# ASSISTIVE TECHNOLOGY

# Request for Service

**Return to:**

Assistive Technology Team Phone: 306-766-5710 ext. 4

Children's Program Fax: 306-766-5189

Wascana Rehabilitation Centre Email:ChildrensProgramATRegina@saskhealthauthority.ca

2180 – 23rd Avenue Regina, SK S4S 0A5

**Please check box if guardian consents:**

[ ]  **The AT Team is allowed to contact caregivers, teachers and treating therapists to obtain additional information.**

* Required paperwork:
	+ Request for Service
	+ Applicable Supplemental Forms (Communication, Access, Gaming)
	+ a copy of the child’s most recent IEP/IIP goals
* Once all required information is collected the caregivers/school will be contacted to schedule an initial appointment.
* It is helpful to have as many participating team members attend the assessment as possible. Virtual options are available.

|  |  |  |  |
| --- | --- | --- | --- |
| **Child’s Name:** |   | **MRN:**  |   |
| **Date of Birth:**  |   | **Health Card:** |   |
| **Address:**  |   | **City:** |   |
| **Phone # (home):**  |   | **(cell) :**  |   |
| **Caregivers’ Names:**  |   |
| **Email (if preferred):**  |   |
| **Person(s) completing this form:**  |   |

**Child’s Diagnosis:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Considerations (check all that apply)**

[ ]  Speech/Language

[ ]  Cognitive Disability

[ ]  Learning Disability

[ ]  Hearing Impairment

[ ]  Vision Impairment

[ ]  History of seizures

[ ]  Tremors

[ ]  Has frequent pain

[ ]  Fatigues easily

[ ]  Mobility: [ ]  Walking aids [ ]  Manual wheelchair [ ]  Power wheelchair

**Assistive Technology Need:**

**We are referring to the AT team to look at technology to support my child with:**

[ ]  **Communication** (complete secondary Communication form)

[ ]   **Academic Tasks** (complete secondary Access and Academics form)

[ ]  **Adaptive Video Gaming** (do not complete the rest of this form but complete Adaptive Gaming form)

|  |
| --- |
| **Current Educational Placement**  |
| **School** |  | **Phone #**  |  |
| **Contact Person**  |  | **Email** |  |

**Classroom Setting**

[ ]  Regular Classroom, Grade \_\_\_\_\_ [ ]  Modified Program \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Educational Assistant

**My child is seen by other therapy programs**: [ ]  Yes [ ]  No

 If yes, please indicate: [ ]  Private [ ]  School [ ]  SHA Therapist

 [ ]  SLP [ ]  OT [ ]  PT

 [ ]  Academic(ie. tutor, Sylvan Learning, etc)

**Tell us about your child’s strengths, learning style, coping strategies and interests.**

**Are there activities or settings your child enjoys? How do they show it?**

**Are there activities or settings your child does not enjoy? How do they show it?**

|  |
| --- |
| **Child’s Team Outside of Children’s Program:** |
| **Role** | **Name** | **Phone/Email** |
| Classroom Teacher |   |   |
| Student Support Teacher |   |   |
| Speech Language Pathologist |   |   |
| Occupational Therapist |   |   |
| Physical Therapist |   |   |
| Other:  |   |   |