Intervention Priority Rating

Child's Name: _____ **Referral Date:** _____ **Date:** _____ **Therapist:** _____
Referred By: _____ **For: OT PT SLP OTHER** _____
Reason for Referral: _____

Assign Value 0-3 for Each Area	0	1	2	3	Total Value
Consider referral issue and need for immediate intervention.	Child does not require intervention or is ineligible	Timing of Intervention is not critical for the child. May be chronic condition.	Child needs to be seen as soon as possible but not necessarily immediately.	Child requires immediate intervention.	
Consider impact of health condition on child's activity participation.	No impact	Minimal impact	Impact evident in some but not all aspects of life	Significantly impacts on all aspects of life	
Child and family reaction to referral issue/health condition.	Not concerned	Somewhat concerned	Noticeably concerned	Extremely concerned	
Child's motivation toward intervention.	Not motivated	Questionable Motivation	Motivated	Highly motivated	
Support offered by family/school/agencies/other	Extensive support	Adequate support	Limited support	No support system	
Effect of other health issues on referral issue.	None	Minimal impact	Noticeable impact	Significant impact	
Factor Total/Urgency Rating:					
Intervention Priority **(Circle One)**	No service initiated.	By date of referral	Fast track	***Urgent***	