| *OFFICE USE ONLY* | |
|---|---|
| File No | |
| Received | |

**ACTU SPECIALIST ASSISTIVE TECHNOLOGY SERVICE**

**Referral Form: Children and Young People**

This referral form is to be filled in by the child's speech and language therapist and/or occupational therapist and physiotherapist, as applicable. Please note that it is essential that the referring therapist is present throughout the assessment process, that they are able to provide regular support to the child, monitor the use of equipment and take part in the assessment review.

Please read the acceptance and exclusion criteria carefully (see attached guideline notes) prior to making a referral.

In order to assist with processing of this referral, please tick all criteria, which apply to this child. The child must meet all acceptance criteria to qualify for this service. **To avoid delay in processing of this referral, please complete all sections of the form and send it to ACTU, Sonia Tanti Independent Living Centre, Ħal Far Industrial Estate, Ħal Far**. Please phone **21653938** / **21653991** or email **actu.sapport@gov.mt** to discuss any queries.

## Acceptance Criteria

A child who is eligible to access a specialist Assistive Technology Service (ATS) has the following:

- A severe/complex communication difficulty associated with a range of physical, cognitive, learning, or sensory deficits

In addition, a child *must*:

- Have developed beyond cause and effect understanding

## Exclusion Criteria

**For AAC referrals:**

- Not having achieved cause and effect understanding
- Have impaired cognitive abilities that would prevent the user from retaining information on how to use equipment

**For EAT referrals including environmental control:**

- Ability to use a standard touch screen, keyboard and mouse with literacy-based software and those who are able to use standard environmental controls.

If the child meets any of the exclusion criteria please phone **21653938** prior to completing the referral if you would like to discuss further.

## SECTION 1: CHILD'S INFORMATION

| **1a. Child's personal information** | | |
|---|---|---|
| Child's name: | | |
| Address: | | |
| Date of birth: | I.D. number: | |
| Gender: Male ☐ Female ☐ | | |
| Parents/Guardians (state names and relationship to the child. Include address if different to the child's address): | | |

| | Parent/Guardian 1 | Parent/Guardian 2 |
|---|---|---|
| Tel: | | |
| Mobile: | | |
| Email: | | |
| Custody | In the event that custody of the minor is vested in one parent, documentary evidence, such as the relative court decree or birth certificate, is to be presented for verification purposes. | |

| School / College name: | School/ College address: |
|---|---|
| Telephone: | |

| **1b. People involved in the child's care (give names and contact details)** | | **Are they aware of the referral?** |
|---|---|---|
| Who should we contact in regards to the person being referred? | | |
| Class teacher: | | |
| HOD inclusion (INCO): | | |
| Speech and Language Pathologist: | | |
| Occupational Therapist: | | |
| Physiotherapist: | | |

Ensure that all appropriate persons are informed that this referral has been made.

| **1c. Diagnosis** (please attach relevant reports) | |
|---|---|
| Primary diagnoses: | |
| Date of onset: | Stable ☐ Deteriorating ☐ Improving ☐ |
| Other significant medical history (please include health factors which may impact on AAC/AT needs/provision e.g. seizures multiple health problems): | |
| List of medications: | |

## SECTION 2: REFERRER'S DETAILS

| **2a. Referrer's information** | |
|---|---|
| Referrer's name: | Referrer's profession: |
| Referrer's address: | |
| Referrer's email address: | Referrer's telephone number: |

## SECTION 3: REFERRAL INFORMATION

| **3a. What Service would you like to access?** |
|---|
| Augmentative and Alternative Communication (AAC): ☐ (Go to section 3b.) |
| Electronic Assistive Technology (EAT) Services:<br>▪ Computer access: ☐ (Go to section 3c)<br>▪ Environmental control (EC): ☐ (Go to section 3c) |
| **3b. AAC service: Meets the following criteria** |
| Does the child understand cause and effect? Yes ☐ No ☐ |
| Is there a discrepancy between their understanding and ability to speak? Yes ☐ No ☐<br>*Provide examples from your observations:* |
| Have low-tech strategies been trialled? Yes ☐ No ☐<br>Are there reasons why low-tech strategies are insufficient to meet communication needs?<br>Yes ☐ No ☐<br><br>Explain further: |

| |
|---|
| ***If you have answered "no" to the above questions the child may not currently meet the eligibility criteria for complex AAC assessment –contact ACTU to discuss and guide you before continuing with the referral.***<br>***If you have answered "yes" to the above questions please proceed to sections 3d onwards*** |
| **3c. EAT services: Meets the following criteria** |
| Is the student able to use a standard touchscreen accurately?<br>Yes ☐ No ☐ |
| Is the student able to use standard keyboard and standard mouse together with literacy-based software?<br>Yes ☐ No ☐ |
| ***If you have answered "yes" to the above questions the child may not meet the eligibility criteria for electronic assistive technology assessment and/or environmental control service –contact ACTU to discuss and guide you further before continuing with the referral.***<br>***If you answered "No" to the above questions, proceed to section 3d, 4c and sections 5 to 9*** |
| **3d. Referral question** |
| What specific problem is the referral intended to address? Why is this referral being made at this particular time? |
| As the referrer what are your goals for intervention? |
| What are the parent/carer's goals for the child for this referral? |
| What are the child/young adult's goals for this referral (if applicable)? |

## SECTION 4: COMMUNICATION

| **4a. Current communication methods: Where possible include a photo/screenshot of any communication tools being used** | | |
|---|---|---|
| **Please attach the most recent speech and language therapy report**<br>**Tick all modes of communication which the child uses in the 'Used' column.** | | |
| | **Used** | **Details/limitations/issues** |
| Verbal expression | ☐ | |
| Written text | ☐ | |
| Partner-assisted scanning | ☐ | |
| Low tech AAC<br>(e.g. paper chart, E-Tran Frame, PECS, communication book) | ☐ | |
| Gesture/Signing/Facial Expression | ☐ | |
| High Tech AAC device | ☐ | |

| | | |
|---|---|---|
| Other | ☐ | |

What strategies help with communication?

**4b. Communication ability**

Speech therapy diagnosis:

| | **Strengths** | **Limitations** |
|---|---|---|
| Speech | | |
| Symbol use<br>(State symbol type) | | |
| Social communication | | |

Understanding (tick the highest level the child can consistently achieve)

☐ Able to follow group conversation
☐ Able to follow long complex commands
☐ Able to follow short complex commands
☐ Able to follow 3+ word commands
☐ Able to follow 2 word commands
☐ Follows only 1 word commands
☐ Unable to follow single word commands

Expression (by any means: tick the highest level the child can achieve)

☐ Able to produce long grammatical sentences
☐ Able to produce simple sentences
☐ Able to produce 2-3 word phrases
☐ Able to produce key word/single word utterances

To indicate *yes* and *no* the student: tick all that apply

☐ Shakes head ☐ Signs ☐ Vocalises ☐ Gestures
☐ Eye gazes ☐ Points to pictures/symbols ☐ Uses word approximations
☐ Does not respond consistently

Tick which one best describes the child's expressive language ability using an AAC system:

☐ Not yet able to use an AAC system
☐ Able to combine words, phrases, or symbols to create more than once concept. Uses high tech aids or low tech systems to select one concept at a time
☐ Able to use complex multi-page vocabulary to combine multiple words, phrases or symbols to compile a sentence
☐ Able to construct novel messages using the alphabet

**4c. Communication functions**

Tell us how the child is able to communicate functionally (e.g. comment, share information, attract attention, etc.)

| |
|---|
| **4d: Communication needs** |
| Where does the child wish to communicate? |
| With whom does the child wish to communicate? |
| Child's first language: |
| Does the child need access to additional languages on a communication device (if yes, list languages needed): |

## SECTION 5: MOTOR AND SENSORY PERCEPTUAL FUNCTION

| **Please attach any reports indicating visual and/or hearing status** | | | |
|---|---|---|---|
| **5a. Sensory perceptual** | | | |
| | **Yes** | **No** | **Comment/Details on function** |
| Visual impairment | ☐ | ☐ | *List any visual perceptual issues experienced by the client* |
| Hearing impairment | ☐ | ☐ | Are hearing aids in place? Yes ☐ No ☐<br>Left ☐ Right ☐ |
| Sensory processing issues | ☐ | ☐ | Please specify |

| **Please attach the most recent occupational therapy and/or physiotherapy reports** | | |
|---|---|---|
| **5b. Physical Abilities** | | |
| 1. Can the child use hands to touch objects or pictures? | Yes ☐ | No ☐ |
| 2. Does movements results in rapid fatigue? | Yes ☐ | No ☐ |
| 3. Is the child's ability to move deteriorating? If 'yes' explain further | Yes ☐ | No ☐ |

| 5c. Upper limb function (fill only in the case of child presenting with motor impairment) | | | |
|---|---|---|---|
| Dominant hand | Left ☐ | Right ☐ | no hand dominance ☐ |
| Fingers, hands and arms | Left | Right | Comment/details |
| Decreased range | ☐ | ☐ | |
| Decreased strength | ☐ | ☐ | |
| Contractures | ☐ | ☐ | |
| Ataxia / Dyspraxia | ☐ | ☐ | |
| Tone | ☐ | ☐ | Increased OR Decreased |
| Poor coordination | ☐ | ☐ | |
| Tremor | ☐ | ☐ | |
| Give examples of what activities of daily living the child can/cannot do with their hands (e.g., eating, writing, pressing/swiping tablets, typing…): | | | |

| 5d. Head/neck control (fill only in the case of child presenting with motor impairment) | | | | |
|---|---|---|---|---|
| | **Yes** | **No** | **Unknown** | **Describe what supports are in place to achieve head control** |
| Rotate head left and right | ☐ | ☐ | ☐ | |
| Flex neck down (look down) | ☐ | ☐ | ☐ | |
| Extend neck (look up) | ☐ | ☐ | ☐ | |
| Flex neck left (ear to shoulder) | ☐ | ☐ | ☐ | |
| Flex neck right (ear to shoulder) | ☐ | ☐ | ☐ | |

| 5e. Eye movement (fill only in the case of child presenting with motor impairment) | | | | |
|---|---|---|---|---|
| | **Yes** | **No** | **Unknown** | **Comment/Details** |
| Up and down movement | ☐ | ☐ | ☐ | |
| Left and right movement | ☐ | ☐ | ☐ | |
| Nystagmus | ☐ | ☐ | ☐ | |
| Strabismus | ☐ | ☐ | ☐ | |

| 5f. Mobility (fill only in the case of child presenting with motor impairment) | | | | |
|---|---|---|---|---|
| | **Yes** | **No** | **Assistance required** | **Comment/Details** |
| Ambulant (able to walk) | ☐ | ☐ | ☐ | Aids (frames/crutches) |
| Manual wheelchair | ☐ | ☐ | ☐ | Make and model (attach photo of user in his wheelchair) |

| | | | | |
|---|---|---|---|---|
| Powered wheelchair | ☐ | ☐ | ☐ | Make and model (attach photo of user in his wheelchair) |
| Buggies/strollers | ☐ | ☐ | ☐ | Make and model (attach photo of user in his wheelchair) |

☐ Uses headrest
☐ Uses wheelchair tray

If the wheelchair is powered, how is it operated?

Joystick ☐ Switch ☐ Scanning device ☐

Other ☐ Please specify _____

If wheelchair is controlled via switches, where are they mounted?

Head switch ☐ Knee switch ☐ Hand switch ☐

Other ☐ Please specify _____

How many switches are used?

Do you know if the wheelchair is likely to change soon?

**5g. Seating: Majority of the day (fill only in the case of child presenting with motor impairment)**

| | Yes | No | Comment/Details – approximately how many hours and where |
|---|---|---|---|
| Armchair | ☐ | ☐ | |
| Manual wheelchair | ☐ | ☐ | |
| Powered wheelchair | ☐ | ☐ | |
| Buggie/stroller | ☐ | ☐ | |
| Bed | ☐ | ☐ | |
| Other | ☐ | ☐ | |

If the child uses a wheelchair, how is he/she transferred?

Please select which diagram below best describes child's seating angle?


To your knowledge in which position does the child function best?

## SECTION 6: COGNITION AND BEHAVIOUR

| **6a. Cognitive function** | | | |
|---|---|---|---|
| **Please attach the most recent psychologist report (if available)** | | | |
| | **Yes** | **No** | **Comment/Details on the ability to learn to use new equipment** |
| Memory impairment | ☐ | ☐ | |
| Reduced learning ability | ☐ | ☐ | |
| Reduced attention span | ☐ | ☐ | |
| Reduced reasoning/problem solving | ☐ | ☐ | |

| **6b: Behaviour** | | | |
|---|---|---|---|
| | **Yes** | **No** | **Comment/Details** |
| Does the child have any current challenging behaviours | ☐ | ☐ | How does the child respond in frustrating situations? |
| Is the child at risk of developing behavioural issues due to lack of communication? | ☐ | ☐ | Describe why you think this may happen |

Describe any emotional / psychological factors which may affect the assessment at ACTU.

Are there strategies that can be used to reduce risk within the assessment?
***Attach any behaviour support plans if these have been written***

## SECTION 7: READING AND WRITING SKILLS

**Please attach the most recent IEP document**

**7. Reading and writing skills**

Reading comprehension (tick all that apply):

- ☐ Able to read short stories
- ☐ Able to read newspaper articles
- ☐ Able to read paragraphs for meaning
- ☐ Able to read sentences for meaning
- ☐ Able to read short sentences for meaning
- ☐ Able to read single words for meaning
- ☐ Unable to read single words for meaning

Spelling/writing e.g. with pen, keyboard, alphabet chart or other means (tick all that apply):

- ☐ Able to use sentences/paragraphs
- ☐ Able to convey short phrases
- ☐ Able to spell single words
- ☐ Emerging/able to spell part of words
- ☐ Not able to spell

## SECTION 8: COMPUTER ACCESS

| **8. Current computer access** |
|---|
| Describe the child's previous experience of using computers/tablets: |
| Does the person have access to a computer? Yes ☐ No ☐ |
| Does the child have access to a tablet? Yes ☐ No ☐<br>If you answered 'yes' please write the model and make of the tablet: |
| How does the child access computers/tablets: |

## SECTION 9: ADDITIONAL INFORMATION

| **9a. Additional information (e.g. include hobbies, cartoons or TV programs, music, other likes and dislikes)** |
|---|
| |

| **9b. Attached documents/reports** |
|---|
| Details of attachment/s:<br>☐ Speech and language therapy report<br>☐ Occupational therapy report<br>☐ Physiotherapy report<br>☐ Psychologist's report<br>☐ IEP<br>☐ Court decree/contract part/birth certificate<br>List other reports here: |

| | |
|---|---|
| **ACTU**<br>**Sonia Tanti Independent Living Centre**<br>**Ħal Far Industrial Estate, Ħal Far** | **Tel: 21653938 / 21653991**<br>**E-mail: actu.sapport@gov.mt** |

## SECTION 10: CONSENT

I/We, the undersigned in my/our capacity of guardian(s) / parent(s) of _____, bearer of I.D. card number _____, (hereinafter referred to as "the Client") am giving my consent to Aġenzija Sapport, to process and hold personal and sensitive personal data concerning the Client as necessary so that the Client can receive ACTU service from the aforesaid Agency in accordance with this application.

I understand that:

- By opting out, my application cannot be processed;
- If I do not give my consent, ACTU professionals authorised by Aġenzija Sapport will not be in a position to provide the Client with any of its service;
- I accept home and school visits from ACTU professionals;
- To ensure that the Client receives professional help, professionals involved in the case and persons authorised by Aġenzija Sapport, who may be assigned with different units and services within the Agency, may have access to the Client's personal and sensitive information, in accordance with the confidentiality policy of the Agency;
- Data provided by the undersigned may be retained by Aġenzija Sapport or transferred to third parties to provide me and the Client with the best possible service or otherwise as required by law. Data about the Client may also be collected from third parties for these purposes;
- Data files would be kept under lock and key when not in use;
- Certain information, which in no way can be used to identify the Client, can be processed for statistical and research purposes;
- Information which I share about minors or persons considered vulnerable who are victims of abuse or who Aġenzija Sapport deems to be at risk of abuse, may be passed on to other relevant authorities, including police, both locally or internationally, in circumstances where this would be in the best interest of the persons in question;
- Information about the Client may be passed on to other relevant authorities, including police, both locally or internationally, in circumstances where Aġenzija Sapport deems that the Client can be a risk either to himself/herself or to a third person or where the Client might potentially be at risk because of someone else, or in circumstances where Aġenzija Sapport is compelled by law to disclose such data;
- Information about the Client may also be disclosed to relevant authorities who are authorised by law to request such data in the exercise of their official authority;

- Aġenzija Sapport workers may be asked to give their testimony in pending or future Court cases, and the Courts may, under certain circumstances, oblige the worker to give witness and pass on information which could have been communicated to them by the Client or by a third person about the Client or about someone else.

- I/we am/are aware that for the purpose of the Data Protection Act (Chapter 440 of the Laws of Malta, 2002), I/we can make a written request to be informed which information about the Client is stored by Aġenzija Sapport. I/we am/are also aware that for the purpose of the same Act, the Data Controller within Aġenzija Sapport is:

Ms Ruth Rose Sciberras, Chief Executive Officer, Aġenzija Sapport

Triq Patri Ġwann Azzopardi, Santa Venera, SVR 1614

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I/we confirm that I/we have read this declaration myself/ourselves and that I/we understood it ☐

I/we confirm that this declaration was read to me/us and that I/we understood it ☐

Parent/Guardian 1: _____ I.D.: _____

Signature: _____

Parent/Guardian 2: _____ I.D.: _____

Signature: _____ Date:_____

*I/we hereby give permission to Aġenzija Sapport to contact me/us to gather information for statistical purposes or to invite me/us or the Client to participate in research studies, even after the Client no longer receives service from Aġenzija Sapport.* ☐

*I/We can be contacted on:* _____

Signature: _____

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