

**ASSISTIVE DEVICES RESOURCE SERVICE
Referral Form**

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| <input type="checkbox"/> Peel
<input type="checkbox"/> Halton
<input type="checkbox"/> Dufferin County |
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<u>PLEASE PRINT AND COMPLETE IN FULL</u>	
Client name:	Diagnosis: <input type="checkbox"/> Stable <input type="checkbox"/> Degenerative
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	DOB: (dd/mm/yyyy) Client E#: <input type="checkbox"/> N/A
Parent/Guardian Names:	
Phone (home):	Phone (work/cell):
Street Address:	City/Postal Code:
School/Daycare:	School/Daycare Phone:
Primary School/Daycare Contact Name(s):	
Parent/Guardian Email: (optional)	School/Daycare Email: (optional)
Primary Language:	Translation Services Required: <input type="checkbox"/> Appointments <input type="checkbox"/> Documentation

ASSESSMENT REQUEST: Select all that apply

- Face to Face Communication (*complete Face to Face Questionnaire*)
- Written Communication (*complete Writing Aid Questionnaire*)
- Adapted Access: for Face to Face Communication technology (*complete Adapted Access Questionnaire*)
- Adapted Access: to computer for non-writing activities (e.g. mouse control, switch access) (*complete Adapted Access Questionnaire*)
- Adapted Access: for toys, Environmental Aids for Daily Living (EADL) (*complete Adapted Access Questionnaire*)

Assessment to address technology needs at:	
<input type="checkbox"/> Home	<input type="checkbox"/> Home and school
Note: <i>If technology is only needed at school, please follow up with your school for service options (e.g. Special Education Resources, School Health Support Services).</i>	

ADRS History:	
<input type="checkbox"/> New ADRS client	<input type="checkbox"/> Previous ADRS client
<input type="checkbox"/> Seating clinic client (current or past)	
Communication Skills:	
<input type="checkbox"/> Verbal	<input type="checkbox"/> Non-Verbal
<input type="checkbox"/> Verbal Challenges (explain):	
Major transition events anticipated within 12 months (e.g. new school, aging out of ErinoakKids, etc.)?	
Additional information you wish to provide:	

<u>SERVICE CLASSIFICATION</u>	
<input type="checkbox"/> Existing ErinoakKids client	<input type="checkbox"/> New to ErinoakKids
<p><i>Complete questionnaire(s) corresponding to the type of referral.</i></p> <p style="text-align: center;"><i>Submit this form and questionnaire(s) to:</i></p> <p style="text-align: center;">ErinoakKids Intake Services 10145 McVean Drive Brampton, ON L6P 4K7 Phone 905-855-2690 (press 1) 1-877-374-6625 (press 1) Fax 905-855-9451</p> <ul style="list-style-type: none"> <u>All</u> of the above must be completed and submitted before the referral will be processed. 	
Referred by:	Contact info:
Referring discipline:	Referral date:

Referral coding (for ADRS to complete)			
1 Priority	2 Consult	3 Re-referral	4 Regular Referral