

**OCCUPATIONAL THERAPY
and
PHYSICAL THERAPY
IN LOUISIANA SCHOOLS**



**REFERENCE HANDBOOK
FOR
SPECIAL EDUCATION ADMINISTRATORS
AND THERAPISTS**

Revised 2006

Cecil J. Picard
State Superintendent of Education

State Board of Elementary and Secondary Education

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Member-at-Large

Ms. Mary Washington

Member-at-Large

Ms. Weegie Peabody

Executive Director

For further information, contact:

Janice Fruge'

Division of Educational Improvement and Assistance

225 342-3730 or janice.fruge@la.gov

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SECTION I
INTRODUCTION

Introduction

Public Law 94-142¹, the Education for All Handicapped Children Act, and R. S. 17:1941 et seq.² insure for all children with disabilities free and appropriate public education, which includes special education and related services designed to meet their unique needs. As a result of the Federal and State legislation, the related services of occupational therapy and physical therapy were integrated into the educational environment in Louisiana's public schools as early as 1978.

The *Reference Handbook for Occupational Therapy and Physical Therapy in Louisiana Schools* is designed to provide special education administrators and therapists with guidance in serving children with disabilities and their families within the educational environment. In the delivery of occupational therapy and physical therapy services, systems and therapists must be cognizant that these school-based services are not intended to replace the primary therapy students receive in medical and rehabilitation settings. Therapy is provided by the school system only when the student needs the service to benefit from special education. The direct supportive relationship of the child's therapy needs and education must be **clearly** evident within the context of the pupil appraisal integrated report and the individual education plan (IEP).

To assist local systems and therapists strengthen educational relationships, the Department of Education, Division of Educational Improvement and Assistance, has published this 2006 edition of the *Reference Handbook for Occupational Therapy and Physical Therapy in the Schools*. Recent developments occurring in these professions and in the State of Louisiana are included in this edition.

Throughout this handbook, the term *school-based therapist* refers to occupational therapists and physical therapists working in the educational environment. If a subject refers to just occupational therapists or physical therapists, it will be specifically stated.

General Information for Therapists

School-based therapists should have an understanding of the legal and legislative foundations for therapeutic services in the educational setting. These settings may include early intervention, preschool, and elementary through high school. In Louisiana specific rules and regulations have been adopted with respect to services provided by therapists in the educational setting. The following information provides a general overview of Federal and State laws and regulations that govern related services.

Federal Statutes and Regulations

The laws referring to special educational and related services are designated as *federal statutes*. Statutes are passed by Congress and signed by the president into law. Statutes are divided into subparts, each subpart having one or more sections. IDEA (Individuals with Disabilities Education Act)³ is the federal law that defines the special education and related service requirements for students with disabilities. Part B is the component written for for students ages 3-21. Part C (formally Part H) is the component written for early intervention services. *Federal regulations* are the rules written by the U.S. Department of Education to help states implement the laws. The regulations provide interpretations and outline specific policies and procedures.

State Statutes and Regulations

The Louisiana law addressing special education and related services is R.S. 17:1941 et seq². The *state statute* was amended in 1990 to included services for infants and toddlers and again in 1998 to bring it more in line with the newly re-authorized IDEA. Louisiana's *regulations* are based on the Federal law and regulations. In Louisiana, occupational therapy or physical therapy services provided through early intervention are categorically defined as direct services. Therapeutic services provided school age students (3-21) are defined as related services.

Local Policies and Procedures

Local education agencies (LEAs) are required to provide assurances that the preschool, elementary, and secondary programs operated by the school board are in compliance with State regulations and any applicable Federal regulations. LEAs must identify, locate, and evaluate each student suspected to have disabilities, birth through 21 years of age, residing within its jurisdiction. LEAs must also provide or cause to be provided, a free appropriate public education which meets State Board of Elementary and Secondary Education (SBESE) standards, including State regulations and all applicable bulletins approved by the State Board.²

Definition of Physical Therapy

Physical Therapy means the art and science of physical treatment of any bodily condition to restore function, relieve pain, and prevent disability by use of physical and other properties of heat, light, water, electricity, sound, massage, therapeutic exercise, mobilization, passive manipulation, mechanical devices, and other physical rehabilitation measures, and shall include physical evaluation, treatment planning, instruction, consultative services, and the supervision of physical supportive personnel.⁴

In the **educational environment**, the physical therapist develops and maintains the physical potential of a child with disabilities for independence and participation in the classroom and in other educational activities. The practice of physical therapy in educational settings consists of the following:

- evaluating students with disabilities by performing and interpreting tests and measurements and/or clinical observations of neuromuscular, musculoskeletal, cardiovascular, respiratory, and sensorimotor functions;
- planning and implementing treatment strategies for students based on evaluation findings;
- improving, maintaining and/or slowing the rate of regression of the motor functions of a child to enable him to function in his educational environment; and
- administering and supervising therapeutic management of students with disabilities, recommending equipment, and providing in service education to parents and educational personnel.⁵

Educational Background of the Physical Therapist

The physical therapist's body of knowledge is acquired through course work and clinical education (including four to six months of clinical internship within a specialized institution of higher education) and is based on a broad background in the humanities, social sciences, and natural sciences. Specifically, the special knowledge and skills acquired in an entry level physical therapy degree fall into four general areas:

- basic natural sciences (including physics, chemistry, and mathematics);
- basic health sciences (including human anatomy, physiology, kinesiology, psychology, and pathology);
- clinical sciences (including principles and practices of physical therapy, clinical medical conditions, and surgical conditions); and
- clinical arts (the administration of evaluative and therapeutic procedures to human subjects).

Definition of Occupational Therapy

Occupational therapy means the therapeutic use of everyday life activities (occupations) with individuals or groups for the purpose of participation in roles and situations in home, school, workplace, community and other settings. Occupational therapy services are provided for the purposes of promoting health and wellness and to those who have or area at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation or participation restriction. Occupational therapy addresses the physical, cognitive, psychosocial, sensory and other aspects of performance in a variety of contexts to support engagement in everyday life activities that affect health, well-being, and quality of life.⁶

In the **educational setting**, the occupational therapist uses purposeful goal-directed activities and adapted techniques and equipment to improve the child's ability to participate effectively. The practice of Occupational Therapy in the educational setting consists of the following:

- evaluating students with disabilities by performing and interpreting tests and measurements and/or clinical observations of neurophysiological, musculoskeletal, sensorimotor functions and daily living skills;
- planning and implementing treatment strategies for students based on evaluation findings;
- improving, developing, restoring or maintaining functions impaired or lost through illness, injury, or deprivation;
- improving or maintaining the ability to perform tasks for independent functioning when functions are impaired or lost; and
- administering and supervising therapeutic management of student with disabilities, recommending equipment, and providing training to parents and educational personnel.⁵

Educational Background of the Occupational Therapist

The occupational therapist's body of knowledge is acquired through a combination of course work and fieldwork (minimum of six months of practice) based on a broad background of liberal arts, sciences, and humanities. The entry-level occupational therapy degree requirements are in the following areas:

- biological, behavioral, and health sciences including anatomy, kinesiology, physiology, neuroanatomy, and neurophysiology, human development, and human behavior;
- occupational therapy theory and practice including human performance and activity processes; and
- application of occupational therapy theory to practice, including assessment and interpretation, directing planning and implementing intervention, program termination, documentation, and research.^{7,8}

Physical Therapy Assistants

Physical therapy assistants (PTA) are individuals who have graduated from an accredited school of physical therapy assisting, which at the time of graduation, was approved by the American Physical Therapy Association or the Louisiana State Board of Physical Therapy Examiners. PTAs assist in

the practice of physical therapy in accordance with the provisions of the Physical Therapy Practice Act and work under the supervision of a physical therapist by performing such patient-related activities assigned by a physical therapist that are commensurate with the physical therapist assistant's education and training. A physical therapist assistant's work shall not include the interpretation and implementation of referrals or prescription, the performance of evaluations, or the determination or major modification of treatment programs.⁴

Certified Occupational Therapy Assistants

Occupational therapy assistants (LCOTA) are individuals who have graduated from an accredited school of occupational therapy assisting, who are certified by the American Occupational Therapy Association, Inc. (AOTA), and who are licensed to assist in the practice of occupational therapy under the supervision of a licensed occupational therapist.⁹ In the educational setting, the occupational therapy assistant's role is in intervention; and therefore, he/she works only under the supervision of the professional occupational therapist at all critical points in the program. The determination of the actual number of hours per week necessary (in excess of the minimum two hours per week) is based on the professional and ethical judgment of the LOT who assumes the responsibility of the actions of the supervisee, taking into consideration the following regarding the individual being supervised: 1) experience, 2) continuing education, 3) population served, 4) requirements of the facility's accrediting agency, and 5) service competency of the individual being supervised.

Credentialing

Licensure

All physical therapists, occupational therapists, and certified occupational therapy assistants and physical therapy assistants practicing in Louisiana must meet the requirements of their respective licensure boards and be re-licensed yearly in Louisiana.^{4,9} Administrators may obtain further information about licensure or confirm the licensure of any therapist by contacting the following for occupational therapists and certified occupational therapy assistants:

Louisiana State Board of Medical Examiners
P.O. Box 30250
New Orleans, Louisiana 70190-0250
504-568-6820
www.lsbme.louisiana.gov

and for physical therapists and physical therapy assistants:

Louisiana State Board of Physical Therapy Examiners
104 Fairlane Drive
Lafayette, Louisiana 70507 337-262-1043 www.lsbpte@latpboard.org

Ancillary Certification

Occupational therapists and physical therapists employed in any school system in Louisiana should apply and receive an ancillary certificate from the Louisiana Department of Education.

This certificate must be renewed every five years. For information about this certification, contact

Louisiana Department of Education
Division of Teacher Standards, Assessments and Certification
Box 94064
Baton Rouge, Louisiana 70804

Standards of Practice

The *Standards of Practice for Occupational Therapy* were revised in 2005 by the AOTA Representative Assembly. These standards are intended to assist occupational therapy practitioners in the provision of occupational therapy services. The standards serve as a minimum and are applicable to all individual populations and the programs in which individuals are served.¹⁰

The Board of Directors of the American Physical Therapy Association approved *Physical Therapy Practice in Educational Environments, Policies, and Guidelines* in January 1990.¹¹

SECTION II

PROCEDURES

Therapists as Members of Pupil Appraisal Services

Procedures in *Louisiana Pupil Appraisal Handbook*⁵ are followed when a child is suspected of being disabled. The initial screening process gathers classroom-based data. As data are reviewed by the school building level committee (SBLC) and Pupil Appraisal Personnel and an evaluation is proposed, written parental approval must be obtained by Pupil Appraisal Personnel. On receipt of parental permission, the evaluation coordinator reviews all pertinent information in order to determine areas requiring assessments during the appraisal process. This parental permission allows the therapist to screen and assess.

Based on the student's needs, the evaluation coordinator draws on different disciplines appropriate to a complete evaluation. Professional members of a pupil appraisal staff include but are not limited to educational diagnosticians, school social workers, school nurses, adapted physical education specialists, school psychologists, speech/hearing/language specialists, audiologists, occupational therapists, and physical therapists. Among other professionals who may be involved are physicians and educational consultants.

Indicators for Inclusion of Therapy in Pupil Appraisal

The following are some of the indications for inclusion of an occupational and/or physical therapist in the multidisciplinary evaluation by Pupil Appraisal, when necessary for a full and accurate assessment of a child's strengths and weaknesses and to determine eligibility for services.

The decision to include a physical therapist and/or occupational therapist is made by the evaluation coordinator, who reviews all screening and other assessment information on the nature and severity of the child's problems. The **educational impact** of these problems must be documented in the written report. Listed below are examples of such required documentation.

- Motor and/or perceptual difficulties interfere with the student's performance on standardized and/or perceptual intellectual assessments and educational evaluations.
- Suspected gross and/or fine motor deficits significantly interfere with the student's functioning in the educational environment.
- Significant perceptual motor or sensorimotor deficits interfere with the student's educational performance
- The use of a wheelchair, braces, crutches, prosthetics, or other specially adapted equipment is necessary for the student to function in the educational setting..
- Degenerative medical condition requires maintenance of mobility and stamina in order for the student to participate in educational activities.
- Difficulty in performing self-help tasks—such as feeding, toileting, and dressing—are present.
- Difficulty with physical endurance for regular school activities requires cardiovascular and respiratory intervention for the student.

Purposes of Occupational and Physical Therapy Assessment

The purposes of an occupational or physical therapy assessment include determining the

- abilities and impairment in physical performances and functional skills;
- extent the impairment affects educational performance;
- developmental levels in gross motor, fine motor, sensorimotor skills, and self care;
- strengths and weaknesses in the areas assessed; and
- student need for occupational therapy or physical therapy service in order to benefit from special education.

Evaluation Methods

An occupational therapy or a physical therapy evaluation may include any or all of the following methods:

- standardized tests (supported by how the results of specific test scores are affecting the child's ability to function in the educational environment);
- formalized non-standardized assessment;
- informal evaluation including observation in the classroom, lunchroom, and playground;
- review of pertinent medical, education, psychological, and speech records;
- interview(s) with student, parent, and/or teacher(s).

Frequently used evaluation tools are listed in Appendix A. The therapist selects the assessment procedures appropriate for each individual child. The following factors are involved in the selection of assessment methods:

- chronological age,
- educational functioning,
- attention to task, and
- medical conditions and contraindications.

Therapy Component of the Written Multidisciplinary Evaluation

The final written report is a compilation of the data gathered during the individual evaluation. The data collected by all Pupil Appraisal Personnel must be integrated and written in language that is clear to the individuals who will use it. To maintain clear communication, the therapist should omit abbreviations. The therapist's written report should include

- diagnosis and relevant information;
- environmental factors, if relevant;
- test behavior;
- evaluation results
 - a description of the standardized and normative assessments used; scores obtained and the analysis of the results;
 - informal methods used and the analysis of the results;
 - a description of functional skills

- adaptive equipment or assistive devices;
- interpretation of results in strengths and needs as they relate to educational functioning;
- application of eligibility criteria;
- explanation of educational relevance in terms of these questions:
 - How does this problem interfere with the student's ability to benefit from his/her educational program?
 - Is there a likely potential for a change in the student's educational functioning if he/she receives therapeutic intervention?
 - The following statement shall be included in the integrated summary:
"Based on this evaluation, ___ (student)_____ appears/does not appear to demonstrate or exhibit a need for intervention in the area of ___(therapy)_____ to benefit from his/her special education program."
- recommendations on the following:
 - need for therapy services
 - any specific recommendations to teachers and parents.

No reference to levels, frequency or duration of services may be made in the evaluation report.

Therapy Assessment for Re-evaluation or Additional Concerns

Assessment for Reevaluations

For students who have been receiving therapeutic intervention, the therapist will be required to participate directly or indirectly in the re-evaluation process. The level of involvement of the therapist shall be determined by the IEP committee. At the time of reevaluation, the therapist shall provide the IEP committee with a written summary of therapeutic intervention and the student's progress toward meeting the IEP goals and objectives targeted for intervention. The summary should include a review of the student's motor abilities and needs and a statement that incorporates the answers to the following questions:

- How does the problem continue to interfere with the student's ability to benefit from his/her educational program?
- Does the potential for change in the student's educational functioning with therapeutic intervention continue to be evident?

The IEP team shall then review the existing evaluation data on the student and determine whether the student continues to need therapeutic services.

Assessment for Additional Concerns

If an exceptional student's need for therapy has not been previously assessed and a new concern in the area of motor functioning is expressed by the parent, teacher, or other personnel, the procedures listed below shall be followed.

- The IEP committee shall reconvene to discuss the concerns. The committee shall be responsible for collecting all available information relative to
 - the student's functional levels;
 - the student's current standardized test results;
 - the student's current medical/health reports if applicable;
 - other pertinent information (e.g. observation, informal measures, etc.); and
 - the student's performance toward meeting his/her IEP goals, objectives and/or benchmarks.
- The PT and/or OT shall assess the student's motor abilities according to the procedures outlined in *Pupil Appraisal Handbook*.⁵ The therapist shall also review information provided by the IEP committee and determine whether there is sufficient data to apply the eligibility criteria for services. If additional data are needed, the therapist should notify the IEP committee as to what information is needed and the most appropriate method for obtaining the information.
- The therapist shall meet with IEP committee to provide an oral explanation of the assessment results. If the eligibility criteria has been met, the therapist shall present his/her professional recommendations and participate in the discussion regarding intervention needs and the service delivery required to meet those needs.

Assessment Areas in Occupational Therapy

Developmental level

- * Fine Motor
- * Gross motor (when necessary)
- * Self-Care

Motor function

- * Muscle tone
- * Strength and endurance
- * Joint range of motion
- * Hand preference
- * Functional grasp and release of objects
- * Functional manipulation of objects (e.g. writing devices, scissors)
- * Coordination and motor planning
- * Balance/postural control
- * Visual tracking/ability to copy written materials

Sensorimotor Skills

- * Ability to process sensory information (internal/external)
- * Awareness and responsiveness to sensory input (defensive/avoiding, seeking behaviors)
- * Body awareness, motor planning, coordination
- * Balance/postural control
- * Functional performance of motor tasks/play skills
- * Impact of the environment on functioning (e.g. noise, visual stimuli, room organization)
- * General activity level
- * Frustration tolerance/coping skills
- * Social responses (e.g. eye contact, engagement with others, motivation)

Perceptual Motor Skills

- * Visual motor integration
- * Visual perception
- * Fine motor coordination
- * Handwriting skills

Self Care Skills

- * Feeding/oral motor skills

- * Cafeteria management
- * Hygiene/toileting
- * Wheelchair use and transfers
- * Functional life skills
- * Dressing skills

Adaptations

- * Need for individual adaptive equipment, (e.g., writing devices, computer adaptations, switches, eating devices, dressing aids, UE positioning devices)
- * Need for classroom environmental adaptations (e.g. seating and positioning, bathroom adaptations, cafeteria modifications, stairs, ramps, doors)
- * Need for sensory environmental adaptations (e.g. alternative seating, lighting)
- * Functional assessment of upper extremity prosthetics and orthotics

Behavioral Observations may include

- * General activity level
- * Frustration tolerance/coping skills
- * Transitions
- * Problem solving skills
- * Organizational skills/work habits
- * Self confidence
- * Ability to follow instructions
- * Attention to task
- * Interaction with peers and adults
- * Social responses (e.g. eye contact, engagement with others)

*****Note: Not all areas require assessment. Areas to be assessed are dependent on the student's needs.***

Assessment Areas in Physical Therapy**

Developmental Level

- * Fine motor (when necessary)
- * Gross motor
- * Self-Help

Motor Skills

- * Muscle tone
- * Strength, endurance and coordination
- * Joint stability, safe passive and active range of motion
- * Eye, hand and foot preference
- * Balance
- * Gait and locomotion
- * Reflex integration
- * Postural assessment
- * Oral motor function

Perceptual Motor

- * Body awareness
- * Spatial orientation
- * Motor planning
- * Bilateral movement and laterality
- * Postural insecurity

Self Care Skills

- * Independent mobility skills
- * Cafeteria management
- * Functional positioning
- * Safe toileting procedure
- * Wheelchair skills
- * Ambulation with and without adaptive equipment
- * Self-help skills

Environment Adaptations

- * Analysis of orthotic and adaptive equipment required for students in educational settings
- * Analysis of educational environmental needs (e.g. architectural barriers, seating and positioning, functional wheelchair use, sensory concerns)

- * Functional assessment of equipment for safe classroom participation, such as:

- Orthotics
- Walkers
- Prone boards
- Crutches
- Specially adapted tables and chairs
- Parapodium

Behavioral Observation

- * General activity level
- * Motivation
- * Aversive reactions to movement, touch or equipment usage
- * Frustration tolerance/coping skills
- * Ability to follow instructions
- * Attention to task
- * Social responses (eye contact, engagement with others)

Associated Physiological Conditions

- * Sensory disturbances
- * Skin disorders
- * Respiratory functions
- * Circulation problems
 - cardiovascular
 - peripheral vascular

****Note: Not all areas require assessment. Areas to be assessed are dependent on the student's needs.**

ABOUT THE CRITERIA OF ELIGIBILITY

The Criteria of Eligibility for Occupational Therapy¹² and the Criteria of Eligibility for Physical Therapy¹³ were officially promulgated by the SBESE on December 17, 1987. These criteria were used by all therapists throughout the state to assist in determining whether a student needs occupational therapy or physical therapy intervention in the school setting. In 1998 the criteria were revised by a State-appointed task force of occupational and physical therapists. The task force made revisions in the outdated terminology and incorporated a new section to address the needs of students with sensorimotor impairments.

Use of Criteria

Upon completion of an occupational therapy or physical therapy assessment, the therapist uses the criteria to determine whether an exceptional student demonstrates/exhibits a need for occupational therapy or physical therapy in the school setting in order to benefit from his/her special education program. The therapist should keep in mind specific factors when using the criteria.

- The therapist should use the motor section, not the developmental delay section, with students who have medical diagnoses, such as spina bifida, muscular dystrophy, and cerebral palsy.
- When using the developmental criteria, the therapist should not average scores to determine the functional educational age; rather he should view the gross or fine motor skill level in comparison to all other scores from other team members.
- Occupational therapists should use the sensorimotor section with students that exhibit an inability to integrate sensory stimuli effectively and whose capacity to perform functional activities within the educational setting is affected. Students evaluated for occupational therapy under the sensorimotor section should indicate an ability to improve functional activity performance through intervention.
- The criteria of eligibility initially determine the need for therapeutic intervention. They should not be used in the re-evaluation process.

OCCUPATIONAL THERAPY⁵

I. DEFINITION

Occupational therapy services include the following procedures.

- A. Evaluating students with disabilities by performing and interpreting tests and measurements and/or clinical observations of neurophysiological, muscu- loskeletal, sensorimotor functions and daily living skills.
- B. Planning and implementing treatment strategies for students based on evaluation findings.
- C. Improving, developing, restoring or maintaining functions impaired or lost through illness, injury, or deprivation.
- D. Improving or maintaining ability to perform tasks for independent functioning when functions are impaired or lost.
- E. Administering and supervising therapeutic management of students with disabilities, recommending equipment and providing training to parents and educational personnel.

Each school system shall identify, locate, and evaluate each suspected student with disabilities, birth through 21 years of age, but is responsible for providing OT services to only those eligible students ages 3 through 21. The provision of services shall be determined at the IEP Team meeting, using the input of the occupational therapist and the results and recommendations of the therapy assessment. The continuation of services shall be determined at the annual IEP review using input of the therapist.

II. CRITERIA FOR ELIGIBILITY

Both A. and B. must be met.

- A. The student is classified and eligible for special educational services. There is documented evidence that occupational therapy is required to assist the student to benefit from the special educational services.
- B. The student demonstrates a motor impairment in one of the following categories: Developmental, Motor Function, or Sensorimotor.

1. Developmental

Students (excluding those with neurophysiological impairments) who demonstrate a fine motor, visual motor, oral motor, or self help delay are as follows:

- a. **Students with disabilities ages 3y0m - 5y6m**
Students who demonstrate a fine motor, visual motor, oral motor or self help delay greater than one standard deviation below functional abilities as measured by an appropriate assessment instrument. Some instruments yield a development age score instead of a standard score. In such cases, a student must demonstrate a delay of at least six months below functional abilities.
- b. **Students with disabilities ages 5y7m - 9y11m**
Students who demonstrate a fine motor, visual motor, oral motor or self help delay greater than one standard deviation below functional abilities as measured by an appropriate assessment instrument. Some instruments yield a developmental age score instead of a standard score. In such cases, a student must demonstrate a delay of at least 12 months below functional abilities.
- c. **Students with disabilities ages 10y0mo - 21y**
Students who demonstrate a fine motor, visual motor, oral motor or self help delay greater than one standard deviation below functional abilities as measured by an appropriate assessment instrument. Some instruments yield a developmental age score instead of a standard score. In such cases, a student must demonstrate a delay of at least 18 months below functional abilities.

Functional abilities are defined as the student's overall educational performance in the areas of cognition, communication, social, self help, and gross motor.

2. **Motor Function**

According to clinical and/or behavioral observations (which may include, but are not limited to available current medical information, medical history and/or progress reports from previous therapeutic intervention), the student exhibits neurophysiological limitations or orthopedic limitations that affect his or her physical functioning in the educational setting. These limitations might include abnormalities in the area(s) of fine motor, visual motor, oral motor, or self help skills.

In addition to OT assessment, current student information must indicate **one** of the following abilities.

- a. An ability to improve motor functioning with occupational therapy intervention;

or

- b. An ability to maintain motor functioning with therapeutic intervention (if the student maintains motor functioning without therapeutic intervention, OT would not be required in the educational setting);
- or**
- c. An ability to slow the rate of regression of motor function with therapeutic intervention (if the student has a progressive disorder).

3. Sensorimotor

According to clinical behavior observation and/or an appropriate assessment instrument, the student exhibits an inability to integrate sensory stimuli effectively, affecting his or her capacity to perform functional activities within the educational setting. These activities might include abnormalities in the area of fine motor, visual motor, oral motor, self help or sensory processing (sensory awareness, motor planning and organization of adaptive responses).

In addition to OT assessment, current student information must indicate an ability to improve functional activity performance through OT intervention.

III. PROCEDURES FOR EVALUATION

- A. The assessment shall be conducted by an occupational therapist and shall include at a minimum the following procedures.
 - 1. A review of available medical and educational information, environmental concerns, anecdotal records and observation of motor skills which document the specific concerns causing the referral.
 - 2. An assessment of motor abilities.

For students ages 6 - 21, the assessment should be conducted in the educational environment.
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- B. The occupational therapist's assessment should be designed to answer the questions listed below.
 - 1. Does this problem interfere with the student's ability to benefit from his or her educational program?
 - 2. Is there a likely potential for change in the student's educational functioning if he/she receives therapeutic intervention?

PHYSICAL THERAPY⁵

I. DEFINITION

Physical therapy services include the following procedures.

- A. Evaluating students with disabilities by performing and interpreting tests and measurements and/or clinical observations of neurophysiological, musculoskeletal, cardiovascular, respiratory, and sensorimotor functions.
- B. Planning and implementing treatment strategies for students based on evaluation findings.
- C. Improving, maintaining and/or slowing the rate of regression of the motor functions of a student to enable him/her to function in his educational environment.
- D. Administering and supervising therapeutic management of students with disabilities, recommending equipment and providing training to parents and educational personnel.

Each school system shall identify, locate, and evaluate each suspected child/student with disabilities, birth through 21 years of age, but is responsible for providing PT services only to those eligible students ages 3 through 21. The provision of services shall be determined at the IEP Team meeting using the input of the therapist and the results and recommendations of the therapy assessment. The continuation of services shall be determined at the annual IEP review using input of the therapist.

II. CRITERIA FOR ELIGIBILITY

Both A and B must be met.

- A. The student is classified and eligible for a special educational program. There is documented evidence that physical therapy is required to assist the student to benefit from special education.
- B. The student demonstrates gross motor impairment in either the Developmental or Motor Function category.

1. Developmental

Students (excluding those with neurophysiological impairments) who demonstrate a gross motor delay are as follows:

a. **Students with disabilities ages 3y0m - 5y 6m**

Students who demonstrate a gross motor delay of six months or more below level of functional abilities as measured by an appropriate assessment instrument.

b. **Students with disabilities ages 5y7m - 9y11m**

Students who demonstrate a gross motor delay of 12 months or more below level of functional abilities as measured by an appropriate assessment instrument.

c. **Students with disabilities ages 10y0 m - 21y**

Students who demonstrate a gross motor delay of 18 months or more below level of functional abilities as measured by an appropriate assessment instrument.

Functional abilities are defined as the student's overall educational performance in the areas of cognition, communication, social, self help, and fine motor.

2. Motor Function

According to clinical and/or behavioral observations—which may include but are not limited to available current medical information, medical history and/or progress reports from previous therapeutic intervention—the student exhibits neurophysiological, orthopedic, cardiovascular, respiratory, or sensorimotor limitation that affect his or her gross motor functioning in the educational setting.

In addition to PT assessment, current student information must indicate **one** of the following.

a. an ability to improve motor functioning with physical therapy intervention;

b. an ability to maintain motor functioning with therapeutic intervention (if the student maintains motor functioning without therapeutic intervention, PT would not be required in the educational setting).

c. an ability to slow the rate of regression of motor function with therapeutic intervention (if the student has a progressive disorder).

III. PROCEDURES FOR EVALUATION

- A. The assessment shall be conducted by a licensed physical therapist and shall include at a minimum the following procedures.
1. A review of available medical and educational information, environmental concerns, anecdotal records and observation of motor skills that document the specific concerns causing the referral.
 2. An assessment of gross motor abilities.

For students ages 6-21, the assessment should be conducted in the educational environment.

- B. The physical therapy assessment shall be designed to answer the following questions.
1. Does this problem interfere with the student's ability to benefit from his or her educational program?
 2. Is there a potential for change in the student's educational functioning if he/she receives therapeutic intervention?

Therapists' Participation in IEP Process^{14,15}

The written individualized educational program (IEP) documents the approach used to ensure that each child is provided a free appropriate public education. The IEP sets forth in writing a commitment of resources of what special education and related services will be provided to meet each child's needs. Decisions about the individual educational program for a child with disabilities are made jointly by parents, school personnel and student (when appropriate) at the IEP meeting. The information used to reach decisions about the IEP includes the child's current educational performance, information supplied by the parents, and the results of the integrated pupil appraisal report.

Occupational and physical therapists play a vital role, with the education team, in developing a student's IEP. This includes identifying the student's present level of performance, strengths and needs, assistive technology use and progress in the general curriculum; identifying educational need areas; developing measurable annual goals (and short term objectives when appropriate); determining appropriate modifications and accommodations; and determining appropriate placement and support services.

When making the decision to include therapy, the IEP committee must first design the program for the student in terms of **educational** annual goals and short term objectives. The annual goals address the curricular areas. Separate therapeutic goals are not necessary; rather they should be integrated into functional educational goals.

No decisions concerning therapy can be made until the IEP goals and objectives have been agreed upon by all. Services and placements are the last things for the IEP team to determine, not the first. IEP team members should ensure that the student's long term goals are the first consideration. This strategy sets up a format that forces the team to determine the present levels of functioning first, before choosing a placement and identifying services.

Once this step has been completed, the committee (including the occupational therapist and/or physical therapist) must give careful consideration to each objective and ask the following questions in relation to each:

- ***Does this goal require occupational therapy or physical therapy intervention in order for the student to achieve success?***
- ***Must the intervention, in order to be effective, be provided to the student during school hours or within educational settings?***

If the answers to both of these questions is "yes" and the IEP Committee agrees the therapy is necessary, the team must then determine the most appropriate way to provide service in the least restrictive environment. Because the environment that is least restrictive differs for each child, the services must be considered individually for each child.

Frequency of occupational and physical therapy services are discussed only after the goals and objectives have been agreed upon and the IEP committee has determined the need for therapeutic intervention. As a member of the IEP committee, the therapist participates in the decision-making process and should present his/her professional recommendations regarding frequency at the meeting. The discussion of frequency should not dwell on “how many minutes” or “how many times” but rather on what the long term therapy needs are for the student.

The priority of the therapist must be to consider the extent to which the deficits identified during assessment interfere with the student’s ability to function in his educational program. Therapy services in a school-based setting are not intended to address every identified deficit area. One of the best practices under IDEA is the provision of a continuum of multifaceted services consistent with therapy philosophy. Services should be adjusted to meet the changing developmental needs of the student and family. The dynamic nature of therapy service needs can be met by providing flexibility in promoting access to those services that respond to the changing needs of the student. The follow factors should also be weighed:

- ***Student's chronological age:*** The younger a student's chronological age, the greater the impact a therapist can have on his/her status. However, special consideration should also be given for older students with late onset disabilities or impairments.
-
- ***Extent of previous therapy:*** If a student has had several years of therapy services, the continued **potential** for change should be carefully considered.
- ***Medical diagnosis:*** A student's medical diagnosis will indicate a progressive disease process, static disease process, or one that is characterized by remissions and exacerbations. Recommendations must reflect the implications of the student's medical diagnosis as it impacts functional performance within the educational setting.
- ***Student’s educational environment:*** Changes in educational placement, school campus and/or community based instruction may warrant flexibility in service delivery and frequency.
- ***Student’s need for assistive technology:*** Students’ needs for assistive technology, including any piece of equipment, product system or item to improve functional capabilities, should be considered. Consideration should be given to training needs, as well as assistive technology uses in the educational environment.
- ***Competency of other personnel:*** Students may greatly benefit from the daily practice with parents, teachers and aides implementing recommended strategies or techniques. However, before this service delivery method can be considered, the therapist should determine 1) whether the student’s health and safety will be protected if the program is carried out by other personnel, 2) whether the person trained can correctly demonstrate the activities without assistance, and 3) whether the person trained can independently recognize problems that would warrant making immediate contact with the therapist.

The focus of all discussion regarding service delivery should be how therapy can help the student to benefit from his/her special education program. Regardless of the frequency selected by the IEP committee, it is important that all of the members recognize that they are participating in a team process and that the common goal is to meet the special educational needs of the student.

If the therapist is not present at the IEP conference and there is some disagreement, the IEP committee should be adjourned and reconvened when the therapist can be present. Pre-IEP conferences can assist the team in integrating related services and can prevent any unnecessary conflict during IEP meetings. The participation of therapists in the development of the IEP will assist in concurrence on goals, reinforce parent's efforts, and enable the child to benefit more fully from participation in school.

Integrating Educational and Related Services in the IEP Process

One of the purposes of the IEP is to serve as a communication vehicle among all participating parties to ensure that they know what the child's strengths, weaknesses, and needs are; what will be provided; and what the anticipated outcomes may be. The role of the therapist in the IEP process is one of communicating with teachers and parents and assisting in determining educational goals and short-term objectives.

A word of caution: the IEP is not intended to be a treatment program; rather it reflects what the student will be able to accomplish in the educational setting. The therapist and teacher should always strive to collaborate in writing goals and short-term objectives, when appropriate. Therapeutic intervention should be integrated into the special education program of a child as a support or related service, not as a primary goal. Integrated or collaborative therapy is a way to provide intervention as a student engages in everyday routines. Regardless of the frequency of service, collaborative therapy is a process that infuses disciplinary methods into instruction that occurs in typical home, school, and community environments. Collaborative therapy services are transdisciplinary because methods and skills must be taught to parents, teachers, paraprofessionals, and other related service personnel. With training and support from a therapist, remediation of deficit skill areas can be addressed on a daily basis within the classroom, the community, and at home.

Examples of integrated IEP objectives involving student, teacher, and therapist are provided below.

- *The student will be able to sit at a desk in an adaptive chair in proper body alignment with verbal cues for five minutes while completing three out of four single multiplication problems correctly on a daily basis.*
- *The student will be able to propel his wheelchair forward with standby in five (5) minutes from the classroom to the bathroom two out of two times daily.*

- *Given assistance and support, the student will hold his head in proper alignment for one minute during story time as measured by a timer.*
- *The student will use write a paragraph using correct letter formation 80% of the time.*

In each of the objectives above, the focus is educational but the therapeutic relationship or need is clearly evident. For additional information on the IEP process and related services, please refer to the *IEP Handbook*.

Service Delivery

A collaborative service delivery model within in the educational setting is considered best practice. Collaborating with team members is a central component for occupational and physical therapy services under IDEA. Successful implementations of therapy services depend upon the therapist's ability to communicate, cooperate, coordinate and integrate with educational team members. Therapy provided in the educational setting should reflect a collaborative team approach and be delivered in many forms according to the focus of services, the individuals who participate, the competencies of the other team members and the delivery site.^{7,15}

The provision of collaborative services may include hands-on student contact and/or services such as consultation with educational staff, family and medical personnel, fabrication of adaptive equipment, and determination of environmental accessibility. One or more service methods may be provided during the school year and changes can be made at any time through the IEP process.

The collaborative model allows continued social integration and ongoing instruction in a range of skills and activities. It also promotes acquisition, use, synthesis and generalization of motor, self help, communication, and social skills. Within this approach, activities are integrated into the instructional program on a daily basis. Collaboration is an effective mechanism for providing support, but it requires special skills of all team members. The therapist must have diagnostic skills to identify student needs, program planning skills to design appropriate interventions, and teaching and supervisory skills to assist others in the immediate environment to carry out the procedure with the student.

Treatment Areas in Occupational Therapy

Therapists should consider current evidenced based practices when designing and implementing therapeutic strategies in the educational environment. Data collection and documentation should be in collaboration with educational staff to effectively measure student outcomes.^{10,15} Improved function in the following areas enables students to participate more effectively in classroom, playground and community activities.

Developmental

- * Fine Motor
- * Gross motor (when necessary)
- * Self-Care

Motor function

- * Muscle tone
- * Strength and endurance
- * Joint range of motion
- * Hand preference
- * Functional grasp and release of objects
- * Functional manipulation of objects (e.g. writing devices, scissors)
- * Coordination and motor planning
- * Balance/postural control
- * Visual tracking/ability to copy written materials

Sensorimotor Skills

- * Ability to process sensory information (internal/external)
- * Awareness and responsiveness to sensory input (defensive/avoiding, seeking behaviors)
- * Body awareness, motor planning, coordination
- * Balance/postural control
- * Functional performance of motor tasks/play skills
- * Impact of the environment on functioning (e.g. noise, visual stimuli, room organization)
- * General activity level
- * Frustration tolerance/coping skills

- * Social responses (e.g. eye contact,

- engagement with others, motivation)
- * Transitions

Perceptual Motor Skills

- * Visual motor integration
- * Visual perception
- * Fine motor coordination
- * Handwriting skills
- * Organizational skills/work habits

Self Care Skills

- * Feeding/oral motor skills
- * Cafeteria management
- * Hygiene/toileting
- * Wheelchair use and transfers
- * Functional life skills

Adaptations

- * Individual adaptive equipment, (e.g., writing devices, computer adaptations, switches, eating devices, dressing aids, UE positioning devices)
- * Classroom environmental adaptations (e.g. seating and positioning, bathroom adaptations, cafeteria modifications, stairs, ramps, doors)
- * Sensory environmental adaptations (e.g. alternative seating, lighting)

Treatment Areas in Physical Therapy

Therapists should consider current evidenced based practices when designing and implementing therapeutic strategies in the educational environment. Data collection and documentation should be in collaboration with educational staff to effectively measure student outcomes.^{10,15} Improved function in the following areas enables students to participate more effectively in classroom, playground and community activities.

Developmental

- * Fine motor (when necessary)
- * Gross motor
- * Self-Help

Motor Skills

- * Muscle tone
- * Strength, endurance and coordination
- * Joint stability, safe passive and active range of motion
- * Eye, hand and foot preference
- * Balance
- * Gait and locomotion
- * Reflex integration
- * Postural assessment
- * Oral motor function

Perceptual Motor

- * Body awareness
- * Spatial orientation
- * Motor planning
- * Bilateral movement and laterality
- * Postural insecurity

Self Care Skills

- * Independent mobility skills
- * Cafeteria management
- * Functional positioning
- * Safe toileting procedure
- * Wheelchair skills
- * Ambulation with and without adaptive equipment
- * Self help skills

Environment Adaptations

- * Analysis of orthotic and adaptive

equipment required for students in educational settings

- * Analysis of educational environmental needs (e.g. architectural barriers, seating and positioning, functional wheelchair use, sensory concerns)
- * Equipment for safe classroom participation, such as
 - Orthotics
 - Walkers
 - Prone Boards
 - Crutches
 - Specially adapted tables and chairs
 - Parapodium

Associated Physiological Conditions

- * Sensory disturbances
- * Skin disorders
- * Respiratory functions
- * Circulation problems
 - cardiovascular
 - peripheral vascular

Continuation or Termination of Therapy Services

The school system is required to conduct an IEP meeting at least annually to review the student's progress toward achieving the annual goals and objectives.¹⁴ At that time, the committee also renews decisions about the program and related services. In addition to the required annual update, the committee must meet when any changes in the educational program or related services are being proposed. These changes include modifications proposed by occupational therapists, physical therapists, other related service personnel, or parents. Therapy modifications may occur if the student is progressing or regressing.

It is not necessary to conduct formal therapy assessments prior to the annual IEP update; however, therapists should provide the IEP committee with all current data relating to student achievement or the lack of success. The committee should carefully consider the professional recommendations of the therapists and the impact on the student each time a change is being proposed.

Termination of any stated related service is an **IEP committee decision**. Unless a termination date is clearly stated on the IEP, the system or one of its employees may not terminate a service.

A student who is currently receiving therapy services may be discharged formally through the IEP process when any of the following occurs:

- a student is reevaluated and found to be ineligible for special education services;
- the IEP Committee agrees the student has achieved maximum benefit from therapy.
- the physician terminates the order of service

The **rationale** for termination of educational occupational therapy and physical therapy services is maintained by the Supervisor of Special Education and includes one of the following:

- documentation by the therapist that maximal benefit from the prescribed therapy to educational programming has been reached;
- physician's order terminating service;
- recommendation of Pupil Appraisal/IEP committee following re-evaluation.

Due Process

If an agreement cannot be reached at the IEP meeting concerning disputed therapy as related services, the disagreeing parties should be made aware of procedural safeguards outlined in the federal regulations¹, and corresponding due process procedures within R.S. 17:1941 et seq. ²

It is vital that all parties understand that occupational therapy and physical therapy are related services to the specialized instruction mandated by free appropriate public education. All service delivery models represent occupational and physical therapy. The amount of therapy determined in an IEP for a child addresses only his educational needs; and if the parents wish to seek additional therapy to meet the other needs of the child, such services are available in the community.

A physical therapist or a occupational therapist serving an exceptional child whose parents/guardian have initiated a due process hearing should be cognizant of the following:

- a due process hearing is akin to a court of law with a hearing officer presiding, attorneys, and a court stenographer recording;
- therapists, if asked to testify, must do so under oath; and
- the documentation of all services rendered, all progress notes and records, all evaluation and re-evaluation data, and IEP goals and objectives, must be available as evidence to be referred to or used as exhibits.

Attending one due process hearing convinces any therapist that recording daily findings following each treatment is a vital part of providing the service.

Record Keeping

Each therapist should maintain an individual folder on each child seen for therapy. These child specific folders and contents are given to the next school-based therapist if there is a change. The following documents are suggested for inclusion in this folder:

- copy of current medical referral from a Louisiana licensed physician prescribing physical therapy or occupational therapy services;
- copy of the IEP;
- copy of the multidisciplinary evaluation;
- release of information form;
- confidentiality form/record of access;
- progress record that indicates attendance, activity child involved in and response, therapist's plan, data collection and review, and reason if child is not seen;
- representative sample of child's work when appropriate;
- if appropriate, copies of communications to parents;
- LEA documentation required for Medicaid billing;
- yearly summary of progress; and
- discharge summary with reason for discharge.

SECTION III

ADMINISTRATION

Qualifications and Credentials for School-Based Therapists

Recommended:

- Membership in professional organizations
- Ability to communicate diplomatically and effectively with educational personnel, parents, and students
- Possession of supervisory and organizational skills required for delivery of physical and occupational therapy services in educational settings
- Flexibility to adapt to different settings and routines
- Interest in helping children acquire skills
- Ability to function as a member of a multidisciplinary team

Required:

- A therapist must be licensed in the State of Louisiana.^{4,9} Licensure requires successful completion of an accredited program, a passing grade on a national examination, and appropriate annual continuing education units.
- A therapist must be certified according to the Louisiana State Department of Education standards. (See below.)

Louisiana Department of Education Requirements for Occupational Therapists

Provisional Ancillary Certification (valid for 2 years; not renewable)

- Must hold a temporary license to practice occupational therapy in compliance with Title 37 of the Louisiana Revised Statutes, Chapter 39, (R.S. 37:3009) as administered by the Louisiana Board of Medical Examiners.⁹ Occupational Therapists with temporary licenses must be supervised by a licensed Occupational Therapist until receipt of the permanent license.
- Revocation, refusal to renew, or suspension of temporary license automatically and immediately suspends this provisional certificate.

Ancillary Certification (valid for 5 years; renewable)

- Must hold a valid Louisiana license to practice occupational therapy in compliance with Title 37 of the Louisiana Revised Statutes, Chapter 39, administered by the Louisiana Board of Medical Examiners⁹ and
- Must have completed two (2) years of successful work experience as an occupational therapist with children and have recommendation(s) of the employer(s).
- Revocation, refusal to renew, or suspension of a license automatically suspends this certificate.

Louisiana Department of Education Requirements for Physical Therapists

Provisional Ancillary Certification (valid for 2 years; not renewable)

- Must hold a valid Louisiana license to practice physical therapy in compliance with Title 37 of Louisiana Revised Statutes, Chapter 29, administered by the Louisiana Board of Physical Therapy.⁴

- Revocation, refusal to renew, or suspension of a license automatically suspends this certificate.

Ancillary Certification (valid for 5 years; renewable)

- Must hold a valid Louisiana license to practice physical therapy in compliance with Title 37 of the Louisiana Revised Statutes, Chapter 29, as administered by the Louisiana State Board of Physical Therapy;⁴ and
- Must have completed two (2) years of successful work experience as a physical therapist with children and have recommendations from the employer(s).
- Revocation, refusal to renew, or suspension of a license immediately suspends this certificate.

Medical Referral

Despite changes approved in the 2003 legislative session which allow limited direct access for occupational and physical therapy in certain situations, the SDE continues to require a medical referral for occupational and physical therapy in Louisiana schools. Therapists may evaluate within the school system and provide system consultation without such a referral. Referrals for school based therapy are considered current and valid for one calendar year. Surgery or other major interruptions should be followed by a new prescription regardless of time frame. Therapists should maintain communication with the referring physician as needed.

Therapists and administrators within each LEA should develop procedures to ensure the timely acquisition of initial doctor referrals and ensure that services are not interrupted due to lapsed physician referral. The LEA must begin providing services as stated on the IEP within 10 calendar days (initial IEP).¹⁴ If the referral is not received within 15 school days, the IEP team is reconvened to reconsider the need for therapeutic intervention.

Medical referral form and parent follow-up letter samples are included in this Reference Handbook.

Legal Considerations Concerning Therapists

Delegation of Tasks

Therapists provide on-site supervision to PTAs, COTAs and educators. Supervision of PTAs and COTAs within school systems involves guidance and oversight related to the delivery of services and the facilitation of professional growth and competence. It is the responsibility of the occupational therapist and the occupational therapy assistant to seek the appropriate quality and frequency of supervision to ensure safe and effective occupational therapy service delivery. The specific frequency, methods and content of supervision may vary by practice setting and are dependent upon the complexity of student needs, number and diversity of students, skills of the OT and COTA, type of practice setting, and other regulatory requirements.¹⁶ Physical therapists must be readily available to physical therapy assistants by beeper or mobile phone, evaluate and establish a written treatment plan prior to implementation of any treatment program; treat and reassess at least every sixth visit (but not less than once a month); conduct weekly face-to-face conferences with each physical therapist assistant to review progress and modification of treatment program; and assess the final treatment rendered at discharge.⁴ Recommendations offered to school personnel or parents to integrate into a special education program should be closely monitored by the therapist. Accurate records of all such recommendations must be maintained in the child's therapy notes, as well as the copy of instructions and to who delegated. Delegated tasks should be those of minimal risk for injury of the child. The specific activities delegated depend upon the therapist's judgment of the child's condition; the expertise, skill, training, and knowledge of those carrying out the activities (tasks); and the nature of the particular interventions to be delegated.

Liability (Malpractice) Insurance

Therapists are encouraged to purchase personal liability insurance (commonly referred to as malpractice insurance). The method of employment (direct vs. contractual) determines the type of liability insurance needed by the therapist. It is the responsibility of therapists to check with the

local education agency's personnel office to determine whether the school system's coverage is sufficient. Many therapists choose to buy their own individual liability policies in addition to any furnished by their school system.

Employment Arrangements, Budgeting and Funding for Therapy Services

Employment Arrangements

Therapists are employed on the basis of the number of students whose IEPs indicate the need for occupational therapy or physical therapy as a related service and the type of service needed. The following is a list of alternative employers:

Direct LEA employment

- Individual LEA employs therapist either full or part-time or
- Consortium of LEAs directly employs therapist

Contract for therapy services

- Contract with an agency
- Contract with a local rehabilitation facility or hospital
- Contract with a therapist in private practice

Contractual arrangements may include the following:

- an agreement on who will supervise the therapist;
- the qualifications of the therapist (licensed and certified);
- coordination of contracted services with educational programming to promote a multidisciplinary approach (which includes evaluation,; IEP development; collaboration with educational team, administrators and parents; provision of services as documented on IEPs; equipment ordering/fabrication; inservices to educational staff; etc.);
- accountability of the therapist to assure his/her input in IEP development and in educational record keeping;
- an agreement on the responsibility for the following:
 - equipment and space,
 - continuing education,
 - travel expenses, and
 - malpractice insurance.

Budgeting

The inclusion of occupational and/or physical therapy services in the educational setting requires more than simply budgeting hourly rates. School systems should consider the following:

- the salary and benefits of the therapist
- appropriate facilities within each school

- large enough for evaluation and treatment
- accessible to all students
- equipment and supply needs
 - specialized equipment
 - assessment tools
 - therapeutic materials
 - reference materials
- continuing education in addition to currently provided educational inservice sessions
- travel expenses according to local and state rates
- therapist access to support services
 - secretarial time
 - office facilities
 - office supplies and forms.

Funding

Funding for occupational therapy and physical therapy services may be provided through the use of the Minimum Foundation Formula (MFP), IDEA discretionary monies, and State and local funds. Local systems may form consortia in order to generate occupational therapy and physical therapy. In addition, therapists may be hired on a half-time basis.

The MFP formula determines the cost of a minimum foundation program of education in all public elementary and secondary schools and helps to allocate the funds equitably to parish and city school systems. The MFP formula also recognizes increased costs for providing special education services by placing additional funding weights on special education students. Within the MFP formula, special education teachers, therapists, paraeducators, and special education supervisors shall be used to provide services only to those exceptional students needing special education and related services or in a program approved by the State Board of Elementary and Secondary Education.

Local Policies and Procedures

Each LEA, with input from the occupational and physical therapists serving the district, should develop policies and procedures to ensure compliance and continuity regarding such areas as:

- * Recordkeeping
- * Medical Referral
- * Medicaid tracking and billing

Factors Determining Therapist Caseload

Caseload maximums are established by the *Regulations for Implementation of the Exceptional Children's Act*. The number of children serviced by individual therapists will vary according to the level of service rendered, the distance traveled between schools, and other responsibilities.

Caseloads must always include scheduling time for paperwork, meetings or staffings, lunch, evaluations/re-evaluations, consultations, and for adapting equipment.

The following are some factors determining the number of students a therapist can adequately serve.

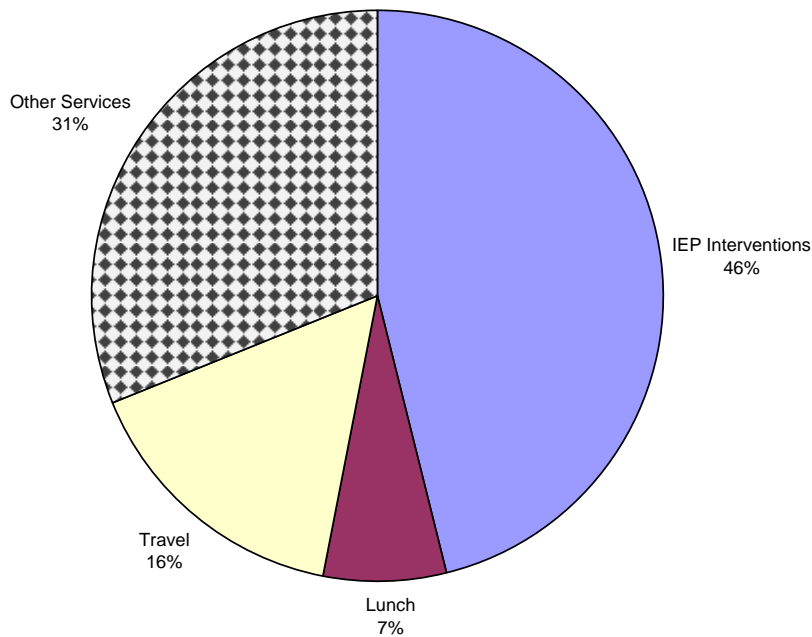
- The occupational therapy and physical therapy evaluation/assessment process is time consuming, and includes
 - testing, observing in current educational setting, scoring, report writing, and staffing;
 - teacher/parent conferences.
- The intensity of therapy service necessary to accomplish goals as determined on IEP's: the more frequent services provided, the smaller the therapist's caseload. Greater numbers of students can be served in less intensive models of delivery.
- IEP participation
- The travel time necessitated by geographical location of students;
- The amount of parental/teacher contact and training required for each student served;
- The availability of aides, assistants, or additional personnel who are needed to assist;
- The availability of treatment space, equipment, room structure and location;
- The additional responsibilities of the therapist for nontreatment activities;
 - inservice training for teachers and other educational personnel
 - system wide consultation
 - Early intervening/pre-referral strategies
 - administrative duties
 - research efforts
 - participation in continuing education
- The availability of secretarial support; and
- The experience and training of the therapist.

The caseload example on the subsequent page is based on full time employment and represents the *average* for most of Louisiana's school systems. Contract therapists working fewer hours per week, cannot be expected to provide services based on the examples given. Contracted services are dependent upon the availability of the therapist and the terms of the individual contract.

When planning a caseload for a therapist, school systems must factor in specific percentages of non treatment time. The following diagram demonstrates an average breakdown of a week for a therapist who is employed or contracted 35 hours per week and whose primary responsibility is service provision, not administration or evaluation. School systems should consider the averages outlined in the diagram to assist in determining staffing needs.

On average, full time therapists spend 46% of their time providing intervention as called for by the

Average Time for Therapists



IEP. This reflects an average of 32 thirty minute slots available for IEP services per 35 hour week. Another 31% of their time goes to participating in initial evaluations, re-evaluations, IEP meetings, constructing specialized equipment for students, consulting with system personnel, and collecting documentation required by the local school system. Most therapists are itinerant and spend 16% of their time traveling between schools for therapy services and/or meetings.

Itinerant therapists provide services to children in a wide variety of settings and locations. Students are usually served in the regular classroom or special education classroom and the therapists are required to travel from school to school. Travel time may vary depending on the demographics of the school system. Travel time may restrict itinerant therapists from serving larger numbers of students.

Itinerant therapists should be allocated time for paper work, evaluation, staffing, and meetings. The variability of the itinerants' schedules determines the amount of non-intervention time needed.

Equipment and Space

Therapists providing physical/occupational therapy services for each LEA should recommend needed equipment before it is ordered. Funding should be available to the therapists for specialized equipment and materials such as

- adaptive classroom seating, specialized work surfaces, standers, walkers, etc.;
- positioning materials such as wedges, bolsters, and mats;
- therapeutic equipment such as balls, vestibular boards, and scooter boards;
- perceptual/fine motor materials such as developmental and age appropriate toys, games, therapeutic handwriting programs, etc.;
- self-help devices such as adapted spoons, dishes, and cups;
- standardized and nonstandardized test manuals, and individual test protocols for each child tested;
- materials for fabrication of adaptive equipment such as velcro, foam, tri-wall, etc;
- resource materials.

Office space and access to office personnel and equipment (file cabinets, telephone, desks and chairs) and materials are required to complete communication and recordkeeping duties. Therapists may require access to woodworking or maintenance shops in order to construct and adapt equipment needed for student functioning within the educational environment.

Therapists provide most services within the individual child's educational environment. However, the therapists will also need access to adequate, additional space at school sites that is well lit, quiet, and accessible for individual testing.

Orientation of Therapists to the LEA

New teachers entering an LEA have a supervisor and fellow teachers who are responsible for acquainting the teacher with the organization and administrative procedures of the LEA. The schools are usually not so well prepared to orient a new occupational or physical therapist. In order to provide services which are appropriate and consistent with the educational system, the therapists must understand that system. The following is a list of subjects to be included in the orientation to the local education agency (LEA) of the occupational therapists and physical therapists.

- **Provide on-the-job orientation by an experienced school-based therapist.**
- **Provide an opportunity for the therapist to observe in a special/general education classroom.**
- **Orient the therapist to community resources relevant to children with disabilities.**
- **Provide the therapist with continuing education opportunities.**
- **Provide the therapist with copies of**
 - OT/PT in Louisiana Schools Reference Handbook
 - *Bulletin 1508 Pupil Appraisal Handbook*
 - *IEP Handbook*
 - *Bulletin 1706: Regulations for the Implementation of the Exceptional Children's Act*
 - Job description
 - LEA Personnel Handbook
 - a directory of LEA offices and schools with names of principals, addresses and phone numbers
 - the schedule of inservice education, especially those related to IEP development and evaluation procedures
 - School calendar
 - due process procedures
 - pupil appraisal forms and
 - other relevant forms and schedules
- **Inform the therapist of LEA procedures for**
 - daily attendance, itinerant sign-in at schools, request for leave
 - travel reimbursement,
 - fire drill and emergency procedures,
 - accident reports (include copy of form),
 - requisitioning materials and equipment,
 - inventory storage,
 - Medicaid billing, and
 - sending Progress Notes to parents,
 - documentation for therapists; and
 - other records and relevant procedures.

- **Introduce the therapist to**
 - the school system's special education administrative and support staff,
 - principals of schools served by therapist,
 - special education teachers and paraprofessionals,
 - evaluation coordinator and pupil appraisal staff,
 - related service personnel,
 - maintenance personnel in schools served, and
 - bus drivers involved in the transport of students with disabilities as appropriate.

Internal Monitoring

Occupational therapists and physical therapists should review their own performance each school year by peer review and/or self-evaluation. Peer review provides the opportunity for therapists to collaborate and problem solve with each other regarding evaluation and therapeutic intervention methods; monitor compliance with federal, state and local requirements; and facilitate consistency. Administrators utilizing contractual services should consult with an occupational therapist and/or physical therapist with expertise in educationally relevant therapy to assist in the review of therapy services delivered within their school system.

Internal Evaluation

The administrator should communicate with occupational and physical therapists on an ongoing basis. The issues listed below should be considered.

- *Therapy staff and resources*
 - Appropriate numbers of occupational and physical therapists are available to meet school system's need.
 - Sufficient materials and equipment are available for therapy.
 - Adequate facilities are available for therapy.
 - Therapists have other necessary resources (office secretarial support, continuing education, travel reimbursement).

- *Therapist record keeping*
 - Procedures regarding evaluations, IEP's, and confidentiality are being followed.
 - Therapists have appropriate access to records.
 - Therapists document assessments and interventions appropriately.
 - Therapists have appropriate medical information and referral.
 - Therapists maintain appropriate documentation for Medicaid billing.

- *Occupational and physical therapy services*
 - An integrated approach is used by therapists.
 - Therapists provide inservice training to family, educators, and other personnel.
 - Therapists have adequate opportunities to communicate effectively with both medical and educational personnel.

SECTION IV



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SECTION V



APPENDICES

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APPENDIX C

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THERAPY RESOURCES

Abilitations
3155 Northwoods Parkway
Norcross, GA 30071
800-850-8603
www.abilitations.com

AOTA Products
P.O. Box 0151
Annapolis Junction, MD 20701-0151
877-404-2682
www.aota.org

FlagHouse Special Populations
601 FlagHouse drive
Hasbrouck Heights, NJ 07604-3116
800-793-7900
www.flaghouse.com

Harcourt Assessment, Inc.
19500 Bulverde Road
San Antonio, TX 78259
800-211-8378
www.harcourtassessment.com

Integrations
One Sportime Way
Atlanta, GA 30340
800-850-8602
www.integrations.com

Kapable Kids
P.O. Box 250
Bohemia, NY 11716
800-356-1564
www.kapablekids.com

Kaye Products
535 Dimmocks Mill Road
Hillsborough, NC 27278
919-732-6444
www.kayeproducts.com
PDP Press
1137 N. McKusick rd. Lane
Stillwater, MN 55082
651-439-1638
www.pdppress.com

Pearson Assessment
PO Box 1416
Minneapolis, MN 55440

800-627-7271
www.pearsonassessments.com

Pocket Full of Therapy
P.O. Box 174
Morganville, NJ 07751
732-441-0404
www.pfot.com

Pro-Ed
8700 Shoal Creek Boulevard
Austin, TX 78757-6897
800-897-3202
www.proedinc.com

Psychological and Educational Publications, Inc.
P.O. Box 520
Hydesville, CA 95547
800-523-5775
www.psych-edpublications.com

Rifton
P.O. Box 260
Rifton, NY 12471-0260
800-571-8198
www.rifton.com

Sammons Preston Roylan
270 Remington Blvd., Suite C
Bolingbrook, IL 60440-3593
900-323-5547
www.sammonspreston.com

Southpaw enterprises
P.O. Box 1047
Dayton, OH 45401
800-228-1698
www.southpawenterprises.com

Therapro
225 Arlington Street
Framingham, MA 01702-8723

800-257-5376
www.theraproducts.com

Therapy Shoppe, Inc.
P.O. Box 8875
Grand Rapids, MI 49518
800-261-5590
www.therapyshoppe.com

VORT Corporation
P.O. Box 60132
Palo Alto, CA 94306
88-757-8678
www.vort.com

Louisiana Department of Education

MEDICAL REFERRAL REQUEST FOR OCCUPATIONAL/PHYSICAL THERAPY

_____ **Parish Schools**

Your child is currently eligible to receive occupational/physical therapy in accordance with his/her IEP. A physician's referral/order is required for intervention to ___ begin or ___ continue. Please provide the following information so that we may contact your child's physician to obtain the referral/order.

Student's Name _____ Student's DOB _____

Physician's Name _____ Telephone _____ Fax _____
Please print

Parent Name _____
Please print

Parent Telephone _____

Signature _____ Date _____

(This signature grants permission for release of information to/from physician and therapist relevant to my child's needs in the educational setting.)

Medical Section (to be completed by the physician)

___OT ___PT services have been included in the above named child's individualized education program (IEP). The parent/guardian has given permission for the service and to contact you for the referral. Should you agree with this recommendation, please complete this referral form within 10 working days so that we may begin his/her program of intervention.

Diagnosis _____

Medications _____

Precautions: ___ Seizure Activity _____
___ Past Surgeries (please describe) _____
___ Allergies _____
___ Shunt _____
___ Other (please describe) _____

The above named student has my permission to participate in the school program of occupational and/or physical therapy.

Physician's Name _____ Physician's ID Number _____
Please print

Physician's Signature _____ Date: _____

Please fax this referral to: Name: _____

Fax #: _____

FORM A 2006

_____ Parish Schools
Occupational/Physical Therapy Department

Student: _____ Date: _____

Dear Parent:

Your child is currently eligible to receive ___ occupational and/or ___ physical therapy services in accordance with his/her IEP. Therapy services cannot begin/continue without the physician's referral/order. We do not have a referral order for the following reason(s):

___ The physician denied the order because your child has not been seen recently.

___ The physician denied the order because your child is no longer a patient.

___ The physician did not return the referral form after repeated requests.

___ _____

other

Attached you will find another copy of the medical referral request which must be signed by the physician. Please contact your child's physician at your earliest convenience. If the attached referral is not received in this office by _____, your child's IEP team will be reconvened to reconsider the need for therapeutic intervention.

If you have questions please call _____ at _____.

Thank you.

FORM B 2006

**INSTRUCTIONS FOR
SECURING PHYSICIAN'S REFERRAL/ORDERS
FOR OT OR PT IN THE EDUCATIONAL SETTING**

Process:

1. Medical Referral Request (A) is signed by the parent at the IEP meeting (unless a referral is provided at the time of the meeting).
2. Referral request (A) is forwarded to the physician by the LEA (fax or mail).
3. If the referral request is not signed and returned within 10 school days, a follow up phone call is made to identify reason.
4. Form letter (B) indicating reason is mailed to parent. Another copy of the medical referral request (A) is attached.
5. If the referral request (A) is not returned within 15 school days, the IEP team is re convened to reconsider the need for therapeutic intervention.

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Louisiana Task Force of Occupational Therapy and Physical Therapy in the Schools

Original Writing Team

Judeyanne Coudrain, LOTR

Ida Richards, LOTR

Lisa Veron, PT

Carolyn Watson, LOTR

Gisa Hill, LOTR

Kim Vitrano, LOTR

Kathy Rodrique, LOTR

Elizabeth Ford, PT

Dawn Tregre, PT

Connie Keppinger, LOTR

Janet Parker, PT

Patricia Hooper, PT

Janice Fruge', OT/PT Liaison

Division of Educational Improvement and Assistance