UPSTATE MUSIC THERAPY CENTER LLC
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MUSIC THERAPY REFERRAL CHECKLIST

NAME: _____

DATE OF BIRTH: _____

SCHOOL/CENTER: _____

INDIVIDUAL COMPLETING CHECKLIST (Relationship to child/student & phone #)_____

_____

The following questions should be answered prior to requesting a music therapy evaluation.

Has the child/student shown limited progress considering the level of his/her disability, toward meeting educational goals? (check the correct response) _____ yes _____no

USUALLY	SOMETIMES	RARELY	
_____	_____	_____	**Does the child/student show an increase in attending when music is used?**
_____	_____	_____	**Can the child/student be motivated to <u>attempt</u> tasks by the use of music?**
_____	_____	_____	**Can the child/student be motivated to <u>complete</u> tasks by the use of music?**
_____	_____	_____	**Does the child/student retain information conveyed in songs more easily than conveyed in spoken interchange?**

Does the child/student belong to one of the disability categories for which there is strong research basis suggesting that music therapy is one of the more effective interventions?

Autism Spectrum _____ TBI _____ Pre-school Child with Disabilities_____

Multiple Disabilities _____ Intellectual Disability_____ Williams Syndrome_____

Down Syndrome _____ Hearing Impaired_____ Speech Delays_____ Apraxia_____

IF THE ANSWERS TO THE PRIOR QUESTIONS ARE PRIMARILY "USUALLY" A REFERRAL SHOULD BE COMPLETED FOR A MUSIC THERAPY ASSESSMENT TO BE ADMINISTERED. (Please complete the assessment referral form)