File number ..... – CONFIDENTIAL A.A ……..

RADIOMARATHON FOUNDATION FOR CHILDREN WITH SPECIAL NEEDS

OCCUPATIONAL THERAPY *ASSESSMENT* FORM

Therapist Name: ..... Register number.....

PRIVATE: Address ..... Tel. ……

Date of Evaluation:.....

A. GENERAL INFORMATION OF THE CHILD:

Name:..... Date of birth.....

Father's Name: ..... Mother's name: .....

Address:..... Telephone:.....

Referred by: .....

Doctors / Therapists who monitor the child: .....

Diagnosis:.....

Quadriplegia: **1. Orthopedic problems:**

Diplegia: **2. Psychomotor retardation:**

Hemiplegia: **3. Genetic abnormalities:**

Paraplegia: **4. Other: .....**

B. CHILD'S HISTORY: ……

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……

C. EVALUATION RESULTS/GENERAL REMARKS

……

……

PROBLEM INTENSITY: **Light / Medium / Severe / Very severe**

E:OBJECTIVES: .....

……

Suggested frequency of treatment: ……

Offered frequency of treatment :……

Reassessment Date: .....

Date:..... **Signature.....**