



OFFICE USE ONLY	
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ACTU SPECIALIST ASSISTIVE TECHNOLOGY SERVICE (TO BE FILLED BY A PROFESSIONAL)

Referral Form: Children and Young People

This referral form is to be filled in by the child’s Speech & 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. For a request to be accepted, sections must all be completed. **Incomplete forms will be returned, including if reports are missing.**

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 Access to Communication and Technology Unit (ACTU), Ċentru Pastorali Qalb ta’ Ġesù, Bizantini Street, Qrendi.** Please phone **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, there *must be*:

- Development beyond cause and effect
- Some evidence of trying to/using AAC, including: unaided/low-tech/high-tech AAC

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 **21653991/email actu.sapport@gov.mt** prior to completing the referral if you would like to discuss further options for accessing ACTU services.

SECTION 1: CHILD'S INFORMATION

1a. Child's personal information		
Child's name:		
Address:		
Date of birth:	I.D. number:	
Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>		
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 <input type="checkbox"/> Deteriorating <input type="checkbox"/> Improving <input type="checkbox"/>
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: SERVICE REQUEST AND EGLIBILITY

3a. What Service would you like to access? Choose only 1	
Augmentative and Alternative Communication (AAC): <input type="checkbox"/> (Go to section 3b.)	
Electronic Assistive Technology (EAT) Services <input type="checkbox"/> (Go to section 3c.)	
3b. AAC service: Meets the following criteria	
Does the child understand cause and effect? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Is there a discrepancy between their understanding and ability to speak? Yes <input type="checkbox"/> No <input type="checkbox"/>	
<i>Provide examples from your observations:</i>	

Have AAC systems and strategies been trialed? Yes No

Which AAC system/strategies have been trialed? Describe the system/strategy?

How is the child able to use the AAC system/strategy?

If they are considered insufficient to meet communication needs, describe below.

****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.***

****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?

Yes No

Is the student able to use standard keyboard and standard mouse to access the computer?

Yes No

If you answered No, explain why:

Is the student able to use standard keyboard and standard mouse together with literacy-based software?

Yes No

If you answered No, explain why:

****If you have answered "yes" to one of 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.***

****If you answered "No" to the above questions, proceed to section 3d, 3e, 4c and sections 5 to 9.***

3d. Which Electronic Assistive Technology service is required?

- Computer access
- Environmental control (EC)

3e. Referral question Carefully consider the abilities question based on the service requested in section 3
What specific goals would you like AAC/ EAT to achieve?
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 Tick all modes of communication which the child uses in the 'Used' column		
	Used	Details/limitations/issues
Verbal expression	<input type="checkbox"/>	
Written text	<input type="checkbox"/>	
Partner-assisted scanning	<input type="checkbox"/>	
Low tech AAC (e.g. paper chart, E-Tran Frame, PECS, communication book)	<input type="checkbox"/>	
Gesture/Signing/Facial Expression Please include results of the AAC Pragmatics Profile/ Communication Matrix	<input type="checkbox"/>	

High Tech AAC device	<input type="checkbox"/>	
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Other	<input type="checkbox"/>	
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What strategies help with communication?

4b. Communication ability

Speech therapy diagnosis:

	Strengths	Limitations
Speech		
Symbol use (State symbol type)		
Social communication		

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

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

Expression (by any means- **including AAC**: tick the highest level the child can achieve)

- Able to communicate basic wants and needs using body/face
- 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 by any means (e.g. comment, share information, attract attention, etc.)

- Requesting _____
- Negation/cessation _____
- Greetings _____
- Other functions _____
- Answering questions _____
- Commenting _____
- Asking questions _____

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

5a. Sensory perceptual			
Please attach any reports indicating visual and/or hearing status			
	Yes	No	Comment/Details on function
Visual impairment	<input type="checkbox"/>	<input type="checkbox"/>	<i>List any visual perceptual issues experienced by the client</i>
Hearing impairment	<input type="checkbox"/>	<input type="checkbox"/>	Are hearing aids in place? Yes <input type="checkbox"/> No <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Please attach audiogram Please specify
Sensory processing issues	<input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Please attach OT report Please specify
5b. Physical Abilities			
Please attach the most recent occupational therapy and/or physiotherapy reports			
1. Can the child use hands to touch objects or pictures?	<input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Does movements results in rapid fatigue?	<input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Is the child's ability to move deteriorating? If 'yes' explain further	<input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
5c. Upper limb function (fill only in the case of child presenting with motor impairment)			
Dominant hand	Left <input type="checkbox"/> Right <input type="checkbox"/> no hand dominance <input type="checkbox"/>		
Fingers, hands and arms	Left <input type="checkbox"/>	Right <input type="checkbox"/>	Comment/details
Decreased range	<input type="checkbox"/>	<input type="checkbox"/>	
Decreased strength	<input type="checkbox"/>	<input type="checkbox"/>	
Contractures	<input type="checkbox"/>	<input type="checkbox"/>	
Ataxia / Dyspraxia	<input type="checkbox"/>	<input type="checkbox"/>	
Tone	<input type="checkbox"/>	<input type="checkbox"/>	Increased OR Decreased
Poor coordination	<input type="checkbox"/>	<input type="checkbox"/>	
Tremor	<input type="checkbox"/>	<input type="checkbox"/>	
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Flex neck down (look down)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Extend neck (look up)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Flex neck left (ear to shoulder)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Flex neck right (ear to shoulder)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

5e. Eye movement (fill only in the case of child presenting with motor impairment)

	Yes	No	Unknown	Comment/Details
Up and down movement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Left and right movement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nystagmus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Strabismus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

5f. Mobility (fill only in the case of child presenting with motor impairment)

	Yes	No	Assistance required	Comment/Details
Ambulant (able to walk)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Aids (frames/crutches)
Manual wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Make and model (attach photo of user in his wheelchair)
Powered wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Make and model (attach photo of user in his wheelchair)
Buggies/strollers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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	<input type="checkbox"/>	<input type="checkbox"/>	
Manual wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	
Powered wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	
Buggy/stroller	<input type="checkbox"/>	<input type="checkbox"/>	
Bed	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	

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

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



upright



tilt



recline

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

SECTION 6: COGNITION AND BEHAVIOUR
THIS SECTION IS REQUIRED FOR ALL REFERRALS

6a. Cognitive function			
Please attach the most recent psychologist report (if available)			
Tick yes/no for the child being assessed	Yes	No	Comment/Details on the ability to learn to use new equipment
Memory impairment	<input type="checkbox"/>	<input type="checkbox"/>	
Reduced learning ability	<input type="checkbox"/>	<input type="checkbox"/>	
Reduced attention span	<input type="checkbox"/>	<input type="checkbox"/>	
Reduced reasoning/problem solving	<input type="checkbox"/>	<input type="checkbox"/>	
6b: Behaviour			
	Yes	No	Comment/Details
Does the child have any current challenging behaviours	<input type="checkbox"/>	<input type="checkbox"/>	How does the child respond in frustrating situations?
Is the child at risk of developing behavioural issues due to lack of communication?	<input type="checkbox"/>	<input type="checkbox"/>	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? <i>*Attach any behaviour support plans if these have been written</i>			

SECTION 7: READING AND WRITING SKILLS
THIS SECTION IS REQUIRED FOR ALL REFERRALS

Please attach the most recent IEP document
7. Reading and writing skills
Reading comprehension (tick all that apply):
<input type="checkbox"/> Able to read short stories
<input type="checkbox"/> Able to read newspaper articles
<input type="checkbox"/> Able to read paragraphs for meaning
<input type="checkbox"/> Able to read sentences for meaning
<input type="checkbox"/> Able to read short sentences for meaning
<input type="checkbox"/> Able to read single words for meaning
<input type="checkbox"/> Unable to read single words for meaning
<input type="checkbox"/> Able to recognise letters
<input type="checkbox"/> Unable to recognise letters
Spelling/writing e.g. with pen, keyboard, alphabet chart or other means (tick all that apply):
<input type="checkbox"/> Able to use sentences/paragraphs
<input type="checkbox"/> Able to convey short phrases
<input type="checkbox"/> Able to spell single words
<input type="checkbox"/> Emerging/able to spell part of words
<input type="checkbox"/> Not able to spell

SECTION 8: COMPUTER ACCESS
THIS SECTION IS REQUIRED FOR ALL REFERRALS

8. Current computer access
Does the child use computers/tablets:
Does the person have access to a computer? Yes <input type="checkbox"/> No <input type="checkbox"/>
Does the child have access to a tablet? Yes <input type="checkbox"/> No <input type="checkbox"/>
If you answered 'yes' please write the model and make of the tablet:
How does the child access computers/tablets:
<input type="checkbox"/> Turn on tablet
<input type="checkbox"/> Locate an app
<input type="checkbox"/> Use a mouse
<input type="checkbox"/> Close an app
<input type="checkbox"/> Watch films/videos

<input type="checkbox"/> Use educational apps
<input type="checkbox"/> Play games
<input type="checkbox"/> Browse
<input type="checkbox"/> Navigate between apps and/or programmes
<input type="checkbox"/> Other: _____

SECTION 9: ADDITIONAL INFORMATION
THIS SECTION IS REQUIRED FOR ALL REFERRALS

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

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9b. Attached documents/reports

Details of attachment/s: <input type="checkbox"/> Speech and language therapy report <input type="checkbox"/> Occupational therapy report <input type="checkbox"/> Physiotherapy report <input type="checkbox"/> Psychologist's report <input type="checkbox"/> IEP <input type="checkbox"/> Court decree/contract part/birth certificate List other reports here:

ACTU Access to Communication and Technology Unit (ACTU), Ċentru Pastorali Qalb ta' Gesu, Bizantini Street, Qrendi	Tel: 21653991 E-mail: actu.support@gov.mt
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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:

Mr Oliver Scicluna, Chief Executive Officer, Aġenzija Sapport
Triq Patri Ġwann Azzopardi, Santa Venera, SVR 1614

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: _____
