Saint Elizabeth
Well beyond health care

Occupational Therapy Infant and Toddler Assessment Form

Client Name _____ Date of Birth (dd/mm/yyyy) _____ Gender: ☐ Male ☐ Female

Reason for Referral: _____

Parent/Substitute Decision Maker name & contact info: _____

Primary Physician & contact info: _____

Therapist Name and Designation _____

Funder/Referral Source: ☐ LHIN ☐ Self-Pay ☐ Other _____

Hand hygiene completed in front of parent/caregiver:
☐yes, at beginning of session ☐yes, at end of session

☐ File reviewed ☐ Consent to Assess obtained ☐ Client Bill of Rights Reviewed ☐ OT Role explained ☐ Informed Consent Process Followed
☐ Consent to collect/disclose information reviewed & obtained ☐ Reason for referral reviewed with parent/legal guardian ERL code: _____ Not Assigned _____
☐ Two identifiers were used to confirm client's identity: ☐Client Name ☐parent/guardian verification ☐Other:

Parent Interview (What is the most important goal I can help you with?)

☐ Refer to progress note/checklist for more details

Parent Goals:

Diagnosis/Significant Medical History

☐ See referral/file for details

(hospitalizations, illnesses, surgery dates/purpose/outcomes, history of respiratory illness, ear infections, frequent colds, GERD, asthma, vomiting, etc.)

Planned Surgeries, Procedures, Medical Visits:

Current Weight/ Percentile (check chart/RD notes/nursing notes) _____

Corrected Age (DOB vs. Due date) _____ ☐ N/A

Medications: ☐no meds or N/A ☐more than 5 meds ☐meds change in past 3 months ☐more than 2 prescribers
☐ if yes to more than two above questions, parent was directed to review meds with their child's physician or pharmacist ☐Yes ☐No
Meds: ☐ parent provided a list of meds

Community Connections: Are joint visits indicated? ☐ Yes ☐ No Details:
☐ N/A ☐ Children's Treatment Centre ☐ Infant Development Program ☐ Private Therapy ☐ Feeding/Swallowing Clinic
☐ Other (specify) _____ Details: _____

Other Persons Involved in Client's Care:
☐ Nurse ☐ Speech Language Pathologist ☐ Physiotherapist ☐ Registered Dietician ☐ Other

Communication ☐ N/A ☐ English as a Second Language Parent has concerns about their child's communication? ☐ Yes ☐ No
Details:

Family Life (parent info, siblings, alternative living arrangements, etc):

_____	_____	_____	_____
Therapist Name, Designation	Initials	Signature	Date (dd/mm/yy)

Saint Elizabeth
Well beyond health care

Occupational Therapy Infant and Toddler Assessment Form

Client Name: **Date of Birth (dd/mm/yy):**

Feeding Status ☐ N/A ☐ if complex, see OT Infant Feeding Assessment Form

Formula &/or Diet _____

Daily Schedule: Sleep/wake _____
Eat _____
Play _____
Other

Evidence of Plagiocephaly ☐ N/A ☐ No ☐ Yes Details:_____

Evidence of Torticollis ☐ N/A ☐ No ☐ Yes Details: _____

Observations of Positioning, Movement, Infant Interactions with Caregivers and Environment:

Summary of Motor Skills ☐ N/A ☐ Refer to Development Checklist

Does parent have concerns about child meeting motor &/or developmental milestones? ☐ Yes ☐ No
Details:

	Not Assessed	WNL	Further Ax Needed	**Details:** Specify possible functional implications, limitations
Asymmetry in Movement &/or Interaction				
Muscle Tone				
Range of Motion				
Strength				
Postural Control				
Skin Health (history, issues impacting skin breakdown)				Is the client at risk of skin breakdown? ☐ no ☐ yes If yes, Pediatric Braden Q Score: Details:

Pain ☐ N/A Does the parent feel that the child is in pain? ☐ Yes ☐ No
Details:

Sensory, Self-Regulation, Emotional Health ☐ N/A ☐ Assess at later date

Observation or Report	Details	
Difficulty calming		☐ Assess further
Difficulty alerting/engaging		☐ Assess further
Child often crying &/or irritable		☐ Assess further
Sensitivities (tactile, noise, etc.)		☐ Assess further
Parent/Caregiver having difficulty with attachment with child		☐ Assess further
Parent having difficulty coping		☐ Assess further

Occupational Therapy Infant and Toddler Assessment Form

Client Name: **Date of Birth (dd/mm/yy):**

Current Equipment (for positioning, interaction, safety, etc.)

Sleeping _____

Play/awake times _____

Toys _____

Eating _____

Mobility _____

Travel (car seat, etc.) _____

Recommendations for Equipment Needed/to be Trialed:

Home Accessibility & Safety ☐ N/A

	N/A	Accessible	Problem &/or Safety Concern	Comments
Enter/Exit Home				
Emergency Exit Plan				
Bedroom				
Bathroom				
Yard				
Kitchen				
Living spaces				

Identify concerns with: ☐unsanitary conditions ☐pets ☐falls/injury ☐child access to unsafe items ☐other

Transition Planning ☐ N/A (will client/family be or has client been experiencing important or potentially difficult life transitions or transitions in care?)

☐ Transitions in care providers: specify _____ ☐ Transition to home from hospital care

☐ **Life transitions:** _____ ☐ Change in living arrangement, specify: _____

☐ Significant recent change in medical status, specify _____

Details about changes and/or strategies to help with transitions:

Ethnic, Spiritual, Linguistic, Values, Beliefs or Cultural Requests:

Additional Assessment Details:

Initials _____ Date (dd/mm/yy) _____

Saint Elizabeth
Well beyond health care

Occupational Therapy Infant and Toddler Assessment Form

Client Name:	**Date of Birth (dd/mm/yy):**

SUMMARY & CLINICAL IMPRESSION

Clinical resources therapist will use to develop intervention plan:
☐ Therapist Past Clinical Experience ☐ Research ☐ Best Practice Guidelines ☐ Practice Resources/Handouts ☐ Clinical Leadership Support
☐ Teamwork ☐ Other:_____

PLAN	**Check "yes"**	**DETAILS/GOAL**
If treatment plan is detailed in another report – specify:		
Equipment Needed		
Parent/Caregiver Training		
Environmental Modification		
Direct Intervention		
Parent Engagement &/or Meeting		
Client Advocacy		
Team Meeting		
Provide/Link with Resources		
Other		

Possible Barriers to Achievement of Goals: ☐ N/A ☐ Service Category Limitations ☐ Funding Limitations
☐ Lack of Support ☐ Lack of consent ☐ Difficulty engaging caregivers
☐ Caregiver preferences are different than proposed plan of care ☐ Other:_____
Details:

Informed Consent
Informed consent to treatment/plan of Care has been initiated with family: ☐ Yes ☐ No
Goals and Plan developed with input from family: ☐ Yes ☐ No: If no, why not?_____
Has the care plan been reviewed with the parents? ☐ Y ☐ N ☐ N/A
Risks and benefits of intervention explained to client/family: ☐ Yes ☐ No

Service Model
Possible Service Category:_____ Number of visits available per service plan: _____
☐ Consultation ☐ Training ☐ Direct Intervention ☐ Combination Care Plan will meet funder service plan: ☐ Yes ☐ No ☐ N/A

Discharge planning discussion was initiated with parent/s: ☐ Yes ☐ No

Additional Details:

Saint Elizabeth
Well beyond health care

Occupational Therapy Infant and Toddler Assessment Form

Client Name: _____ Date of Birth (dd/mm/yy):_____

DEVELOPMENTAL MILESTONES - USE CORRECTED AGE	Yes	No	Comments
Birth to 3 months			
• Smiles			
• Holds head at midline without support			
• By 3 months, begins to raise head and chest when lying on tummy			
• Begins to grasp objects			
• Can visually track objects to midline			
• Evidence of head support with pull to sit (head lag ends)			
By 6 months			
• Babbles and laughs, tries to imitate sounds			
• Purposeful grasp of objects			
• Able to grasp and play with feet			
• Rolls from tummy to back			
• Rolls from back to tummy			
• Moves objects from one hand to the other			
• Brings hands to midline to grasp toy or clasp hands			
• Beginning to respond to own name			
By 9 months			
• Sits without support			
• Able to "rake" using fingers to grasp small objects			
• Able to bring finger and thumb together			
By 12 months			
• Able to transition from floor to sit independently			
• Crawls well			
• Kneels			
• Some babies pulling to stand at furniture			
• Some babies "cruising" along furniture			
• Some babies beginning to walk without support			
• Says at least one word			
By 18 months			
• Walks independently			
• Attempts at meaningful vocalization and/or communication			
• Drinks from a cup			
• Walks well			
• Will attempt stairs, running, etc.			
By 2 years			
• Runs			
• Speaks in two-word sentences			
• Follows simple instructions			
• Begins make-believe play			
By 3 years			
• Climbs well			
• Speaks in multiword sentences			
• Sorts objects by shape and colour			
• Rides a tricycle			