# 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](mailto: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: |  |  |