Limitless
Pediatric Solutions
www.limitlesspeds.com (843)706-9367

SCREENING REQUEST FORM

Child's Name:_____ Date of Birth:_____

Address:_____

_____

Phone:_____Parent/Guardian Name:_____

Child's Pediatrician:_____ Insurance:_____

Attends School:___yes___no, If yes, Name of School:_____

Check all Areas Requesting to be Assessed:

OCCUPATIONAL THERAPY

Fine Motor Skills:___ (grasp, holding marker or spoon, cutting, manipulating buttons)

Visual Motor Skills:___ (puzzles, blocks, mazes)

Social/Play Skills:___ (avoids play with others, avoids exploring toys, difficulty using toys appropriately i.e. mouths, throws or lines up toys)

Daily Living Skills:___(dressing, feeding, sleeping)

Sensory Processing: ___Self-Regulation (tantrums, negative behaviors, poor transitions)
___Hyperresponsive: (dislikes certain sounds and textures, picky eater)
___Hyporesponsive: (clumsy, "on the go", poor safety awareness)

PHYSICAL THERAPY

Gross Motor Skills:___ (walking, throwing, jumping, weak core, w-sits)

Balance:___(trips, falls frequently, clumsy)

Coordination:___(difficulty getting on and off surfaces or up and down from surfaces, poor navigating environment independently)

SPEECH THERAPY

Articulation:___(difficulty to understand, poor pronouncing of sounds)

Feeding:___(dislikes eating, only eats soft foods, picky eater, poor chewing, pockets food in mouth, over stuffs mouth)

Fluency and Stuttering:___ (repeats words, says words over and over)

Language:___(not talking, very few words).

___Receptive: (doesn't understand what is being said)

___ Expressive: (unable to express wants or needs)

Complete form and email to limitlesspeds.com or mail to 128 Colvin Dr. Bluffton SC 29909
If you have questions and/or concerns you can always call (843) 706-9367.

Parent Guardian Signature:_____Date:_____

I give permission to Limitless Pediatric Solutions, LLC to share the screening findings with my child's pediatrician___yes___no and school ___yes___no.

Parent Guardian Signature:_____Date:_____