



## MONONGALIA COUNTY SCHOOLS MOTOR TEAM

Westover Annex  
200 West Park Avenue  
Westover, WV 26501

Phone: (304) 291-9288 ext. 1710  
Fax: (304) 291-9311

Welcome to the Motor Team. We are a group of Physical Therapists, Occupational Therapists, and an Adapted Physical Educator.

The purpose of this packet is to provide you will all the information for the Motor Team Referral Process for IEP students, SAT/504 students, and transfer students.

Our team currently consists of the following:

Physical Therapists:	John Patti	<a href="mailto:jpatti@k12.wv.us">jpatti@k12.wv.us</a> 304-841-3161
	Lisa Ammons	<a href="mailto:lrammons@k12.wv.us">lrammons@k12.wv.us</a> 304-216-8967
Occupational Therapists:	Breanne Oleksa	<a href="mailto:boleksa@k12.wv.us">boleksa@k12.wv.us</a> 304-319-2642
	Paula Sisler	<a href="mailto:psisler@k12.wv.us">psisler@k12.wv.us</a> 304-288-8573 or 376-4007
	Alex Boyles	<a href="mailto:aboyles@k12.wv.us">aboyles@k12.wv.us</a> 304-476-2793
Adapted Physical Educator:	Lorri Lipscomb	<a href="mailto:llipscom@k12.wv.us">llipscom@k12.wv.us</a> 304-216-7865

If, at any time, you have questions about your student's therapy program, please don't hesitate to contact your student's therapists/ service provider. Educating your students is a team effort and we look forward to working with you. Our office phone number is 304-291-9288 ext. 1710. Phone messages are checked on Fridays. To contact staff more rapidly, please refer to the above e-mail addresses and phone numbers. The phone numbers are for **internal use only** (since they are our private cell phone numbers) and we would appreciate it that our phone numbers not be given to parents.

# Monongalia County Schools Motor Team Referral Process

## For Students with an Existing IEP (PreK – 12)

### At IEP

- Motor Team Referral Process Explanation provided
- A signed Notice of Individual Evaluation/Reevaluation Request by the parent (please specify whether evaluation(s) is for PT/OT/APE when checking Motor Skills)
- Signed Release of Information Form with Physician contact information provided

The following items are collected and forwarded to the Motor Team (Please do not attempt to give this information to a Motor Team Member)  
Attn: John Patti (Westover Annex)

- A copy of the Notice of Individual Evaluation/Reevaluation Request
- A signed Physician Release of Information form from Parent
- A copy of the Tracking Form

### Following the Evaluations,

- An Evaluation Response Memo will be sent/email from John Patti
- An IEP meeting is scheduled with the evaluating PT/OT/APE personnel

# Monongalia County Schools Motor Team Referral Process

## For Students being referred via SAT or 504 Process

### At SAT/504

- Motor Team Referral Process Explanation provided
- A copy of the signed Informed Consent for SAT evaluation(s)
- Signed Release of Information Form with Physician contact information provided

The following items are collected and forwarded to the Motor Team (Please do not attempt to give this information to a Motor Team Member)  
Attn: John Patti (Westover Annex)

- A copy of the Informed Consent for SAT evaluation
- A signed Physician Release of Information from Parent
- A copy of the SAT/504 Referral Cover page

### Following the Evaluations,

- An Evaluation Response Memo will be sent/email from John Patti
- A SAT/504 meeting is scheduled with the Evaluating PT/OT/APE personnel

## Monongalia County Schools Motor Team Referral Process For Students Transferring into Monongalia County Schools

Special Education Specialist/ Special Education Teacher is to:

- Notify John Patti of student transferring
- Forward/ FAX the copy of the student's existing IEP to the Motor Team

John will:

- Log the transfer student's information
- Contact the appropriate Motor team member who will service that transferring student

For the PWN the Motor Team Member(s) will:

- Write up a word document that contains:
  - The present levels with the following: Student name, transfer from (location), student is currently receiving (PT/OT/APE) for the following reasons (will list.....) Example attached
- We will treat the student for 30 minutes 2x within the next 30 days to determine appropriate present levels, needs, frequency, and goals
- We will fax/email the word document to the attending IEP Specialist

- Within the 30 day time frame, an IEP will need to be scheduled to review our findings

Student's Full Name Student name

Date \_\_\_\_\_

## PART VII: PRESENT LEVELS OF ACADEMIC ACHIEVEMENT AND FUNCTIONAL PERFORMANCE

**SAMPLE WRITE UP**

\_\_\_\_\_ is a transfer student from \_\_\_\_\_. \_\_\_\_\_ was receiving occupational therapy services two times a month for a total of 60 minutes per month with the focus on fine motor skills and visual motor skills needed for legible writing and self-care skills. Per the previous OT report: \_\_\_\_\_ has met the objective to tie a bow and is independent in tying his shoes. (S)He uses scissors to cut out intricate shapes with accuracy and colors within small spaces with accuracy. \_\_\_\_\_ demonstrates the ability to produce legible writing with size functional for space provided when working one to one or in a small OT group. Letter formation has improved. (S)He continues to have some difficulty with keeping his/her letters on the bottom line.

Time: two 30 minutes sessions within one month

Goal: Given appropriate instruction and equipment, \_\_\_\_\_ will safely access his school environment, 100% of the time. Therapy progress notes, teacher report, quarterly progress reports.

# NOTICE OF INDIVIDUAL EVALUATION REEVALUATION REQUEST

Monongalia County Schools

Student's Full Name \_\_\_\_\_  
School \_\_\_\_\_  
Parent(s) Guardian(s) \_\_\_\_\_  
Address \_\_\_\_\_  
City State \_\_\_\_\_

Date \_\_\_\_\_  
DOB \_\_\_\_\_  
Grade \_\_\_\_\_  
WVEIS= \_\_\_\_\_  
Telephone \_\_\_\_\_

INITIAL

REEVALUATION

OTHER \_\_\_\_\_

Dear Parent(s) Adult Student:

Your permission is requested to conduct an evaluation to determine the student's educational needs. If the student has been receiving special education services, a reevaluation is required at least every three years or more frequently, if warranted. Upon completion of the evaluation, a meeting will be scheduled to discuss the evaluation results.

This evaluation will be conducted by qualified professionals and will include the areas checked below. A written description of each evaluation component is provided. The evaluation results will be used as the primary source to determine the student's eligibility for special education and related services and/or to adjust the student's educational services.

- |                                                           |                                                      |                                                                                     |
|-----------------------------------------------------------|------------------------------------------------------|-------------------------------------------------------------------------------------|
| <input type="checkbox"/> Academic Information             | <input type="checkbox"/> Developmental Skills        | <input type="checkbox"/> Transition Assessments                                     |
| <input type="checkbox"/> Achievement                      | <input type="checkbox"/> Health _____                | <input type="checkbox"/> Functional Vocational Evaluation                           |
| <input type="checkbox"/> Classroom Performance            | <input type="checkbox"/> Hearing                     | <input type="checkbox"/> Vocational Aptitudes                                       |
| <input type="checkbox"/> Teacher Report                   | <input type="checkbox"/> Information from the Parent | <input type="checkbox"/> Interests Preferences                                      |
| <input type="checkbox"/> Adaptive Skills                  | <input type="checkbox"/> Intellectual Ability        | <input type="checkbox"/> Vision                                                     |
| <input type="checkbox"/> Assistive Technology             | <input type="checkbox"/> Motor Skills                | <b>NOTE: Please specify PT, OT, and/or APE evaluation(s) beside "Motor Skills".</b> |
| <input type="checkbox"/> Behavioral Performance           | <input type="checkbox"/> Observation(s)              |                                                                                     |
| <input type="checkbox"/> Functional Behavioral Assessment | <input type="checkbox"/> Perceptual-Motor            |                                                                                     |
| <input type="checkbox"/> Communication                    | <input type="checkbox"/> Social Skills               |                                                                                     |

- Procedural Safeguards Brochure explaining parent student rights and the responsibilities of the county school district is enclosed for an initial referral.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

I have read, or had read to me, the above Notice of Individual Evaluation Reevaluation Request regarding the student. I understand the contents and implications of this notice and have been advised of my rights.

Check one:

- I give permission to evaluate/reevaluate.  
 I wish to schedule a conference before I decide.  
 Do not evaluate/reevaluate the student.

\_\_\_\_\_  
Parent/Adult Student Signature

\_\_\_\_\_  
Date

**\* REQUIRED \***  
Received by school/county:

\_\_\_\_\_  
Date

\_\_\_\_\_  
Personnel

Please return this signed form within 5 days and retain a copy for your records

## Informed Consent for SAT Evaluations

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

School: \_\_\_\_\_ Teacher: \_\_\_\_\_

Dear Parent:

As the result of a Student Assistance Team meeting, it is recommended your child be administered one or more screening instruments designed to measure academic achievement, ability, and/or behavior functioning. Parent is advised the purpose of these evaluations is not to determine eligibility for special education related services but to gather additional evaluative information in order to make more objective informed decisions in regard to possible interventions, instruction, behavior planning, need of further evaluation monitoring, and/or need for a multidisciplinary evaluation to explore possible special education eligibility. Parent is also advised of the right to request a multidisciplinary evaluation regardless of this request and/or following any screening evaluations. All evaluation results, findings or plans resulting from these evaluation will be provided to the parent/guardian.

Consent is being requested to complete the following marked items:

<b>Intelligence:</b> <input type="checkbox"/> Kaufman Brief Intelligence Test-2 <input type="checkbox"/> Other:	<b>Rating Scales:</b> <input type="checkbox"/> Conners' Rating Scales <input type="checkbox"/> Brown ADD Scales <input type="checkbox"/> BASC-2 <input type="checkbox"/> Other:
<b>Achievement:</b> <input type="checkbox"/> KTEA <input type="checkbox"/> Key Math <input type="checkbox"/> TOWL <input type="checkbox"/> Other:	<b>Behavior:</b> <input type="checkbox"/> Behavior Intervention Plan <input type="checkbox"/> Functional Behavior Assessment (FBA) <input type="checkbox"/> Classroom Observation <input type="checkbox"/> Other:
<b>Fine Motor (Specify):</b> <input type="checkbox"/> Occupational Therapy Evaluation, including a teacher referral report	<b>Gross Motor (Specify)</b> <input type="checkbox"/> Physical Therapy Evaluation, including a teacher referral report
<b>Other (Specify):</b> <b>NOTE: If APE evaluation is requested, specify in this section.</b>	

Please check one:

\_\_\_\_\_ I have read the above information, and I give my consent for evaluation

\_\_\_\_\_ I have read the above information, and I do not give my consent

\_\_\_\_\_ I have read the above information, and I would like to have a conference before making a decision

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# 504 Consent Form

## Notice of Individual Evaluation /Reevaluation Request

### Monongalia County Schools

Student: \_\_\_\_\_ Date: \_\_\_\_\_  
School: \_\_\_\_\_ Grade: \_\_\_\_\_  
Teacher: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ WVEIS #: \_\_\_\_\_  
City/State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Telephone: \_\_\_\_\_

#### Dear Parent(s) Guardian/Adult Student:

Your permission is requested to conduct an evaluation to determine your student's educational needs and make more informed decisions and plans to meet your child's needs. If your child has not been deemed eligible for 504, the evaluation might be utilized to determine 504 eligibility and develop an appropriate Accommodation Plan for your child. If your child already has a 504 Plan, the evaluation information might be utilized to continue, discontinue their eligibility and/or to improve their current plan.

<input type="checkbox"/> Classroom Performance	<input type="checkbox"/> Interests/Preferences	<input type="checkbox"/> Adaptive Functioning
<input type="checkbox"/> Assistive Technology	<input type="checkbox"/> Auditory Processing	<input type="checkbox"/> Functional Behavior FBA
<input type="checkbox"/> Developmental Skills	<input type="checkbox"/> Intellectual Ability	<input type="checkbox"/> Perceptual/Motor
<input type="checkbox"/> Behavior Functioning	<input type="checkbox"/> Behavior Intervention Plan	<input type="checkbox"/> Observation(s)
<input type="checkbox"/> Social Skills	<input type="checkbox"/> Teacher Report	<input type="checkbox"/> Vocational Aptitude

Academic Achievement—Specify: \_\_\_\_\_

Developmental History (Parent Questionnaire)

Occupational Therapy Evaluation, including teacher referral report

Physical Therapy Evaluation, including teacher referral report

Health—Specify: \_\_\_\_\_

Vision/Hearing—Specify: \_\_\_\_\_

Other—Please specify: \_\_\_\_\_

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\_\_\_\_\_  
Monongalia County Schools Notice of Parent/Student Rights in Identification, Evaluation, and Placement Explanation has been provided in regard to Section 504 of Rehabilitation Act of 1973.

I give permission to evaluate \_\_\_\_\_ Parent Signature

I wish to schedule a conference before I decide.

Do not evaluate my child \_\_\_\_\_ Date:



Monongalia County Schools  
13 South High Street, Morgantown, WV 26501  
(304) 291-2766  
Consent to Release Information

\_\_\_\_\_  
(FULL NAME OF STUDENT) (DATE OF BIRTH) (TELEPHONE NUMBER)

\_\_\_\_\_  
(STREET ADDRESS) (CITY, STATE, ZIP CODE)

**MEDICAL HISTORY:** \_\_\_\_\_

\_\_\_\_\_  
MEDICAL DIAGNOSIS \_\_\_\_\_

\_\_\_\_\_  
THERAPY HISTORY: \_\_\_\_\_

*Authorization to Release & Obtain Information*

*As parent or legal guardian of the above student, I grant permission for Monongalia County Schools (MCS) to obtain and/or release information regarding my son/daughter from the school, department, agency, or person identified below. This information may be shared with any MCS employee involved in providing services for him/her. I understand the purpose and intent of this release is to obtain and share information in order to provide coordinated services for my son/daughter. This request shall remain in effect for one full year (365 days) from the date of the signature unless revoked in writing. A copy or FAX of this release shall be as binding as the original.*

\_\_\_\_\_  
Primary Care Provider Phone/FAX number

\_\_\_\_\_  
Orthopedic Physician Phone/FAX number

\_\_\_\_\_  
Neurologist Phone/FAX number

\_\_\_\_\_  
Orthotist Phone/FAX number

\_\_\_\_\_  
Rehabilitation Technology Specialist Phone/FAX number

\_\_\_\_\_  
SIGNATURE OF STUDENT IF 18 YEARS OLD DATE

\_\_\_\_\_  
SIGNATURE OF PARENT/GUARDIAN IF DATE  
STUDENT IS UNDER 18 YEARS OLD



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# Memo

**To:** \_\_\_\_\_  
**From:** John M. Patti, DPT  
**Date:** \_\_\_\_\_  
**Re:** \_\_\_\_\_

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The following evaluations have been completed:

- \_\_\_\_\_ Physical Therapy
- \_\_\_\_\_ Occupational Therapy
- \_\_\_\_\_ Adapted Physical Education

\*Please schedule follow up as needed. Please contact and notify the evaluating Motor Team therapist prior to scheduling the EC/IEP/SAT/504 Meeting. **The evaluating therapist must be present at the meeting to present and interpret the evaluation.**

### E-mails (Physical Therapy evaluations):

John Patti: [jpatti@k12.wv.us](mailto:jpatti@k12.wv.us)

Lisa Ammons: [lrammons@k12.wv.us](mailto:lrammons@k12.wv.us)

### E-mails (Occupational Therapy evaluations):

Breanne Oleksa: [boleksa@k12.wv.us](mailto:boleksa@k12.wv.us)

Paula Sisler: [psisler@k12.wv.us](mailto:psisler@k12.wv.us)

Alex Boyles: [abovles@k12.wv.us](mailto:abovles@k12.wv.us)

### E-mails (Adapted Physical Education evaluations):

Lorri Lipscomb: [llipscom@k12.wv.us](mailto:llipscom@k12.wv.us)