Alberta Health Services

Affix patient label within this box

I CAN Centre for Assistive Technology
Request for Services, Children

■ 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)*
Daytime Phone	Email
Parent's Names	

Medical Information

Medical Diagnosis

Medical considerations

☐ Speech/Language
☐ Cognitive Disability *(attention, memory, new learning)*
☐ Has frequent ear infections
☐ Learning Disability
☐ Hearing Impairment
☐ Vision Impairment
☐ Emotional Disturbance
☐ Mobility
  ☐ Walking aides ☐ Manual wheelchair ☐ Power wheelchair
  ☐ Seating system _____
  Last seating appointment _____
☐ History of seizures
☐ Has degenerative medical condition
☐ Has frequent upper respiratory infections
☐ Has digestive problems
☐ On medication for seizure control
☐ Tremors
☐ Currently taking medication for _____

Are there any behaviors (both positive and negative) that significantly impact your child's performance?

_____

_____

Are there significant factors about your child's strengths, learning style, coping strategies, or interests, the team should consider?

_____

_____

Hospital Use Only

WL	Booked

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Assistive Technology Need

My referral to the I CAN Centre is to look at technology to support my child with

☐ **Communication** *(complete secondary form **Child Communication**)*
- ☐ Classroom Participation and Group Discussions
- ☐ Social Interaction and Conversation
- ☐ Other *(please describe)* _____

☐ **Academic Tasks** *(complete secondary forms **Composing Written Materials, Mechanics of Writing, Reading Skills**)*
- ☐ Writing
- ☐ Reading
- ☐ Math
- ☐ Organization

☐ **Play and Leisure Activities**

☐ **Power Mobility** *(complete secondary form **Child Power Mobility**)*

Program Information

Child is seen by other Glenrose programs ☐ Yes ☐ No

Please list _____

My child receives therapy services
- ☐ At Home
- ☐ At school
- ☐ SLP
- ☐ OT
- ☐ PT
- ☐ Academic

Current Educational Placement
- ☐ Early Education Program
- ☐ Elementary, Gr. _____
- ☐ Pre School Program
- ☐ Junior High, Gr _____
- ☐ Kindergarten
- ☐ High School Gr _____
- ☐ Other _____

Classroom Setting
- ☐ Regular classroom
- ☐ Educational Assistant
- ☐ Modified Program

School Name	School Contact person

Address *(Street, city, Postal Code)*	Phone	Email

Student's Team	**Name**	**Contact Info**
☐ Classroom Teacher		
☐ Special Education Teacher		
☐ Educational Assistant		
☐ Principal		
☐ Speech Language		
☐ Occupational Therapist		
☐ Physical Therapist		
☐ Other		

Are there likely to be changes in the child's program in the near future?

☐ New Teacher/Educational Assistant ☐ New School ☐ New Program

What issues or question(s) would you like the I CAN Centre team to address through this referral? Please be as specific as possible. _____

Person(s) completing form *(Print Name)*	Parent's Signature
School Contact Signature	Date Completed *(yyyy-Mon-dd)*