BC Children's Hospital
4500 Oak Street, Vancouver, BC V6H 3N1

Phone: 604-875-2345
Toll Free: 1-888-300-3088
Fax: 604-453-8321

THERAPIST REFERRAL FORM for ASSISTIVE TECHNOLOGY TEAM (ATT) SERVICES
NEUROMOTOR PROGRAM

Date of Referral: ____________________

The Sunny Hill Assistive Technology team (ATT) provides services to children birth to 19 years with developmental and/or Neuromotor disabilities.

We provide consultation/ assessment services for children who meet the criteria below:

- ☐ The community team has new questions that they cannot address
- ☐ The child is followed by a community therapist team
  - ☐ Speech Language Pathologist (SLP) ☐ Occupational Therapist (OT) ☐ Physiotherapist (PT)

Please check all that apply:

- ☐ The child is nonspeaking or speaking only a few words
- ☐ The child has limited physical ability to play with toys or access technology
- ☐ The child has computer access challenges
- ☐ The child has power mobility issues

Services may be provided in-person, by telephone or virtually.

❖ Note: The AT Team does not provide ongoing therapy. Children will only be seen for repeat visits if they have new needs or if the family/community team have new questions.

If this form is not completely filled out and signed by the legal guardian, it will not be processed and will be returned to the referral source.

CHILD'S NAME: ____________________

Birthdate: (day/ month/ year)____________ Gender:__________ PHN:____________

Address:____________________ City:____________ Postal code:__________

Home Phone:(________)____________________ Work Phone: (________)____________________

Email Address: ____________________

Child lives with: Mother____________ Father____________ Foster Family____________

Legal Guardian Name(s):____________________ Phone: (________)__________

Legal Guardian Address:____________________ City:__________ Postal code:__________

Language:____________________ Interpreter needed? ☐ Yes ☐ No

Is Legal Guardian aware of therapist's referral for SHHC service? ☐ Yes ☐ No

Primary Care Physician:(Print Name) ____________________ Physician is aware of therapist's referral? ☐ Yes ☐ No

Address:____________________ City:____________ Postal code:__________

Office Phone:(________)____________________ Fax number: (________)____________________

REFERRING THERAPIST: (Print Name) ____________________ Title: ☐ SLP ☐ OT ☐ PT

REFERRING THERAPIST SIGNATURE: ____________________

Facility Name: ____________________

Address:____________________ City:____________ Postal Code:__________

Office Phone:(______)____________________ Email Address:____________________

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THERAPIST REFERRAL FORM for ASSISTIVE TECHNOLOGY TEAM (ATT) SERVICES NEUROMOTOR PROGRAM

Date of Referral: ____________________

Please indicate the ATT specialized services being requested:

☐ Augmentation communication assessment
☐ Access assessment (method of using technology for play, computer, communication devices, i.e. switches, joysticks, eye-gaze etc.)
☐ Power mobility (ability to drive a power wheelchair)
☐ Written output assessment
☐ Other (please describe) ____

What are your therapy goals for this child?

What is your question to ATT?

Child's current and/or working diagnosis:

☐ **PLEASE ATTACH A COPY OF ALL PERTINENT CONSULTS, REPORTS AND MEDICAL INVESTIGATIONS**

Please describe any problems related to:

☐ Hearing ____

☐ Vision ____

☐ Behaviour ____

☐ General Health ____

Does child attend daycare / preschool / school?
☐ Yes, please provide name of school: ____
☐ No

If child is attending school, what therapies are involved?
☐ Speech Language Pathologist ☐ Occupational Therapist ☐ Physiotherapist ☐ Resource Teacher

Has a referral to SET BC been made?
☐ Yes, what was the outcome? ____
☐ No

SERVICES CURRENTLY RECEIVING:

COMMUNITY SERVICES	NAME	TELEPHONE NUMBER	EMAIL ADDRESS
Speech Language Pathologist			
Occupational Therapist			
Physiotherapist			
Teacher			
Other			

Is the child on a waitlist for the above services?
☐ Yes, please list____
☐ No

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NEUROMOTOR PROGRAM

Date of Referral: ____________________

What kind of expressive communication does the child currently use: (check all that apply)

Verbal Speech: ☐ No words yet ☐ Single words ☐ 2 word phrases ☐ 3+ word phrases

Emotional response: ☐ Crying ☐ Facial expressions

Gestures / Behaviours: ☐ Looking ☐ Reach/Grab ☐ Pointing

Other: please explain ____

Does the child have cause and effect? ☐ Yes ☐ No
Can the child understand yes/no questions? ☐ Yes ☐ No
Can the child communicate yes/no responses? ☐ Yes ☐ No
Can the child follow a one-step direction? ☐ Yes ☐ No
Does the child understand their name? ☐ Yes ☐ No

What type of AAC interventions have been tried? Please explain.

☐ Sign language ____

☐ Picture symbols (i.e. communication books, core board) ____

☐ Picture exchange communication (i.e. PECS) ____

☐ Communication device (i.e.big mac, go talk, etran, iPad) ____

☐ Others ____

Is child ambulatory? ☐ Yes ☐ No

Does the child have seating and mobility devices? (check all that apply)
☐ Wheelchair
☐ Walker
☐ Standing Frame
☐ Supportive Seating System
☐ Tray

Hand Dominance: ☐ Right ☐ Left ☐ Unestablished yet

Is the child able to point?

☐ Yes ☐ No, please describe the child's hand / arm movements ____

____

Have any switches been trialed?

☐ Yes ☐ No

Please describe ____

____

Is the child able to (check all that apply):

☐ Grasp objects ☐ Release objects ☐ Manipulate objects ☐ Write with a pen/pencil ☐ Use touch screen devices

Activities the child likes: ____

____

____

Activities the child does not like: ____

____

____

Date of Referral: ____________________

Parent / Legal Guardian consent:

Email Acknowledgement

At times our team uses email to share information with clients. We will share information with you by email if you give us permission to do so. Your health information is private and personal and there are some risks to sending this information by email.
Some of these risks are:

- Once an email message is sent we can't guarantee who will be able to see it.
- We will double-check that the email address you give us is right but sometimes we may make a mistake and the message could be sent to the wrong person.
- We recommended that you delete emails you get from us. Sometimes, even if you delete emails, backup copies may exist on your computer or in cyberspace.
- Someone could hack your email account and look at your private information.
- We don't check our email account everyday so if you need help right away, you must call Neuromotor Program (NMP) at 604-875-2345.
- We have no way of knowing if you have read the email we sent to you.
- It is your responsibility to let us know if your email address changes.
- It is your responsibility to let us know if you no longer want to receive your information from us by email.

If you have read and understand these risks, please check the "I Agree" box below.
If you have questions about this email acknowledgement, please call Neuromotor Program (NMP) at 604-875-2345 between 9:00 AM and 4:00 PM Monday to Friday.

☐ I Agree.

Personal Information Collection

I hereby authorize the sharing of information to/from the above community therapists / services to/from Neuromotor Program (NMP), Sunny Hill Health Centre. Personal information is collected by the Neuromotor Program (NMP) and its regional service teams under the authority of the Freedom of Information and Protection of Privacy Act, section 26(c). The information is used to help us assess your child's needs; determine how well we are meeting families' needs; how we can improve our program and services; and how we can assure quality of care. For more information about the collecting or sharing of information by NMP, contact either the Neuromotor Program (NMP) at 604-875-2345 or the privacy officer in your local health authority.

______________________________________   ____________________
SIGNATURE OF LEGAL GUARDIAN   DATE

If referral is not signed by legal guardian, referring professional must check BOTH boxes below:

Referring professional confirms the legal guardian has consented to the referral.

Referring professional confirms the legal guardian has consented for the above* community professionals to be contacted to assist with ATT's intake, assessment and consultation.

*Ensure to list names/contact details of community professionals on page 2.