



**PHYSIOTHERAPY SCREENER**

*Complete for all clients with PT concerns.*

**Client First Name:**

**Client Last Name:**

**Date of Birth:** (mm-dd-yyyy)

**EMHware # (if known):**

**Informant:**

**Date of Screener:** (mm-dd-yyyy)

**Is the child currently receiving or have they received PT services in the past:** Yes No

**If yes, date of service:**

**Name of PT Service Provider:**

*Please advise the parent/guardian the Physiotherapist will require previous assessments and if possible to bring previous assessments with them to their first appointment.*

**If this client is an infant, were they born significantly premature? (More than 4 weeks)**

Yes No Unknown If "yes" refer for PT Services if parent/guardian agrees.

**# of weeks of gestation:**

**Is the child/youth meeting the developmental milestones for holding up head (4 months), rolling (6 months), sitting (11 months), crawling (12 months) or walking (24 months)?**

Yes No Unknown

**Does the child/youth have a diagnosis or specific developmental concern identified by a medical professional? Such as,**

- Auto-immune disorder such as Juvenile Rheumatoid Arthritis Brain Malformations
- Cerebral Palsy Chronic Respiratory issues such as Bronchiectasis Cystic Fibrosis
- Developmental Coordination Disorder Down Syndrome Global Development Delay
- Head Injury Muscular Dystrophy Vision Impairment Scoliosis
- Seizure Disorder Spina Bifida Torticollis

Plagiocephaly (head shaping)

Genetic Disorders/Syndromes, specify

*If the child/youth has any of the above concerns they are eligible to receive support from FIREFLY PROP.*

*NOTE: If the child/youth was born premature they may also be eligible for support from other Child Development Programs.*

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**Does the child/youth have walking concerns such as?**

Toe-walking (3 yrs. +)

Balance (4 yrs. +)

Coordination (5 yrs. +)

Gait resulting in significant falls (5 yrs. +)

**Does the child/youth have significant or asymmetrical lower extremity concerns? (After 5 years of age)**

In-toeing

Out-toeing

Bow legs

Knock knees

*If the child/youth has concerns related to walking and they are not yet school aged they are eligible for FIREFLY PROP.*

*If the child/youth has concerns related to walking or their lower extremities and they are school aged they are eligible to receive support from the School Based Rehab Services (SBRS).*

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**Does the child/youth have a Musculoskeletal or Acute Respiratory concern?**

Fracture

Sprain/Strain

Osgood-Schlatter disease

Severs

Acute Respiratory Condition

Legg-Perthes Disease

other, please list below:

*If the child/youth has any of the above concerns please redirect to the local hospital or private physiotherapy service.*

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**Are there any gross motor concerns at school?**

Yes, continue below      No

**Which School Board?**

**What grade is the child/youth in?**

RRDSB      KPDSB      KCDSB      TNCDSB      CSDCAB

**Are there any safety concerns at school?**

Yes, please describe:      No

**Does the child/youth receive support from an Education Assistant?**

Yes      No

**Describe how the problem is affecting the student's ability to access the curriculum:**

**List any equipment the student currently uses at School:**

**Are there any classroom provisions in place to support the child?**

Yes, please describe:      No

**How does the child mobilise around the school?**

Independently      Independent with aids      Supervision required

Dependent with Aids