**ASSISTIVE TECHNOLOGY SERVICE REFERRAL FORM**

**Incomplete forms will not be accepted and may delay the assessment process.**

**Please note: prior to submitting this referral, please confirm that the patient meets the eligibility criteria for Environmental Controls (EC) listed below.**

* Profound and potentially complex physical disability, such that they are unable to operate standard controls for functioning independently in the home (for example, a TV remote).
* Cognitively and physically able to operate EC equipment consistently.
* Able to demonstrate sustained motivation to use the EC equipment.
* Individuals requiring multiple control functions integrated into a single means of access and for whom multiple devices, each with separate function are inappropriate.
* Where individuals have a variable condition (for example, a progressive neurological condition), the above criteria can be applied with regard to the person’s anticipated needs and abilities within a clinically appropriate time period. Referrals can be accepted on this basis.

**Please read through the exclusion criteria prior to submission below:**

* Where the intention for the equipment is for critical care needs, emergency purposes, or nurse calls.
* Where non-specialist solutions to the identified needs of the patient are available and appropriate for the individual (for example, Amazon Alexa).
* The individual patient does not have the cognitive ability or motivation to learn to operate the EC equipment. This shall normally be established through a period of trial of some sample solution of equipment.
* Provision of equipment is inappropriate due to social environmental, or other circumstances.
* Where the referred need is for equipment primarily for educational, communication, or employment/ “Access to Work” requirement.

**Please be aware we do not provide the following:**

* Voice-activated equipment
* Door openers, window openers, curtain/blind openers, or electronic door-locking devices
* Access to gaming
* Access to overhead lighting

|  |
| --- |
| **PATIENT INFORMATION** |
| Title |  |
| Full Name |  |
| Date of Birth |  |
| NHS No. |  |
| Address |  |
| Postcode |  |
| Property Type + Ownership |  |
| Tel |  |
| Email |  |
| Ethnicity |  |
| Patient’s first language |  |
| **Are two person visits recommended for this patient? Please include information of any risks/hazards in the home.**  | Yes / No |
| Is there a requirement for an interpreter during the assessment? If ‘Yes’, please include the language required.  | Yes / No |
| Are there any special instructions for gaining access to the property (e.g keysafe code)? |  |
| Are there **any** **known safeguarding** issues with this patient? |  |
| Please provide Next Of Kin (NOK) details for this client (including name, relationship to client, contact details, any power of attorney arrangements that are in place)  |  |

|  |
| --- |
| **GP DETAILS** |
| GP Name |  |
| GP Address |  |
| GP Postcode |  |
| CCG |  |

|  |
| --- |
| **REFERRER DETAILS** |
| Referrer Name |  |
| Referrer Address |  |
| Referrer Contact Details |  |
| Referrer Working Hours |  |
| Do you wish to be present for the assessment if possible? | Yes / No |

|  |
| --- |
| **OTHER PROFESSIONALS INVOLVED** |
| Name | Profession | Address | Telephone |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |
| --- |
| **DIAGNOSIS INFORMATION** |
| Primary Diagnosis |  |
| Date of onset (if known) |  |
| Other diagnoses |  |
| Transfer Method |  |
| Is the patient invasively or non-invasively ventilated? Please give times and details when ventilation is used. | Yes / No |

|  |
| --- |
| **FUNCTIONAL ABILITY***Please be as detailed as possible, as this helps the assessment process and ensure provision is granted as quickly as possible.* |
| **Head/Neck -** available range of movement, etc. |
|  |
| **Upper Limbs -** hand function, grip strength, dexterity, reach, etc. |
|  |
| **Lower Limbs -** mobility, strength, etc. |
|  |
| **Vision and Hearing -** hearing aids, double vision, nystagmus etc. |
|  |
| **Cognitive Ability -** any difficulties that could affect assessment e.g memory, concentration, comprehension, ability to learn, problem solving, etc. |
|  |
| **Behavioural & Psychological Factors -** any information we should be aware of for the assessment e.g if client can be aggressive/easily irritated, mental health concerns, etc. |
|  |
| **Communication –** any AAC used, if they are known to a speech service, etc. |
|  |

|  |
| --- |
| **Does the client’s functional ability vary throughout the day?** |
|  |
| **Has the client experienced a change or decline in function within the past two months? Please provide details.**  |
|  |

|  |
| --- |
| **ENVIROMENTAL FACTORS** |
| **Accommodation** |
| Please detail the type of dwelling & which floor the client lives on.*
 |
| Are there any adaptations to the property?*
 |
| Is there level access?*
 |
| **Care Arrangements** |
| Please describe any care in place, both formal and informal. *
 |
| Does the client spend any portions of the day alone? |
| **Daily Routine** |
| Which room does the client spend most of the day in? Do they spend most of their day in bed/riser recliner/comfy chair?*
 |
| Do they have any regular appointments or outings that we should be aware of? (e.g day centre, respite, etc)*
 |
| **Mobility** |
| How does the client move around, both inside and outside? Please give as much detail as possible, e.g powered or manual wheelchair, type of walking aid, etc. *
 |
| If the client has a powered wheelchair, how is the chair controlled? (e.g joystick/switch etc)*
 |

|  |
| --- |
| **ENVIRONMENTAL CONTROLS** |
| Please provide details on what the client would like to access with environmental controls. *
 |
| Is the client familiar with technology at all?*
 |
| Do they have anyone that could support them with technology?*
 |

|  |
| --- |
| **COMPUTER ACCESS***Only complete this section if you are requesting a computer access referral as part of the assessment. If you would only like environmental controls to be assessed, you can leave this blank.* |
| What devices does the patient currently have? (Including computers, laptops, tablets, phone). Please list the make, model, and operating system.  |
| What would the patient like to use the computer for? |
| Is there any specific or specialist software they are interested in using? (e.g Photoshop, accounting software, video editing, art software, etc) |

|  |
| --- |
| **ANY OTHER INFORMATION** |
|  |

|  |  |
| --- | --- |
| Has the patient consented to the referral? | Yes / No |
| Has the patient consented to this referral being shared with other relevant health professionals or agencies? | Yes / No |
| Referrer Signature + Date |  |
| **Please return to:**Clare Oakley (Service Lead)**Email:** supportAT@stgeorges.nhs.uk**Tel**: 020 8487 6027*Please observe confidentiality guidelines with regard to sending client information.* |