Evaluation / Consult Intake Data Sheet

DATE: ____________________

Child's Name: ____

Age: ____

DOB: ____

Diagnosis: ____

Parent(s)/Guardian(s) Name: ______________________________________

Referred by: ____

Phone Numbers: ____

Email Address: ____

Mailing Address: ____

____

Interested in a 45-minute consultation or the 2-hour full evaluation: _______________

Availability during the week? ____

Why are you seeking OT services? What are your primary concerns?

____

____

Will you be seeking reimbursement from (1) insurance or the (2) school district for an Individualized Education Evaluation (IEE)?

If yes….

1. Insurance Provider: ____
   a. Member ID: ____

2. Individualized Education Evaluation Information (IEE)

School District: ____

School Address: __________________________________

Teacher/School Contact:______________

School Observation: Y_N_ Date: _______________

Internal Checklist

Therapist assigned to Client___________________________

Confirmation Email Sent ___ DATE ______

Client info added to Acuity Scheduler____ Zoho Invoice_____

Intake Forms Sent_____ DATE ______

1. Background History/FIQ
2. Fee Schedule
3. Clinic Health and Safety Guidelines
4. Consent Forms
5. COVID Waiver
6. Credit Card Authorization

Questionnaires Provided

1. ABAS (Age 5-21) Home / Teacher
    a. Age 0-5 Home
    b. Age 2-5 Teacher
2. SPM Home / Classroom
    a. SPM-P (Age 2-5) Home / Classroom
3. BRIEF Home / Teacher
4. DP3
5. Sensory Profile (Age 0-3)