

**ASSISTIVE DEVICES RESOURCE SERVICE
Questionnaire - Adapted Access Referral**

<input type="checkbox"/> Peel <input type="checkbox"/> Halton <input type="checkbox"/> Dufferin County
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PLEASE PRINT AND COMPLETE IN FULL
To be submitted with the ADRS Referral Form.

Name of Client:	Diagnosis:
D.O.B.: (dd/mm/yyyy)	E #:

Switch Access: check any that apply

Client is motivated by/demonstrates interest in: _____

Client demonstrates cause and effect skills/awareness.

Client has a body part with consistent/accurate movement: _____

Client has tried switches (switch type?): _____

Client tried simulated switch use: _____

Activities client has tried switches with:

toys with movement
 toys with music/sound
 toys with lights
 computer (see next section) speech generating device: _____
 other: _____

Non-writing computer use: check any that apply

Client has tried using a standard keyboard yet has physical difficulty accessing it.

Client has tried using a standard mouse yet has physical difficulty handling it.

Client has tried alternatives to a standard keyboard and/or mouse: _____

Client would like to use a computer:

to play keyboard/mouse based games
 to access early education software
 to develop keyboarding skills
 other: _____

Additional information:

Completed by:	Date completed:
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