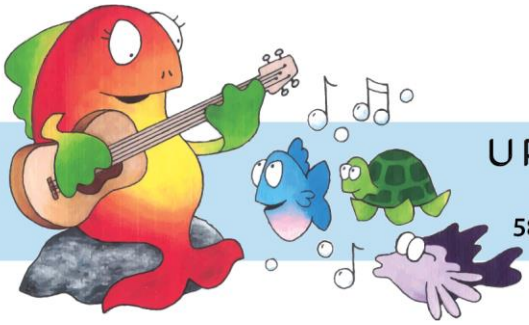


UPSTATE MUSIC THERAPY CENTER LLC
401 Penbrooke Drive • Bldg. #3, Suite SE • Penfield, NY 14526
585.377.1000 • amy@upstatemtc.com • www.upstatemusictherapy4kids.com

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 assessment.

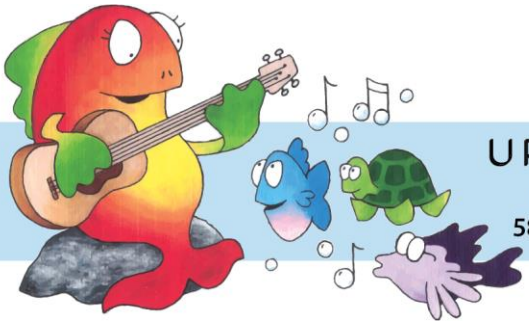
Has the child/student shown limited progress considering the level of his/her disability, toward meeting developmental/educational goals? (check the correct response) _____ yes _____ no

Has the child/student been observed engaging at a higher level in an environment when music is present? (check the correct response) _____ yes _____ no

USUALLY	SOMETIMES	RARELY	(CHECK ANY THAT APPLY)
_____	_____	_____	**Does the child/student show an increase in attending when music is used?**
_____	_____	_____	**Does the child/student produce more verbalizations or vocal sounds when singing versus when speaking?**
_____	_____	_____	**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?**

Please also complete the Music Therapy Assessment Referral Form

The American Music Therapy Association (AMTA) site www.musictherapy.org provides links to research and supporting articles related to Music Therapy with children and teens.



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MUSIC THERAPY ASSESSMENT
REFERRAL FORM

Name of Child _____ D.O.B. _____

Referral Date _____ Disability(s) _____

Name of Center Based Program _____

Contact _____ Phone_____

Parent Name(s) _____

Address _____

Phone: Home _____ Work _____ Cell _____

School District _____

List the primary and secondary areas of needs for this child/student:

Primary: _____

Secondary: _____

List therapies that the child/student is currently receiving:

_____

Physical or Behavioral Limitations: (that will limit the child during the evaluation, eg. vision, hearing, motoric, medical, sensory)

_____

_____

_____

Mode of Communication (eg. switches, Dynavox, sign language, vocalizations, picture symbols, gestures, body movement, word combination, complete sentences)

_____

_____

_____

List all observed significant responses to music

_____

_____

_____

Contact person/teacher & phone number for scheduling evaluation

_____

The most recent IEP must accompany this form.
When completed, please return to:
Amy Thomas, LCAT, MT-BC – Director amy@upstatemtc.com