Central Remedial Clinic
Assistive Technology and Specialised Seating Department

External Referral Form

Section 1: Client details		
Surname:	**Forename:**	**Date of Birth:**
Eircode:		**Address:**
Phone No 1 :	**Phone No 2:**	**email:**
Medical Card No:	**Expiry date:**	**LTI No:**
Consent given for This Referral? Yes ☐ No ☐	**First Language:** Interpreter Required? Yes ☐ No ☐	

Key Contact Person/ Next of Kin		
Surname:	**Forename:**	**Relationship to client:**
Address:		
Phone No 1:	**Phone No 2:**	**email:**

Section 2 : Referrer Details		
Surname:	**Forename:**	**Profession:**
Address:		**Email:**
Phone No 1:	**Phone No 2:**	**Referral Date:**

Section 3 : Medical Information
Primary Diagnosis:
Additional Relevant Medical/Surgical Information:
Medication:
Additional Infection Controls Required: No ☐ Yes☐ Please detail:

Section 4 : Reason for Referral	
☐ **Specialised Seating Support** ☐ **Manual Wheelchair Assessment** ☐ **Manual Wheelchair Review** ☐ **Power Wheelchair Assessment** ☐ **Power Wheelchair Review** ☐ **Specialised Comfort Seating** ☐ **Activity Chair Assessment** ☐ **Buggy Assessment**	☐ **Pressure/Skin Integrity Concerns** ☐ **Access to Technology Assessment (e.g. Eyegaze/ Switch)** ☐ **Alternative and Augmentative Communication (AAC)** ☐ **Environmental Independence Technology** ☐ **Alternative Methods of Driving Power Wheelchairs** ☐ **Phone Consult regarding:**

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	
Manual wheelchair make & model: Size: Date Issued: Self Propel: Yes ☐ No ☐ Sometimes ☐	Backrest: Cushion: Accessories:
Power wheelchair make & model: Date Issued: Type of Controller:	Backrest: Cushion: Accessories:
Details of other equipment trialled? Has power mobility training taken place in the past? Are Daily Environments Accessible?	

Section 7: Assistive Technology Devices	
Upper Limb Function: Good ☐ Limited ☐ Absent ☐ Dominant Side:	
Direct Access (e.g. Hand): Yes ☐ No ☐	**Where Are the Switches Located?**
Visual Aids Used:	**Joystick/Mouse Alternative** (Name)**:**
Eyegaze System (Name):	**Details of Any Other Equipment Trialled:**

Section 8 : Functional Information	
Measurements (for guidance only) Hip width: Seat depth:	**Level of Sitting Support required:** Min ☐ Moderate ☐ Maximum ☐
Is there abnormal tone? Detail;	
Are there significant postural assymetries? Detail;	
Is there a history of pressure injuries? Detail;	
Feeding: Are there any concerns?	**Weight Trend:** Stable ☐ Upward ☐ Downward ☐
Vision: Are there any concerns?	**Hearing:** Are there any concerns?
Cognitive: Has the client a learning disability? No ☐ Mild ☐ Moderate ☐ Severe ☐ Profound ☐ Unknown ☐	

Section 10: Communication:
Does the client have any difficulties in the area of communication? Yes ☐ No ☐ Sometimes ☐ **Methods of Communication:**
Verbal: Fully Intelligible ☐ Intelligible to Familiar People only ☐ Unintelligible ☐
Written:
What is the client's highest level of symbol recognition? Imaging ☐ Object level ☐ Photos of objects ☐ Picture symbols ☐ Alphabet ☐
Does the client currently have a communication system? Detail;
Please identify communication partners:

Section 11 : Team Details				
Professional	**Name**	**Location**	**Tel No.**	**Email**
Occ. Therapist				
Physiotherapist				
S&L Therapist				
Psychologist				
G.P.				
PA/Carer				
School				
Care Facility				

Section 12: Additional Information:
Is there any other information that you feel is relevant to our first appointment with this client? Attachments (if applicable):