CRC Central Remedial Clinic

Assistive Technology & Specialised Seating (ATSS)

ATSS Referral Form

REFERRAL CRITERIA

SCAN ME

Section 1: Client Details

Please complete all required fields marked with an asterisk (*)

1.1 Client's Personal Details:

dd/mm/yyyy

Surname:*		First name:*		DOB:*	
Address:*				Eircode:*	
Phone #1:		Phone #2:		Email:	
Medical Card No. / Long-Term Illness (LTI) No.:*				Expiry Date:	
Has client given consent for this referral?*	◯ Yes ◯ No			1st language:	English
				Interpreter required?	◯ Yes ◉ No

1.2 Key Contact Person / Guardian / Next of Kin:

Surname:		First name:		Relationship:	Please select
Address:				Eircode:	
Phone #1:		Phone #2:		Email:	

Section 2: Referrer Details

2.1 Referrer Details: (Person who is referring the Client)

Surname:		First name:		Role:	
Address:				Email:	
Phone #1:		Phone #2:		Referral Date:	

Section 3: Medical Information

3.1 Medical Details:

Primary Diagnosis:	Select or enter diagnosis
Additional relevant medical / surgical information:	
Relevant Medication: *Include medications that may have an impact on mobility, comfort, or require consideration for assistive technology due to side effects such as drowsiness.*	

Section 4: Reason for Referral

Assistive Technology (AT):

- ☐ Access to Technology Assessment *(eg, eyegaze / switch)*
- ☐ Alternative & Augmentative Communication *(AAC)*
- ☐ Alternative Methods of Driving Power Wheelchairs
- ☐ Environmental Independence Technology

☐ Phone Consult — *provide details of consult request*

Specialised Seating:

- ☐ Activity Chair Assessment
- ☐ Buggy Assessment
- ☐ Manual Wheelchair Assessment
- ☐ Manual Wheelchair Review
- ☐ Power Wheelchair Assessment
- ☐ Power Wheelchair Review
- ☐ Pressure / Skin Integrity Concerns
- ☐ Specialised Comfort Seating
- ☐ Specialised Moulded Seating
- ☐ Specialised Seating Support

Section 5: Goal Identification (What difficulties are being experienced, that you are hoping we can help to address?)

1.	
2.	
3.	

Section 6: Mobility Devices - Currently in Use

6.1 **Manual Wheelchair Details:** (Current equipment details)

Not Applicable

6.2 **Power Wheelchair Details:** (Current equipment details)

Not Applicable

6.3 **Details of other equipment used:**

Not Applicable

Section 7: Current Assistive Technology (AT) Devices

Not Applicable

Section 8: Functional Information

Not Applicable

8.4 **Sensory & Cognitive:**

Vision: Are there any concerns?		**Hearing:** Are there any concerns?	

Has the client a learning disability?	◯ No ◯ Mild ◯ Moderate ◯ Severe ◯ Profound ◯ Unknown

Section 9: Communication Information

Not Applicable

Section 10: Team Details

Professional	Name	Location	Tel No.	Email
Care Facility / School				
Doctor				
Occupational Therapist				
Physiotherapist				
Speech & Language Therapist				
Other				
Other				

Section 11: Any Other Relevant Information

Is there any other information that you feel is relevant prior to our first appointment with this client?

Kindly submit the completed form to our ATSS Referral Team via one of the following methods:

Email: **atssreferrals@crc.ie** or Postal Address: **ATSS, CRC, Vernon Avenue, Clontarf, Dublin 3, Ireland, D03 R973**

ADMIN ONLY SECTION

Referral Status: ◯ Pending ◯ Approved ◯ Rejected

Follow-up Action: --- Select Follow-Up Action ---

Comments:

Internal Notes:

Clear Form