

# Electronic Assistive Technology Service for Wales

## Patient Referral Request

Note: The EAT Service Wales cannot accept a referral that has not been consented to by the person being referred or their legal representative. Additionally, the referral cannot be accepted without the NHS Number. Information not supplied that **will** result in this form being returned is outlined with a RED text box: . Failure to answer the questions that follow **will** result in delays to the referral acceptance process.

This referral form is being revised for submission electronically and the various choices appearing on it will then appear as drop down menus. In this paper format, where options are provided, please enter **the number** **only** of the option that is closest to your answer, or Y / N where appropriate.

Once you have completed **all sections** of this form, please send to:

**The EAT Service Coordinator**  
**The National Centre for Electronic Assistive Technology, Wales**  
**Rookwood Hospital**  
**Fairwater Road**  
**Llandaff**  
**Cardiff CF5 2YN**

**Telephone: 029-2031-3976**

"Data Protection Act 1998"

Personal data supplied on this form may be held and/or verified by reference to information already held on computer.

## Electronic Assistive Technology Service for Wales

All sections of the form **must** be completed unless directed. Incomplete forms **will** be returned

### Details of Person Being Referred

### Section 1

Surname:

Forname(s):

Title:  D.O.B.

Address:

Ethnic Origin:  See page 13

**NHS No:**

ALAS No:

(if known)

Gender:  (enter text)

Male      Female  
 TransF    TransM  
 Gender Neutral

Post Code:  Tel. Number:

Email:

What is the person being referred's preferred language?  
 Where is this language used (e.g. school/home...)?

If "bilingual", what language do they prefer to use?

Y/N

Will an interpreter be required at face to face assessments? (Y/N)

Contact details of Next of Kin/Parent/Guardian/Carer	Available Dates/Times

Address / Tel. number, where we could visit the person being referred e.g home/school/day centre

Post Code:

If the person being referred is currently in hospital, is there a discharge date? (Y/N)

Discharge date:

1 to 10

Which statement best describes the situation in which the person being referred is living?

1. Lives at home alone with no carer support
2. Lives at home alone (carers visit the property to aid with daily functions)
3. Lives with a partner (carers visit the property to aid with daily functions)
4. Lives at home (carers provide around the clock support)
5. Lives at home with their family

PTO

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- 6. Lives in shared accommodation
- 7. Lives in a nursing/care home
- 8. Currently in hospital
- 9. Lives alone in sheltered accommodation
- 10. Lives in a residential school

### Capacity and Consent

### Section 2

a. Has the person being referred consented to this referral? (Y/N)  Y/N  
*If "Yes", go to Section 3*

b. If "No" to a., does the person being referred lack the mental capacity to be able to consent? (Y/N)  Y/N

c. If the person being referred is a child or if "Yes" to b., please name the person who consented on their behalf?   
1 to 3

d. And in what capacity?   
1. Parent 2. Legal guardian 3. Power of attorney for medical care

**Warning: If consent to this referral has not been provided, the referral will NOT be accepted**

### Details of Person Making this Referral

### Section 3

Surname:

Forname(s):

Title:  Profession:

Address:

Registration No:   
**The EAT Service Wales will only accept referrals from state registered Medical or HCPC professionals.**

Post Code:  Tel. Number:

Email:

Date of this Referral:

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### Details of Professionals Involved in this Case

### Section 4

#### General Practitioner

GP Name:

Address:

Post Code:

Tel. Number:

Y/N

Is the person being referred's General Practitioner aware of this referral? (Y/N)

*(If "No" or "unknown", please inform their GP that you are making this referral)*

#### Social Services Occupational Therapist

OT Surname:

OT First Name:

OT Address:

Tel. Number:

Email:

Other

Agencies:

### Medical Diagnosis

### Section 5

Diagnoses:

Date of

Diagnosis:

ICD Code if known:

If no official diagnosis has been established, please describe the symptoms below:

1 to 4

Is the person being referred's condition:

1. Stable 2. Plateaud 3. Deteriorating 4. Improving

1 to 4

If the condition is changing, how quickly?

1. Very slowly 2. Slowly 3. Quickly 4. Very quickly

Comments:

**Motivation**

**Section 6**

How easily is the person being referred able to be motivated?   
 1. Easily 2. With difficulty 3. Not motivated

Give examples of what motivates him/her:

**Cognitive Ability / Memory**

**Section 7**

Does the person being referred understand "cause and effect"? (Y/N)   
*If the person being referred does not understand cause and effect, do not refer*

Does the person being referred have a cognitive impairment? (Y?N)   
 If "Yes", is it 1. Mild 2. Moderate 3. Severe? 1 to 3

Does the person being referred have problems with visual-spacial perception? (Y?N)   
 If "Yes", is it 1. Mild 2. Moderate 3. Severe? 1 to 3

Does the person being referred have problems with concentration/attention? (Y?N)   
 If "Yes", is it 1. Mild 2. Moderate 3. Severe? 1 to 3

Does the person being referred have problems with immediate memory? (Y/N)   
 If "Yes", is it 1. Mild 2. Moderate 3. Severe? 1 to 3

Does the person being referred have problems with short term memory? (Y/N)   
 If "Yes", is it 1. Mild 2. Moderate 3. Severe? 1 to 3

*If the person being referred has significant problems with immediate memory, do not refer*

Does the person being referred have problems with long term memory? (Y/N)   
 If "Yes", is it 1. Mild 2. Moderate 3. Severe? 1 to 3

Does the person being referred have a learning disability?   
 If "Yes", is it 1. Mild 2. Moderate 3. Severe? 1 to 3

*If the person being referred has PMLD, please consider the relevance of this referral*

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Give any further relevant information regarding this section in the box below:

### Communication

### Section 8

1 to 4

How effective is the person being referred's current communication?

1. Very effective 2. Mostly effective 3. Partially effective 4. Ineffective

*If "1. Very effective", go to Section 9*

### Method

1 to 12

What is their current main means of communication?

1. Speech 2. Vocalisation 3. Writing 4. Signing 5. Communication Chart  
6. Electronic Communication Aid 7. Symbols 8. Photographs 9. Objects  
10. Limb/Eye Pointing 11. Gesture 12. Behaviour

Please provide more detail regarding their current means of communication in the box below:

### Initiation

1 to 4

Which statement best describes the person being referred's initiation of communication?

1. Initiates communication with all
2. Initiates communication with familiar partners
3. Initiates communication only in familiar surroundings
4. Does not initiate communication

Please describe the circumstances/environments in which the person being referred initiates or does not initiate communication.

### Speech

What expressive speech disorders does the person being referred have?  
*(tick all that apply and indicate whether it is 1. Mild, 2. Moderate or 3. Severe)*

√

	Dysarthria
	Dysphonia
	Dyspraxia
	Phonological
	Dysfluency
	Developmental
	Other

1 to 3


1 to 4

How well can the person being referred make themselves understood orally?

1. Understood at all times 2. Understood by all within context  
3. Understood only by familiar people within context 4. Rarely or never understood

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Please provide details in the box below:

### Language

Does the person being referred have a **receptive** language impairment? (Y/N)

Y/N

1 to 6

If "Yes", which statement best describes their receptive language ability?

1. Inconsistent at single word level
2. Understands words within context/routine only
3. Understands single words
4. Understands short phrases
5. Understands complete sentences
6. Understands a sequence of complex instructions

*Warning: If inconsistent at single word level, a high tech AAC system will not be appropriate*

What formal assessment(s) have been undertaken regarding this person's receptive language (e.g. PALPA, CAT) and what were the results/scores? *This is mandatory when dysphasia is suspected*

Does the person being referred have an **expressive** language impairment? (Y?N)

Y/N

1 to 7

If "Yes", which item below best describes their expressive language ability?

1. Pre-intentional communication
2. Vocalisations with communicative intent
3. Representational sounds
4. Single words
5. Short phrases
6. Simple sentences
7. Able to relate a narrative

*Warning: If "Pre-intentional communication", a high tech AAC system will not be appropriate*

What is the person being referred's **current** reading ability?

1 to 4

1. Unable to read
2. Some difficulty
3. No difficulty
4. Age appropriate

1 to 4

What is the person being referred's current spelling ability?

1. Unable to spell
2. Some difficulty
3. No difficulty
4. Age appropriate

1 to 4

What is the person being referred's pre-morbid reading or spelling ability? (if applicable)

1. Unable to spell or read
2. Some difficulty
3. No difficulty
4. Age appropriate

### Low Tech Communication

Please describe in detail in the boxes below, what low tech assessments and trials have been undertaken with the person being referred, the results and why they were unsuccessful

*This information is mandatory if the person being referred's communication is not effective*

Trialed?

PTO

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Results?

"TOMS for AAC" Scores: (Indicate the 'TOMS for AAC' score that you have given this person)

**Communication**  
prior to referral  
to EAT Service

**Participation**  
prior to referral  
to EAT Service

*Warning: If you are the referring SLT, you must enter the "TOMS for AAC" score for this referral to be accepted. Please ensure that you have undertaken a "TOMS for AAC" measurement and not the general TOMS tool*

Please describe in the box below what you would expect as a result of this referral?

Please describe in the box below how you intend to support the person being referred in their use of any device during trials and if provided.

### Physical Impairment

### Section 9

Does the person being referred have a physical impairment? (Y/N)

Y/N

*If "No" go to Section 10*

If "Yes", which statement best characterises the degree of involvement?

1 to 13

1. Persistent vegetative state 2. Locked in 3. Quadraplegic 4. Tetraplegic 5. Paraplegic  
6. All limbs affected to some degree 7. Lower limbs mainly affected 8. Upper limbs mainly affected  
9. Lower limbs only affected 10. Upper limbs only affected 11. Hemiplegic Left side  
12. Hemiplegic Right side 13. Speech only affected

*Warning: If "persistent vegetative state", the EAT Service will not accept this referral, do not submit*

### Upper Limb Range of Movement

1 to 4

What is their upper limb range of movement?

1. Full range 2. Slightly reduced range 3. Significantly reduced range 4. No movement

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<b>Strength</b>	
In the impaired area, what is the level of strength?	1 to 4 <input style="width: 100px; height: 20px;" type="text"/>
1. Normal strength 2. Reduced strength 3. Significantly reduced strength 4. Barely detectable	
<b>Accuracy of movement</b>	
Please indicate if the person being referred has any of the following:	1 to 3
<i>(Tick all that apply and please indicate with the appropriate number whether 1. Mild 2. Moderate or 3. Severe)</i>	
<input type="checkbox"/> Tremor	<input type="text"/>
<input type="checkbox"/> Ataxia	<input type="text"/>
<input type="checkbox"/> Dyskinesia	<input type="text"/>
<input type="checkbox"/> Dyspraxia	<input type="text"/>
<input type="checkbox"/> Chorea	<input type="text"/>
<input type="checkbox"/> Rigidity	<input type="text"/>
<input type="checkbox"/> Spasticity	<input type="text"/>
<input type="checkbox"/> Athetosis	<input type="text"/>
<input type="checkbox"/> Other	<input type="text"/>
If "Other" or you are unable to classify please describe in the box below.	
<input style="width: 100%; height: 40px;" type="text"/>	

<b>Interaction with High Technology</b>	<b>Section 10</b>
Is the person being referred able easily to operate remote controls (e.g. TV, music ...) within the home? (Y/N)	Y/N <input style="width: 100px; height: 20px; border: 2px solid red;" type="text"/>
Is the person being referred able easily to operate light switches and other sockets within the home? (Y/N)	Y/N <input style="width: 100px; height: 20px; border: 2px solid red;" type="text"/>
Did the person being referred use a computer/tablet prior to their current situation? (Y/N)	Y/N <input style="width: 100px; height: 20px; border: 2px solid red;" type="text"/>
If "Yes" to above, are they still able to access it? (Y/N)	<input style="width: 100px; height: 20px; border: 2px solid red;" type="text"/>
If "No" above, do they wish to use a computer/tablet now? (Y?N)	<input style="width: 100px; height: 20px; border: 2px solid red;" type="text"/>
What system available to them would they use mainly?	<input style="width: 100%; height: 20px;" type="text"/>

<b>Mobility</b>	<b>Section 11</b>
Is the person being referred currently fully mobile without a mobility aid? (Y/N)	Y/N <input style="width: 100px; height: 20px; border: 2px solid red;" type="text"/>
<i>If "Yes" go to section 12</i>	
If "No", which statement below best describes their level of mobility?	1 to 5 <input style="width: 100px; height: 20px;" type="text"/>
1. Able to walk with an aid 2. Able to self propel a wheelchair and transfer independently 3. Able to self propel a wheelchair 4. Able to control a powered wheelchair 5. No independent mobility	
Which statement below best describes the person being referred's ability to sit?	1 to 5 <input style="width: 100px; height: 20px;" type="text"/>
1. Can sit without support 2. Can sit the with armrests 3. Can sit with supporting aids 4. Requires a moulded seat 5. Cannot tolerate being seated	

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Does the person being referred have one or more wheelchairs? (Y/N)	<input type="text"/>
Does the person being referred have a powered wheelchair? (Y/N)	<input type="text"/>
In either (or both) case(s) please indicate the make and model of the wheelchair if known	
<input type="text"/>	

### Sensory Impairment

### Section 12

Does the person being referred have a sensory impairment? (Y/N) (Vision, hearing, touch...)	<input type="text"/>
	<i>If "No", go to section 13</i>

#### Vision

Does the person being referred have normal vision when aided or unaided? (Y/N)	<input type="text"/>
Which statement below best characterises the sight of the person being referred?	<input type="text"/>
1. Full sight loss in both eyes 2. Full sight loss in left eye 3. Full sight loss in right eye 4. Partial sight loss in both eyes 5. Partial sight loss in left eye 6. Partial sight loss in right eye 7. Has visual field neglect 8. Has double vision	
Please describe in the box below any additional factors affecting the vision of the person being referred.	
<input type="text"/>	

#### Hearing

Does the person being referred have normal (or near normal) hearing when aided or unaided? (Y/N)	<input type="text"/>
If No, which statement best characterises the hearing ability of the person being referred?	<input type="text"/>
1. Complete hearing loss (both sides) 2. Partial hearing loss (both sides) 3. Complete hearing loss (left side) 4. Complete hearing loss (right side) 5. Partial Hearing loss (left side) 6. Partial hearing loss (right side) 7. Mild hearing loss	

#### Touch

Does the person being referred have any impairment to their sense of touch? (Y/N)	<input type="text"/>
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If "Yes", which statement best characterises their level? 1 to 6

1. No sense of touch in either hand/fingers    2. No sense of touch in left hand/fingers  
 3. No sense of touch in right hand/fingers    4. Altered sensation or numbness in both hands  
 5. Altered sensation/numbness in left hand    6. Altered sensation/numbness in right hand

Please elaborate on the selection above if there is complex involvement:

### Psychological / Psychiatric Factors Section 13

Y/N

Does the person being referred have any psychological or psychiatric factors that should be taken into account? (Y/N) *If "No", go to section 14*

	√		1 to 3
If "Yes", is there evidence of:	<input style="width: 40px; height: 20px;" type="text"/>	Depression	<input style="width: 100px; height: 20px;" type="text"/>
	<input style="width: 40px; height: 20px;" type="text"/>	Anxiety	<input style="width: 100px; height: 20px;" type="text"/>
and is it: 1. Mild 2. Moderate or 3. Severe	<input style="width: 40px; height: 20px;" type="text"/>	Psychosis	<input style="width: 100px; height: 20px;" type="text"/>
	<input style="width: 40px; height: 20px;" type="text"/>	Other	<input style="width: 100px; height: 20px;" type="text"/>

Please describe in the box below how well any of these are managed, or any other relevant information.

### Emotional Factors Section 14

Y/N

Does the person being referred have any emotional factors that need to be taken into account? (Y/N) *If "No", go to section 15*

If "Yes" please describe in the box below.

1 to 3

Also if "Yes", rate the severity of these emotional factors:

1. Mild 2. Moderate 3. Severe

**Pain and Risk of Harm**

**Section 15**

**Pain**

Y/N

Does the person being referred experience significant episodes of pain? (Y/N)

1 to 3

If "Yes", how does the person being referred rate their severity of pain? 1. Mild 2. Moderate 3. Severe

**Harm**

If this person were not to be provided with an EAT system, are they likely to be at significant risk:

Financially?	<input type="text"/>
Socially?	<input type="text"/>
Physically?	<input type="text"/>
Psychologically?	<input type="text"/>
Educationally?	<input type="text"/>
Other?	<input type="text"/>

If "Yes" to any of the above, please provide further information in the box below.

Y/N

Does the person being referred have any self injurious behaviour(s)? (Y/N)

1 to 3

If "Yes", please rate the severity of these behaviours:  
1. Mild 2. Moderate 3. Severe

Also if "Yes", please describe in the box below.

Y/N

Could the person being referred, as a result of their condition be a potential risk of harm to others if they were not provided with Electronic Assistive Technology?

If "Yes", please describe in the box below.

Y/N

Does the person being referred, display any behaviours that could be challenging? (Y/N)

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Y/N

Are there any environmental factors that could potentially be of harm to the person being referred? (Y/N)

If "Yes", please describe in the box below.

Y/N

Is the person being referred dependent on or require ventilation? (Y/N)

### Appendix:

Ethic Origin	Code No
Any white background	1
White & black Caribbean	2
White & black African	3
White & Asian	4
Any mixed background	5
Indian	6
Pakistani	7
Bangladeshi	8
Any Asian background	9
Caribbean	10
African	11
Any other black background	12
Chinese	13
Any other ethinc group	14
Not stated	15