Centre de réadaptation MAB-MACKAY Rehabilitation Centre

Last Name:			
First Name:			
File N°:			
D.O.B. *(yyyy/mm/dd)*:		**Sexe:**	**M** ☐ **F** ☐
Program:			

SERVICES FOR ASSISTIVE TECHNOLOGY (SAT-COM) REFERRAL

SAT-COM provides three types of assessment:

A ***face-to-face communication*** assessment is appropriate for clients who are unable to speak or whose speech is insufficient to meet their everyday needs (e.g.: clients whose speech is very difficult to understand). The SAT.COM team will assess communication techniques that replace or supplement speech, such as switch use, picture boards, or voice output devices.

A ***written communication*** assessment is appropriate for clients who have basic literacy skills who need to produce written work, but who are unable to do so because of physical limitations. The SAT.COM team will assess techniques for producing written work, such as using specialized software and **alternate** ways of accessing the computer (ie: Large or mini keyboard, joystick, switches, etc).

A ***complex powered wheelchair and/or environmental control*** assessment is appropriate for clients who, due to limited voluntary body movements, require innovative access methods for mobility and control of their environment.

Please indicate which type of assessment you are requesting:
(*check one or more*):

☐ **Face-to-face communication** (complete part A, B & E)
☐ **Written communication** (complete part A, C & E)
☐ **Complex powered wheelchair and/or environmental control** (complete part A, D & E)

PART A – PLEASE COMPLETE THIS PART FOR ALL REFERRALS

Referral Source: _____

Contact Information: _____

Is the child presently a client at MAB-Mackay Rehabilitation Centre?

☐ Yes ☐ No

Tel: (514) 488-5552
3500 Decarie Blvd - Montreal – QC - H4A 3J5
ATS/TTY (514) 482-4536 - Fax: (514) 482-4536
7000 Sherbrooke West – Montreal – Qc – H4B 1R3 - Fax: (514) 489-3477

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1. Type of disability:
   (Please check any that apply. If you check more than one, please circle the primary disability)

   ☐ Cerebral Palsy ☐ Developmental Delay ☐ Down Syndrome
   ☐ Autism /PDD ☐ Spina Bifida ☐ Head Injury
   ☐ Muscular Dystrophy ☐ Arthritis ☐ Speech/Language Impairment
   ☐ Visual Impairment ☐ Hearing Impairment ☐ Other: _____

   Is the disability considered to be degenerative (rapidly progressive)?
   ☐ Yes ☐ No

2. Preferred language for assessment: ☐ English ☐ French
   ☐ Would like an interpreter who speaks: _____

3. Does the client walk? ☐ Yes ☐ No
   What mobility aids are used, if any?
   ☐ Walker ☐ Crutches
   ☐ Manual Wheelchair ☐ Power Wheelchair
   ☐ Other: _____

   If the client uses a wheelchair, is a tray attached? ☐ Yes ☐ No
   If the client uses a power wheelchair, is it operated by:
   ☐ Joystick ☐ Head Switches ☐ Other: _____

4. Does the client require specialized seating for writing, computer use or other?
   ☐ Yes ☐ No

5. Client's Educational Placement : (if applicable)
   ☐ Regular Class (Grade: _____) ☐ Special Class
   School: _____ School Board: _____

   Address: _____

   _____

   Tel#: (_____) _____

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6. Has the client received service in any of the following areas?

SERVICE	NAME OF PERSON / AGENCY	TEL#	DATE
Speech and Language Pathology			
O.T.			
Physiotherapy			
Seating			
Hearing			
Vision			
Psychology			
CRDI			
CLSC			
Other			

7. Please describe any problems relating to:
   a. General health: _____
   _____
   b. Vision: _____
   _____
   c. Hearing: _____
   _____
   d. Seizures: _____
   _____
   e. Behavior: _____
   _____
   f. Other: _____
   _____

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8. What do you hope to attain by referring your client to SAT-COM: _____

_____

_____

_____

PART B – PLEASE COMPLETE THIS PART IF REFERRAL IS FOR FACE-TO-FACE COMMUNICATION

1. How does the client generally communicate?
(Please check all that apply, and circle the primary one)

	At home	At school
Speech	☐	☐
Gestures	☐	☐
Pictures or symbols	☐	☐
Sounds or noises	☐	☐
Sign language	☐	☐
Word or alphabet board	☐	☐
Facial expression	☐	☐
Responds yes/no when questioned	☐	☐
Other: _____	☐	☐

2. For what purposes does the client generally communicate
(Please check all that apply)

	Example	At home	At school
Greetings/Closings		☐	☐
Requests Attention		☐	☐
Initiates		☐	☐
Acceptance/Rejection		☐	☐
Choice-Making		☐	☐
Request for Assistance		☐	☐
Request Object/Action		☐	☐
Comments		☐	☐
Shares Information		☐	☐
Asks Questions		☐	☐
Answers Questions		☐	☐

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3. Please indicate what the client is able to understand *(Please check all that apply)*:

- ☐ Cause and effect
- ☐ Names of familiar people
- ☐ Names of familiar objects or routines
- ☐ Simple commands *(e.g.: sit down, come here)*
- ☐ Abstract concepts *(e.g.: colors)*
- ☐ Categories *(e.g.: animals, food*)
- ☐ Conversation

4. Please give a general idea of the client's hand function *(Please check all that apply)*:

- ☐ Can point with finger
- ☐ Can point with hand
- ☐ Can reach
- ☐ Can grasp
- ☐ No functional hand use

5. Has the client used a computer or other technology *(ie: iPad)* before. If so how have they accessed it *(please check all that apply)*:

- ☐ Regular Keyboard
- ☐ Mouse
- ☐ Touch screen
- ☐ Switches
- ☐ _____

PART C – PLEASE COMPLETE THIS PART IF REFERRAL IS FOR WRITTEN COMMUNICATION

1. Please give us an idea of the client's literacy skills (check all that apply):

- ☐ Independently identifies all letters of the alphabet
- ☐ Independently spells familiar words *(e.g.: mom, cat, dog)*
- ☐ Independently writes phrases and sentences

2. What are the client's writing needs:

	At home	At school
Homework	☐	☐
Letter	☐	☐
Lists	☐	☐
Cards/invitations	☐	☐
Projects	☐	☐
Other (*please specify):* _____	☐	☐

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3. How are the client's writing needs met at present?
   a. At home: _____
   _____
   b. At school: _____
   _____

4. What are the limitations of the client's present system of written communication?
   ☐ Legibility ☐ Speed ☐ Effort ☐ Fatigue ☐ Motivation
   ☐ Other: _____

5. Please give us a general idea of the client's hand function:

	Right Hand	Left Hand
Can reach	☐	☐
Can point using index finger	☐	☐
Can isolate some finger movements	☐	☐
Can isolate all finger movements	☐	☐
No functional use of hand	☐	☐

6. Has the client used a computer or other technology (ie: IPad) before. If so how have they accessed it (please check all that apply):

   ☐ Regular Keyboard
   ☐ Mouse
   ☐ Touch screen
   ☐ Switches
   ☐ _____

PART D – PLEASE COMPLETE THIS PART IF REFERRAL IS FOR COMPLEX POWER WHEELCHAIR AND/OR ENVIRONMENTAL CONTROLS

1. What types of wheelchair controls or environmental controls have been tried in the past?
   ☐ Joystick ☐ Switches ☐ Head control ☐ Sip n' puff
   ☐ Other: _____

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2. Please describe the limiting factors of this type of control:

☐ Speed ☐ Effort ☐ Fatigue ☐ Motivation ☐ Inconsistency

☐ Other: _____

3. What part of the body does your child have the most voluntary control of?

☐ Fingers ☐ Hand ☐ Elbow ☐ Head ☐ Knee ☐ Foot

☐ Other: _____

4. What would you like your child to be able to control with the use of technology?

☐ Powered wheelchair ☐ TV/DVD ☐ Radio/CD/IPOD ☐ Lights ☐ Doors

☐ Other: _____

5. Is your home accessible? ☐Yes ☐ No _____

6. Do you have an adapted van? ☐Yes ☐ No _____

PART E - PLEASE ADD ANY OTHER RELEVANT INFORMATION OR COMMENTS BELOW. IF APPLICABLE, PLEASE DESCRIBE WHAT HAS BEEN TRIED

(i.e., child has just been introduced to pictures, child is using 1-switch for cause/effect, would like to know how to introduce 2-switches, etc.)

_____

_____

_____

_____

_____

_____ _____

Referring therapist's or parent's signature Date

Please return the completed form, signed by the referral source, to:

Services for assistive technology - Communication(SAT-COM)
MAB-Mackay Rehabilitation Centre
3500 Decarie Blvd
Montreal, Qc H4A 3J5
Tel: (514) 488-5552 Ext. 2202 - Fax: (514) 482-4536

Please attach the request for services form and the most recent therapy reports (e.g. Occupational Therapy, Speech-Language Pathology, Psychology).
You will be contacted when the completed referral form is received.