

Assistive Technology & Specialised Seating (ATSS) ATSS Referral Form



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?*		<input type="radio"/> Yes <input type="radio"/> No		
		1 st language:		
		Interpreter required? <input type="radio"/> Yes <input type="radio"/> No		
1.2 Key Contact Person / Guardian / Next of Kin:				
Surname:	First name:	Relationship:		
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:	
Additional relevant medical / surgical information:	
Relevant Medication: <i>Include medications that may have an impact on mobility, comfort, or require consideration for assistive technology due to side effects such as drowsiness.</i>	

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)

Make & Model:		Backrest:	<input type="checkbox"/> Standard	Specify:
Size:			<input type="checkbox"/> Custom	
Date Issued:			<input type="checkbox"/> Other	
Self-Propel: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Sometimes <input type="radio"/> Power-Assist		Cushion:	<input type="checkbox"/> Standard	Specify:
			<input type="checkbox"/> Custom	
		<input type="checkbox"/> Other		
Accessories:	<input type="checkbox"/> Anti-Tippers	<input type="checkbox"/> Footplates / Legrests	<input type="checkbox"/> Specialist Wheels / Tyres	
	<input type="checkbox"/> Armrests / Armpads	<input type="checkbox"/> Headrests & Neck Supports	<input type="checkbox"/> Tilt-in-Space Seating System	
	<input type="checkbox"/> AAC Device Mounts	<input type="checkbox"/> Oxygen Tank Holders	<input type="checkbox"/> Trays & Tables	
	<input type="checkbox"/> Cup Holders	<input type="checkbox"/> Lights	<input type="checkbox"/> Wheel Locks or Brakes	
	<input type="checkbox"/> Custom Upholstery / Padding	<input type="checkbox"/> Seat Belts / Harnesses	<input type="checkbox"/> Other (please specify below)	
	additional information			

6.2 Power Wheelchair Details: (Current equipment details)

Make & Model:		Backrest:	<input type="checkbox"/> Standard	Specify:
Size:			<input type="checkbox"/> Custom	
Date Issued:			<input type="checkbox"/> Other	
Type of Controller:		Cushion:	<input type="checkbox"/> Standard	Specify:
			<input type="checkbox"/> Custom	
		<input type="checkbox"/> Other		
Accessories:	<input type="checkbox"/> AAC Device Mounts	<input type="checkbox"/> EC Interfaces	<input type="checkbox"/> Power Tilt	
	<input type="checkbox"/> Alternative Drive Controls (e.g., head arrays, switch controls)	<input type="checkbox"/> Footplates / Legrests	<input type="checkbox"/> Seat Belts / Harnesses	
	<input type="checkbox"/> Anti-Tippers	<input type="checkbox"/> Headrests & Neck Supports	<input type="checkbox"/> Specialty Seat Options (e.g., ventilated or pressure-relief seats, WheelAir etc.)	
	<input type="checkbox"/> Armrests	<input type="checkbox"/> Oxygen Tank Holders	<input type="checkbox"/> Specialty Wheels & Tyres (for outdoor or off-road use)	
	<input type="checkbox"/> Attendant Controls	<input type="checkbox"/> Power Elevated Legrests	<input type="checkbox"/> Other (please specify below)	
	<input type="checkbox"/> Cup Holders	<input type="checkbox"/> Power Recline		
	additional information			

Has power mobility training taken place in the past? No Yes

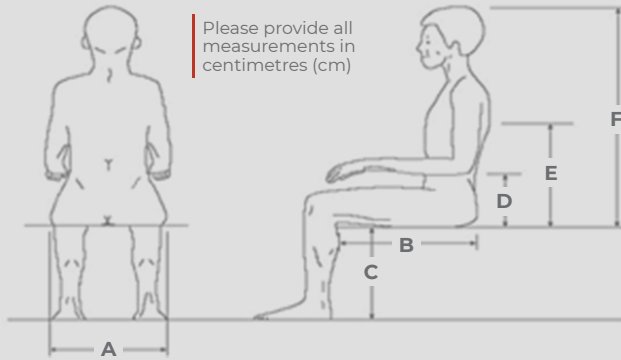
6.3 Details of other equipment used:

Are daily environments accessible? <small>(e.g. turning space, narrow doorways, steps)</small>

Section 7: Current Assistive Technology (AT) Devices

Upper Limb Function: <input type="radio"/> Good <input type="radio"/> Limited <input type="radio"/> Absent	Dominant Side:
Hand Function: <input type="radio"/> Full Function <input type="radio"/> Limited Function <input type="radio"/> No Function	Switch Location:
List any AT equipment currently being used:	

Section 8: Functional Information

Level of sitting support required: <input type="checkbox"/> Minimum <input type="checkbox"/> Moderate <input type="checkbox"/> Maximum												
8.1 Measurements: (for guidance only) <table border="1"> <tr><td>A Hip width</td><td></td></tr> <tr><td>B Seat depth</td><td></td></tr> <tr><td>C Seat to footplate height</td><td></td></tr> <tr><td>D Seat to armrest height</td><td></td></tr> <tr><td>E Backrest height (seat to inferior angle of scapula)</td><td></td></tr> <tr><td>F Seat to head height</td><td></td></tr> </table>	A Hip width		B Seat depth		C Seat to footplate height		D Seat to armrest height		E Backrest height (seat to inferior angle of scapula)		F Seat to head height	
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 <p>Please provide all measurements in centimetres (cm)</p>												
8.2 Physical: (specify & provide detail) <table border="1"> <tr><td>Is there abnormal tone?</td><td></td></tr> <tr><td>Are there significant postural asymmetries?</td><td></td></tr> <tr><td>Is there a history of pressure injuries?</td><td></td></tr> </table>	Is there abnormal tone?		Are there significant postural asymmetries?		Is there a history of pressure injuries?							
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8.3 Feeding & Nutrition: <table border="1"> <tr> <td>Feeding: Are there any concerns?</td> <td>Weight Trend: <input type="checkbox"/> Stable <input type="checkbox"/> Upward <input type="checkbox"/> Downward</td> </tr> </table>	Feeding: Are there any concerns?	Weight Trend: <input type="checkbox"/> Stable <input type="checkbox"/> Upward <input type="checkbox"/> Downward										
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8.4 Sensory & Cognitive: <table border="1"> <tr> <td>Vision: Are there any concerns?</td> <td>Hearing: Are there any concerns?</td> </tr> <tr> <td colspan="2">Has the client a learning disability? <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe <input type="radio"/> Profound <input type="radio"/> Unknown</td> </tr> </table>	Vision: Are there any concerns?	Hearing: Are there any concerns?	Has the client a learning disability? <input type="radio"/> No <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe <input type="radio"/> Profound <input type="radio"/> Unknown									
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Section 9: Communication Information

Difficulties with communication? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Sometimes	Verbal Communication: <input type="checkbox"/> Fully intelligible <input type="checkbox"/> Intelligible to familiar people only <input type="checkbox"/> Unintelligible													
List the client's current methods of communication:														
Regarding literacy skills, please select any applicable challenges your client may experience. <table border="1"> <tr> <td><input type="checkbox"/> Fully literate</td> <td><input type="checkbox"/> Limited writing skills</td> </tr> <tr> <td><input type="checkbox"/> Dyslexia</td> <td><input type="checkbox"/> No functional literacy skills</td> </tr> <tr> <td><input type="checkbox"/> Limited reading comprehension</td> <td><input type="checkbox"/> Other (Please specify below)</td> </tr> <tr> <td colspan="2"><input type="text"/></td> </tr> </table>	<input type="checkbox"/> Fully literate	<input type="checkbox"/> Limited writing skills	<input type="checkbox"/> Dyslexia	<input type="checkbox"/> No functional literacy skills	<input type="checkbox"/> Limited reading comprehension	<input type="checkbox"/> Other (Please specify below)	<input type="text"/>		Which of the following does the client currently use? <table border="1"> <tr><td><input type="checkbox"/> Object Level</td></tr> <tr><td><input type="checkbox"/> Photos of Objects</td></tr> <tr><td><input type="checkbox"/> Picture Symbols</td></tr> <tr><td><input type="checkbox"/> Alphabet</td></tr> <tr><td><input type="checkbox"/> Unsure</td></tr> </table>	<input type="checkbox"/> Object Level	<input type="checkbox"/> Photos of Objects	<input type="checkbox"/> Picture Symbols	<input type="checkbox"/> Alphabet	<input type="checkbox"/> Unsure
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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



Postal Address:

ATSS, CRC, Vernon Avenue, Clontarf, Dublin 3, Ireland, D03 R973

ADMIN ONLY SECTION

Referral Status:	<input type="radio"/> Pending <input type="radio"/> Approved <input type="radio"/> Rejected	Follow-up Action:	
Comments:		Internal Notes:	