Alberta Health Services

Affix patient label within this box

I CAN Centre for Assistive Technology
Request for Services, Adults

■ Please return with completed secondary forms and supporting documents

MAIL
I CAN Centre for Assistive Technology
Glenrose Rehabilitation Hospital
Room 38, 10230 – 111 Ave.
Edmonton, AB, T5G 0B7

FAX 780-735-6072
EMAIL icancentre@albertahealthservices.ca

This referral form is used to gather information that is needed to assess your need for assistive technology. It may be filled out in consultation with family members, caregivers and therapists, if applicable. Please complete the secondary forms related to your need.	
Name	Personal Health Care Number
Date of Birth *(yyyy-Mon-dd)*	Home Address *(Street, City, Postal Code)*
Medical Diagnosis	Date of Onset of Symptoms or Diagnosis
Daytime Phone	Email

Alternate Contact	Daytime Phone
Relationship to Client	Email
Many people benefit from having a family member, caregiver, or other professional to help them with equipment trials and ongoing use of assistive technology. Without such a person, assistive technology is often unsuccessful. Do you have someone who can support you in this way? If possible, this person should come with you to the assessment	
Name of Support Person	
Daytime Phone	Email
Where do you live now? ☐ Home *(Same address as above)* ☐ Acute Care Hospital ☐ Extended Care ☐ Lodge ☐ Group Home	
Facility name and address *(Street, city, postal code)*	Phone
Hospital Use Only	
WL	Booked

Alberta Health Services

I CAN Centre for Assistive Technology
Request for Services, Adults

Information About You

Cognitive Status/Involvement Which areas are affected? *(√ Check all that apply)*	**Sensory/Perceptual Status** *Are there concerns in the following areas? (√ Check all that apply)*
☐ Attention ☐ Concentration ☐ Short Term Memory ☐ Judgment ☐ Insight ☐ Problem Solving ☐ Ability to learn new tasks ☐ Fatigue / endurance ☐ Orientation to person ☐ Orientation to time ☐ Orientation to place ☐ Frustration tolerance ☐ Ability to change task or topic ☐ History of learning disabilities	☐ Neglect ☐ Visual Tracking ☐ Visual field deficits ☐ Nystagmus ☐ Visual scanning ☐ Hemianopsia ☐ Shifting gaze between targets ☐ Double vision ☐ Blurred vision ☐ Fluctuations in vision ☐ Visual acuity ☐ Wears corrective lenses ☐ Altered / diminished sensation ☐ Hearing ☐ Other perceptual difficulties

Physical Abilities and Limitations

Describe tremor, weakness, or paralysis *(e.g. unable to move legs, weak arms, and shaky head)*.
How does your condition affect your physical abilities?

Describe movements that are easy to perform (*e.g. tip head sideways, shoulder shrug, pointing with index finger)*.
Are these movements consistent? Do they cause fatigue? How many repetitions can you reliably do?

Alberta Health Services

I CAN Centre for Assistive Technology
Request for Services, Adults

Communication Abilities

My primary language is ☐ English ☐ Other *(Specify language spoken)* _____

Which of the following people understand your speech?

☐ No one
☐ Family members ☐ Friends and acquaintances
☐ Caregivers ☐ Strangers
☐ Everyone

How do you indicate yes and no?

☐ Speaking
☐ Head movements
☐ Eye blinks ☐ Pointing to printed words
☐ Other: _____

Work and Education History

Are you currently working or going to school? What is your education and work history? _____

_____

_____

Information About your Need for Assistive Technology

What tasks do you have difficulty with that you feel may be helped by Assistive Technology? *(√ Check all)*

☐ Spoken Communication *(complete secondary form **Adult Communication Form**)*
If your diagnosis is **aphasia** *(complete secondary form **Adult Communication Skills Communicator Types for Aphasia**)*
You may need a Speech Language or Rehab Therapist to help you complete this form.
☐ Using a computer or mobile device for:
☐ Writing *(complete secondary forms **Mechanics of Writing, Composing Written Material**)*
☐ Reading *(complete secondary form **Reading Skills**)*
☐ Communication
☐ Memory and organization
☐ Using a telephone, home entertainment equipment, call bell access
☐ Driving a power wheelchair *(complete secondary form **Adult Power Mobility Form**.)*

What Assistive Technology do you currently use *(√ Check any that apply)*	**Using now**	**Has used**	**Not working**
☐ Communication board with picture/symbol display			
☐ Communication board with words and letters			
☐ Communication device with voice output			
☐ Amplification system			
☐ Vision aids			
☐ Computer, no modifications			
☐ Computer, with modified keyboard or mouse			
☐ Writing aids *(e.g. pencil grip)*			
☐ Environmental control unit			
☐ Manual wheelchair			
☐ Power wheelchair			
☐ Other *(describe)*:			

Is there technology you have seen or heard about that you think may be helpful to you?

_____

Alberta Health Services

I CAN Centre for Assistive Technology
Request for Services, Adults

Information From Other Rehabilitation Professionals			
If you have seen a speech-language pathologist or other rehabilitation professionals for assessment or therapy regarding your present condition, they may have information helpful to us. Please ask them to forward any available reports to the I CAN Centre. May we contact them? ☐ Yes ☐ No			
Your Team	**Name**	**Phone**	**Email**
☐ Speech Language Pathologist			
☐ Occupational Therapist			
☐ Physical Therapist			
☐ Home Care Worker			
☐ Caregiver / Companion			
☐ Other			

Person completing form *(Print Name)*	Date*(yyyy-Mon-dd)*	Phone
Relationship to client	Signature	