

**ASSISTIVE TECHNOLOGY SERVICE REFERRAL FORM**

Please complete all questions (use additional sheets if required)

Incomplete forms may not be processed

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| --- | --- |
| **Are two person visits recommended for this patient** | **No/Yes** |

**Patient Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Title: | Mr/Mrs/Miss |
| Address: |  | DOB: |  |
| Postcode: |  | NHS Number: |  |
| Tel Home: |  | Ethnicity: |  |
| Tel Mobile: |  | Email: |  |

**GP Details**

|  |  |  |  |
| --- | --- | --- | --- |
| GP Name: |  | CCG: |  |
| GP Address: |  | GP  Postcode: |  |

**Referrer Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Referred by: |  | Profession: |  |
| Address: |  | Telephone: |  |
| Email: |  | Working days: |  |

**Other Professionals Involved**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Profession** | **Address** | **Telephone** |
|  |  |  |  |

**Diagnosis** *(include date of onset if known)*

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|  |

**Functional Ability**

*(Please give as much information as possible)*

|  |  |
| --- | --- |
| **Control of Movement** |  |
| Head |  |
| Trunk |  |
| Arms |  |
| Hands |  |
| Legs |  |
| Feet |  |
| Vision and Hearing |  |
| Cognitive Ability |  |
| Psychological/behavioural |  |
| Speech/communication  *(AAC device in situ or referral placed to an AAC Hub)* |  |

**Accommodation**

*(detailing type of dwelling, whether adapted etc)*

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| --- |
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**Care Arrangement**

*(Details, dependency, informal/formal care, times alone etc)*

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**Environmental Controls**

*What does the patient want to control with environmental control equipment?*

***(Please note the service does not provide window, curtain or door openers. We are also unable to provide voice activated equipment or mainstream equipment such as the Amazon Echo)***

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**Computer Access** *(if relevant to referral)*

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| What computer does the patient currently have? *Laptop/Desktop/Tablet*  What operating system? *Windows/Mac/Linux* |

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| Does the patient know how to use a computer? If not what support do they have to learn?  Is the patient currently able to use a computer?  How does the patient currently access the computer?  What is the computer used for? What would the patient like to use the computer for? |

**Any other relevant information**

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| --- |
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|  |  |
| --- | --- |
| **Any risks/hazard in the home environment** |  |
| **Has the patient consented to the referral** | Yes/No |
| **Has the patient consented to this referral being shared with other relevant health professionals/agencies** | Yes/No |

|  |
| --- |
| **Signature of referrer:**  **Designation: Date:** |

|  |  |
| --- | --- |
| **Please return to:**  Clare Oakley (Service Lead)  **Email:** [**clare.oakley@stgeorges.nhs.uk**](mailto:clare.oakley@stgeorges.nhs.uk)  or clare.oakley1@nhs.net | **Tel:** 020 8487 6027 |
| Please observe confidentiality guidelines with regard to sending client information. |
|  | |

Referral Form – Updated June 2019