**Helping Hands Screening Tool**

Helping Hands addresses the ongoing health needs of Special Olympics athletes with a special focus on developing hand skills, play, and self-help abilities. During these screenings, OT practitioners and OT/OTA students conduct observations and converse with children, parents, and others about skills that may be necessary for children to have to participate in sports and other activities required for occupational performance. The focus on the screening process is prevention and early detection in challenges. The screening may also help to identify a need for referral for OT services and as a platform or process to educate parents and others about OT-related skills.

**Directions:** Respond “yes” or “no” to each of the items below.. Based on the child’s age, check if they are able to complete the task or if the behavior describes them. If they cannot, leave the box blank.

* **Name of Child:**
* **Age of Child:**
* **Was the child born pre-term (before 37 weeks gestation)?**
* **Which hand do they show dominance towards (if any)?**
* **Does your child have an IEP from school?**
* **Is your child currently receiving OT services at school and/or in a clinic or have they gotten OT services in the past?**

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| Skills | Age/Skill Level |
| --- | --- |
| Young Athletes | Sport Team Athletes |
| 3-5 years old, preschool age | 5-7 years old, early elementary school age | 8-10 years old, upper elementary school age |
| Fine Motor Skills |
| Does the child pick up small items by using the tips of their thumb and index finger as if they are pinching?  |  |  |  |
| Can the child turn over a coin from head to tail without swiping the coin off on the edge of a table or desk? |  |  |  |
| Have you noticed the child using both hands to complete some tasks? |  |  |  |
| Can the child open jars or other types of lids? |  |  |  |
| Handwriting Readiness and Writing Skills |
| Can the child color within the lines of a basic shape? |  |  |  |
| Can the child copy the letters in their first and last name from an example? |  |  |  |
| Can the child print first and last name within the lines on lined paper? |  |  |  |
| Can the child cut paper along a straight line with scissors? |  |  |  |
| Can the child flip over a pencil to have the pencil tip and then the eraser pointed down, using just one hand? |  |  |  |
| Can the child squeeze a drop of glue from a glue bottle? |  |  |  |
| Can the child remove and replace the top of something small like a glue stick? |  |  |  |
| Dressing/clothing management |
| Can the child tie their shoes? |  |  |  |
| Can the child manage buttons, snaps, and zippers on coats and jackets? |  |  |  |
| Can the child dress/undress themselves? |  |  |  |
| Can the child put on/carry a backpack? |  |  |  |
| Can the child put on/remove shoes? |  |  |  |
| Visual Skills |
| Can the child find a toy on a shelf or in a toybox, an item in a backpack, or a specific piece of clothing in a closet or drawer? |  |  |  |
| Is the child able to use their eyes to visually track to follow a moving object? |  |  |  |
| Does the reach for and pick up an item without knocking other things over in the process? |  |  |  |
| Does the child demonstrate an interest in books?  |  |  |  |
| Is the child able to read at age level? |  |  |  |
| Is the child able to print letters of the alphabet without reversals/writing the letters backwards? |  |  |  |
| Sensory Processing  |
| Does the child prefer/seek out OR try to avoid certain textures, sounds, sights, tastes, scents, positions, or movements? |  |  |  |
| Does the child have difficulty calming down at times - more often than you expect?  |  |  |  |
| Is the child drawn to OR so they try to avoid specific repetitive motions or activities involving movement (like riding in a car)? |  |  |  |
| Does the child seem to notice when they fall and get hurt?  |  |  |  |
| Feeding  |
| Does your child have issues with choking, gagging, or coughing during a meal/feeding? |  |  |  |
| Does your child avoid a certain texture or nutrition group? (examples: avoids wet textures, won’t eat any fruits or vegetables, etc.) |  |  |  |
| Does your child demonstrate any behaviors associated with feeding/mealtimes that concern you? (examples: putting too much food in mouth, holding food in mouth, throwing food on the floor, etc.)  |  |  |  |
| Can the child feed him/herself? Use utensils? Finger feed? |  |  |  |
| Daily Routines |
| Does the child struggle to participate in family or individual routines (waking, getting ready, meals, leisure, outings, sleep)? |  |  |  |
| Does the child have a consistent sleep routine? |  |  |  |
| Does your child have difficulties with changes in routine or transitions to new activities/environments? |  |  |  |
| Toileting/Hygiene |
| Does the child indicate the need for toileting? |  |  |  |
| Can the child manage their own clothing during the toileting routine? |  |  |  |
| Can the child manage necessary hygiene during toileting? |  |  |  |
| Can the child turn on water, get soap, rub hands together, turn off water and dry hands? |  |  |  |
| Does the child have difficulty brushing teeth or hair? |  |  |  |
| Social Participation  |
| Does the child have difficulty taking turns in either play or conversation? |  |  |  |
| Does the child struggle to use appropriate body language with peers (i.e., standing too close/too far, does not maintain eye contact/stares fixedly, does not read facial cues, etc.)? |  |  |  |
| Does the child always play alone or struggle to make friends? |  |  |  |
| Does the child have trouble in social situations such as holiday get-togethers, birthday parties, or classroom free time? |  |  |  |

**Comment section: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Internal Memo:

Equipment and supplies needed to conduct these screenings, with a quantity based on 100 athletes:

* Pencils
* Crayons or markers
* Paper (lined and unlined)
* Scissors (child-sized) - standard and lefty
* Utensils
* Ziplock bags, tupperware containers, jars with lids
* Glue stick and glue bottle
* Playground ball
* Coins

**Helping Hands Occupational Therapy Referral Form**

**Demographic Information**

Name (first and last): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of screening: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for recommendation for evaluation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Screener’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_