Barnsley AT Team Referral Form

This form should be completed by relevant professionals wishing to refer a client to the [Barnsley Assistive Technology Team](http://www.barnsleyhospital.nhs.uk/assistive-technology/). Please read the service criteria for referral and provision prior to sending a referral. These criteria and further information are available on our website pages:

* [Environmental Control - Key Documents](http://www.barnsleyhospital.nhs.uk/assistive-technology/about-assistive-technology-at/environmental-control-ec/#Key-Documents)
* [AAC - Key Documents](http://www.barnsleyhospital.nhs.uk/assistive-technology/about-assistive-technology-at/augmentative-alternative-communication-aac/#Key-Documents)

We apply nationally defined prioritisation criteria to referrals, and these include: where there is rapid progression; where the individual is in a period of transition; where current equipment has broken down; and where there are safety critical factors.

Please note that for AAC referrals a Speech and Language Therapist must be actively involved; for Environmental Control referrals the referrer should remain involved for at least the first assessment visit to determine if further local involvement is required.

## Further Guidance, Resources & Training

Further guidance and criteria documents are available on our website. Specifically:

* [Training](https://www.barnsleyhospital.nhs.uk/assistive-technology/training-courses/) is available related to AAC and EC interventions
* [Resources to support local teams](https://www.barnsleyhospital.nhs.uk/assistive-technology/resources-and-information/) are available, including our [local services resource pack](https://www.barnsleyhospital.nhs.uk/assistive-technology/resource/local-services-resource-pack/) which includes examples of AAC and EC equipment that is expected to be provided locally.

Please contact the team if you have further questions about what information should be provided.

## Sending this form

The form will be returned if all relevant sections are not completed.

Please ensure fields marked with an \* are completed.

Please ensure that the client’s Home and/or Mobile phone number are completed.

Please email this form to our team address: barnsley.at@nhs.net.

If you are sending from another nhs.net email address, this is secure. Alternatively you can send the referral as an encrypted (256bit) document.

In all cases, please ensure you are complying with your organisation’s information governance and data protection procedures when sending this form.

You will receive an acknowledgment of receipt of this referral by email. If you do not receive this within 1 week, [please get in touch](https://www.barnsleyhospital.nhs.uk/assistive-technology/contact-assistive-technology/) to confirm that we have received the form.

*Form Version: V4. 8-2-2024*

Barnsley AT Team Referral Form

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| **Section 1: Client’s details** |
| **\*Forename(s):**      | **\*Surname:**      | **Title:**      |
| **\*NHS Number:**       | **\*Date of Birth:**      | **Gender:**      |
| **\*Diagnosis:**      | **\*GP Name and Practice:**      |
| **Any other relevant medical conditions:**      |
| **Are you aware of the client using any Aerosol Generating Procedures or Equipment?**      |
| **\*Home address:**      | **\*Daytime location (if different to home)**  *e.g. School, Day Centre***:**     **\*Daytime address:**     **\*Phone number for the above:**      |
| **#Home phone:**      | **#Mobile phone:**      |
| **Email:**       |
| **\*Client Preference for Contact:** |
| Directly with client by:  | Or by contacting the nominated contact below: [ ]  |
| **Main contact for client, if not the client (*e.g. Parent, Guardian, Advocate, Family Member)*** |
| **Name:**      | **Relationship:**      |
| **Phone:**      | **Email**:       |

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| **Access information and risks***Are there any health and safety or safeguarding issues we need to be aware of? Are there any special instructions for gaining entry to the property?* |
|       |

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| **Referrer details** |
| **\*Name:**      | **\*Job title, profession or role:**      |
| **Marketing Permissions** [ ]  I would like to sign up for email updates about the Barnsley AT Team. *Emails are sent using the team’s online MailChimp account and your name and email address will be stored on this system. You can change your mind at any time by clicking the unsubscribe link in the footer of any email you receive from us, or by contacting* *barnsley.at@nhs.net* *.* |
| **Service name (what your team calls itself):**      |
| **\*Address:**       | **\*Phone:**       |
| **\*Email**:       |
| **Other:**       |
| **\*Signature:**      | **\*Date:**       |

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| **Referral Summary** |
| **Prioritisation:** |
| Is this a priority referral? [ ]  | Reason (if yes):       |
|  **\*Is the client or guardian aware of this referral?**  |
| Yes: [ ]  No: [ ]  |
| **\*Is the client willing to participate in an assessment by Barnsley Assistive Technology Team?** |
| Yes: [ ]  No: [ ]  |
| **What are the primary goals of this referral?** (tick all that apply) |
| 1. Assessment of the most appropriate method for accessing communication
2. Assessment of the most appropriate symbol or text based vocabulary system
3. Assessment for an environmental control system
4. Assessment for computer access
5. Provision of specialised communication aid (no assessment – see Guidance)
 | [ ] [ ] [ ] [ ] [ ]  |
| **What are the client’s (and/or family’s) expectations for this referral?**       |
| **Following assessment, if the criteria for provision of specialised equipment is not met please state what funding routes exist for provision of non specialised equipment:**      |

| **Relevant Contacts** *Please provide details of other professionals involved with the client.**Aware = Aware of referral. Invite = Invite to assessment visit.* |
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| **Speech and Language Therapist**: |
| **Name:** |       | **Phone:**  |       | **Aware?** | **[ ]**  |
| **Address:** |       | **Email:** |       | **Invite?** | **[ ]**  |
|  | **Other:** |       |  |  |
| **Occupational Therapist:** |
| **Name:** |       | **Phone:**  |       | **Aware?** | **[ ]**  |
| **Address:** |       | **Email:** |       | **Invite?** | **[ ]**  |
|  | **Other:** |       |  |  |
| **Equipment and Adaptations Occupational Therapist**(Responsible for arranging adaptations if required for EC provision) |
| **Name:** |       | **Phone:**  |       | **Aware?** | **[ ]**  |
| **Address:** |       | **Email:** |       | **Invite?** | **[ ]**  |
|  | **Other:** |       |  |  |
| **Physiotherapist:** |
| **Name:** |       | **Phone:**  |       | **Aware?** | **[ ]**  |
| **Address:** |       | **Email:** |       | **Invite?** | **[ ]**  |
|  | **Other:** |       |  |  |
| **Relevant Consultant:** |
| **Name:** |       | **Phone:**  |       | **Aware?** | **[ ]**  |
| **Address:** |       | **Email:** |       | **Invite?** | **[ ]**  |
|  | **Other:** |       |  |  |
| **Teacher / Education Contact:** |
| **Name:** |       | **Phone:**  |       | **Aware?** | **[ ]**  |
| **Address:** |       | **Email:** |       | **Invite?** | **[ ]**  |
|  | **Other:** |       |  |  |
| **Other Contact:** |
| **Name:** |       | **Phone:**  |       | **Aware?** | **[ ]**  |
| **Address:** |       | **Email:** |       | **Invite?** | **[ ]**  |
|  | **Other:** |       |  |  |

| **Section 2: Client Details***Please provide further information on the following.* |
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| **Physical abilities *(e.g. mobility, use of wheelchair, posture and positioning, gross movement and fine motor control, voluntary and involuntary movements, endurance/fatigue):*** |
| Upper limb and hand function:     Other physical abilities:      |
| **Vision (e.g. any impairment, glasses, glaucoma, cataracts, strabismus, nystagmus):** |
|       |
| **Hearing (e.g. any impairment, hearing aids worn):** |
|       |
| **Cognition (e.g. attention, understanding of cause and effect, problem solving, memory, ability to initiate):** |
|       |
| **Psychological factors (e.g. motivation, mental health, behaviour, social skills):** |
|       |
| **Other factors (e.g. medication, effect of medical conditions on wellbeing and function):** |
|       |
| **Further information on diagnosis (e.g. time since onset, rate of progression):** |
|       |
| **Social situation (e.g. lives alone, carers, care package, level of dependency, who will support the use of assistive technology):** |
|       |
| **Accommodation (e.g. type of property, ownership of property):** |
|       |

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| **Section 3: Communication***Please see the* [*AAC criteria*](http://www.barnsleyhospital.nhs.uk/assistive-technology/about-assistive-technology-at/augmentative-alternative-communication-aac/#Key-Documents) *and referral guidance for AAC referrals. If you are only referring for an environmental control assessment please go straight to section 4.*  |
| **Current communication skills** |
| **Expressive and receptive language - please include details of any standardised or non standardised assessments carried out, observational assessments are also helpful:**       |
| **Details of literacy skills:**      |
| **Current AAC strategies** |
| **How does the individual indicate ‘yes’ or ‘no’?**      |
| **What other non-verbal means of communication does the individual have (e.g. vocalisations, gesture, eye pointing)?**      |
| **What paper or partner based AAC systems have been tried, and what is being used currently (e.g. alphabet board, symbol book, Etran frame)?**       |
| **How does the individual access this system (e.g. direct touch, eye pointing, partner assisted scanning) and how successfully?**       |
| **If there is no paper-based AAC system currently in place, please describe why not (e.g. lack of motivation from the client, complex access, lack of support in the environment):** |
| **Please provide details of the individual’s exposure to and use of symbols e.g. PCS, Widget, Symbolstix (what system is used in the environment, what exposure have they had, are they using a symbolic system expressively?):**      |
| **Please list the current Speech & Language Therapy goals for this individual:**       |

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| **Current and previous use of powered voice output communication aids (these could be specialised or** [**non specialised aids**](https://www.barnsleyhospital.nhs.uk/assistive-technology/resource/local-services-resource-pack/)**, this may be left blank if no previous experience):** |
| **Name of current device (e.g. Tobii i12, Liberator Accent 800, iPad, Go Talk 9+, BigMack):**       |
| **Name of current communication software (e.g. Grid3, NuVoice, GoTalk Now, Proloquo2Go):**      |
| **Name of current vocabulary package (e.g. Word Power, Words For life app, Symbol Talker):**      |
| **Current access method (e.g. direct touch, switch scanning, eye tracker):**      |
| **Please describe how the individual’s current system is no longer meeting their needs (e.g. broken, outgrown the language package, access method no longer suitable):**      |
| **Please describe any previous trials of voice output communication aids, the access methods used and the outcome:**       |
| **Reasons for communicating**  |
| **Please describe how they currently communicate (If possible, give an example of a recent conversation or SLT task and how the individual joined in):**      |
| **Please describe how their current means of communicating are limiting them, and how you feel an alternative communication system might improve this?**       |

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| **Opportunities** |
| **Named person(s) who will support the assessment (please note that the person(s) named must have consented to this):**      |
| **Is staff training likely to be required?**       |
| **Details of how the assessment will be supported (e.g. time available for one to one support, use at home):**      |
| **When is the individual likely to use an AAC system (e.g. at school/home/work, for certain activities)?**      |
| **Details of support available to implement the recommendations of the assessment (i.e. who is going to support the on-going long-term implementation of an AAC system and how):**       |

| **Section 4: Environmental Control** *Please see the* [*EC Criteria*](http://www.barnsleyhospital.nhs.uk/assistive-technology/about-assistive-technology-at/environmental-control-ec/#Key-Documents) *and* [*Referral Guidance*](http://www.barnsleyhospital.nhs.uk/assistive-technology/contact-assistive-technology/referrals)*.* |
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| **Home control** |
| **What are the client’s goals for home/environmental control (e.g. TV/Hifi, landline telephone, mobile telephone, door intercom, door opening, lights, attention calling)?**      |
| **Has the client tried any non specialist alternative methods to achieve their EC goals (e.g. large button remote controls and telephones, remote sockets, pager** [**– as in our local service resource**](https://www.barnsleyhospital.nhs.uk/assistive-technology/resource/local-services-resource-pack/) **pack)?**      |
| **If so, please list these and describe the outcome?**      |
| **Has a referral been made to the local Equipment and Adaptations service for any adaptations that may be required to the fabric of the building (e.g. door opener/lock release)?**      |
| **Computer Control** |
| **What type of computer does the client have (e.g. Windows desktop, laptop, tablet, Apple or Android, access via smartphone)?**      |
| **What does the client currently use their computer for (e.g. emails, internet browsing, banking, social media, games)?**      |
| **How does the client currently access their computer?**      |
| **Has the client tried any alternative methods for accessing their computer (e.g. ergonomic mouse, large keyboard, use of accessibility options in the operating system of computer or tablet/phone)?**      |