying or teasing from others
- With being overly quiet or passive
- Getting off favourite topics or interests when others don't share the interest
- Interacting with the teacher or other adults
- Cooperating with requests or tasks
- With high activity level; fidgeting, squirming
- Controlling emotions when necessary
- With lying to get out of trouble
- With lying to manipulate others (dominate peers, get others into trouble)
- Bullying, threatening, or deliberately annoying others
- With taking others' comments too literally
- Accepting praise; recognizing own success

1. Please indicate what strategies have already been tried. What worked/did not work?

2. Additional Comments:

NURSING

My child:

- Has diabetes (insulin, blood sugar monitoring).
- Has a heart condition/blood pressure problems (pacemaker, regular blood pressure monitoring, low activity tolerance, tires easily, dizzy spells).
- Requires special medical devices or treatments to assist with breathing (oxygen, suction, tracheostomy, ventilator, oxygen monitor, pacemaker, and inhalers).
- Has chronic pain and requires treatments/medications related to pain relief (Rheumatoid arthritis, Cancer).
- Is on a special diet/at risk for choking/requires assistance to feed (special consistency, meals cut up, allergies, G-tube, pump, assistance of another for feeding).
- Requires assistance with elimination (help with toileting, catheterization, changing diapers, special bowel or bladder routine, regular toileting).
- Requires special treatments, dressing changes, I.V. therapy, medication monitoring, and wound care.

1. Please indicate what strategies have already been tried. What worked/did not work?

2. Additional Comments (Please comment on concerns indicated above):
