Assistive Technology – Regional Service

Forms for Referral & Information Pack.

A.T. Regional Service, Enable Ireland, Seamus Quirke Road, Galway. **H91 E8P4**

atwest@enableireland.ie

091 545 800

Enable Ireland, Seamus Quirke Road, Galway. **H91 E8P4.** Tel: **091 545 800** Email: **atwest@enableireland.ie.**

Assistive Technology – Regional Service
Information for Your Referral

Background: This booklet aims to describe the process for submitting a referral to the A.T. Regional Service. This booklet includes all of the necessary forms to support your referral.

The A.T. regional team supports the **lead clinician model**. Further detail about this model as it relates to a referral, can be found on **Page 4** of this booklet under the **Assistive Technology Service Pathway.** This model operates under the principals of the "National Policy on Access to Services for Children & Young People with Disability and Developmental Delay" - **Ref** http://bit.ly/PDSDoc2019.

For a referral to be accepted, this form must first be completed in full and then returned to the team for consideration. Forms received and which are incomplete, **will be returned**.

While recommendations for Assistive Technology may form part of an episode, referrers should be aware that the A.T. Team does not provide funding for these items.

This booklet is available in alternative forms. If required, please **email** your request to atwest@enableireland.ie or, **phone** the Team Administrator at **091 545800.**

Essential Requirements - For All Referrals

		Please ✓
Contact details (in FULL). Include contact details for the child / YP (Young Person), and their parent / guardian. School, CDNT and Lead Clinician information is also essential.	Pages 6 & 8	☐
Reason for referral. Please provide details about the specific challenge/s it is hoped this referral will address.	Page 7	☐
Reports / Programmes - relevant to referral. Reports should support the purpose for this referral. Furthermore, this information should highlight all previous strategies used to address the reasons for submitting this referral.		☐
Details of all CDNT Clinicians / Professionals actively involved with the child / YP.	Page 8	☐
Consent for Service Forms – Signed by all relevant parties. Note: Forms are age dependant. Not all of the forms included may be relevant to the child / YP.	Pages 9 - 12	☐

Service Exclusion Criteria

Child / YP is already receiving assistive technology support/s through another service or team.

Referrals seeking support around mainstream technology (I.T. support) and / or general I.T such as (but not limited to):

- Learning how to use a keyboard, typing programmes or using a standard mouse
- General computer maintenance
- Setting up home printers, networks or cable systems etc

Information for CDNTs in advance of referral. All pre-referral stages from **TABLE A** below, should be completed in full before contacting the A.T. Regional team. Once team contact is initiated, the following are essential to support a full referral pathway;

1. Information on current programmes (including interventions and treatments) – with a particular focus on those which support the identified functional goal/s.
2. Details of the relevant functional goals. This should include the reason behind considering the use of assistive technology. **TABLE B** provides a support in this regard.
3. Evidence of all of the previous strategies used to advance the functional goal/s. This should include the levels of success and if relevant, why they weren't achieved.

Table A: Preparing for Referral

Recommended sequence

	Check ✓
CDNT complete their goal setting with the parent / guardian and if appropriate, the child / YP being considered for referral.	☐
Functional goals – those which are deemed relevant through use of assistive technology and which have been identified by the CDNT.	☐
CDNT review potential resources and approaches to address these goals – **REF: Table B** below.	☐
CDNT nominate a key contact person **(Lead clinician)** to direct the referral on behalf of the child / YP / family for the duration of their A.T. involvement – a period referred to as an **Episode of Care (EOC).**	☐
The Lead clinician contacts the A.T. Administrator / Team to discuss the most appropriate referral approach – * **Phone or Video Consultation / Information / Full Referral.** Should a full referral pathway be deemed appropriate, a referral form will be sent to the Lead Clinician who then then takes responsibility for gathering all relevant reports / programmes to support their referral.	

* Phone and video consultations are available to discuss and identify the appropriateness of a referral and potentially, relevant strategies.

Table B: Assistive Technology Resources

Enable Ireland website - www.enableireland.ie/services/assistivetechnology.
Enable Ireland (A.T.) YouTube Channel – www.youtube.com/user/enableirelandat
"ATandMe" Blog - www.atandme.com

Enable Ireland, Seamus Quirke Road, Galway. H91 E8P4. Tel: 091 545 800 Email: atwest@enableireland.ie.

Assistive Technology (WEST) - Regional Service Pathway

Preparing for Referral: Primary (CDNT) Team.

Local team complete the Referral preparation steps - **Table A** on **Page 3**.

Lead Clinician nominated for CDNT goal/s setting.

Lead Clinician

Contact A.T. Admin.
T: 091 545800
E: atwest@enableireland.ie.

Episode of Care (E.O.C)

Lead Clinician Roles

- ✓ Attends for all meeting/s with the child / family & A.T. team.
- ✓ Advocates needs of child / YP.
- ✓ Liaises with the CDNT on programme planning, goal setting & equipment trial.
- ✓ Maintains contact with A.T. team around programme work & equipment trial.

Collaboration Phase

Phone / Video Consultation

Referral / E.O.C: Assistive Technology Team

Administration (Approx. 3 weeks to Complete)

Referral request reviewed by Team in line with referral criteria. If successful, A.T. team lead is identified and appointment detail sent to local team.

Successful

Referral Unsuccessful

Episode of Care (E.O.C)

- ✓ Team meeting with child / young adult / parent / guardian with lead clinician.
- ✓ Assessment. EOC detail agreed. **Plan** including estimated timeframes.
- ✓ Equipment **trial & review.**

E.O.C. - Complete.

- **Report** – if relevant.
- **Recommendations** sent to parent / guardian and the lead clinician.
- **E.O.C Closure / Service discharge.**

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Assistive Technology Referral Form Child / Young Person (YP)

OFFICE USE ONLY		
DATE RECEIVED		NOTES
INITIAL CRITERIA MET	YES ◯ NO ◯	
APPT TYPE	IP ◯ PHONE ◯ VIDEO ◯	

Child / Young Person

Name	
Home Address	
Eircode	
Date of Birth	Gender
Translator required for appointments?	Yes ◯ No ◯
Preferred Language	

Guide on How to Complete

If this your first occasion to compete a referral as a lead clinician, please read **PAGES 2 - 4** of this booklet.

Incomplete referrals - i.e. referral forms submitted without the relevant report/s and / or with incomplete detail - will be returned.

Parent 1 / Guardian

Name	
Mobile No.	
Email	

Parent 2 / Guardian

Name	
Mobile No.	
Email	

Name of the primary guardian for A.T. team contact	
*Address (if different to the home above)	

* Please indicate relevant home arrangements for postages. For example, if parents are not living together and require correspondence to be sent to two contact addresses.

[1] Lead Clinician

Name		Role	
Mobile No.		Tel No.	
Contact Address		**Eircode**	
Email			
Signature		Date	

[1] In line with the National Policy on Access to Services for children and young people with Disability and Development Delay (Ref No SC&PC 01; Date 24.02.2016), all referrals should be completed by a lead clinician from the CDNT.

Referral Detail			
Type of Referral (Tick one)	**Information** ○	**Training** ○	**Assessment (Full)** ○

Tell us what you would like the assistive technology to achieve.	
	Task
1	
2	
3	

How does this child / YP currently perform these tasks and what supports are in place?
Please provide details

Has this child / YP used Assistive Technology previously?
If yes, please provide these details below and including a short summary around its impact.

Product	**Period In Use**	**Level of Success - Including The Goals Achieved**

Has this child / YP been diagnosed with a condition associated with [2]complex needs.
Please detail

Is (or has) this child / YP accessed A.T. services or products through another team or service?
Please ✓ and if relevant, detail the team involved.

Yes ○ **No** ○

Please detail e.g.CDNT, Dept of Education, Private, Other.	

[2] As defined within the National Policy on Access to Services for children and young people with Disability and Development Delay (Ref No SC&PC 01; Date 24.02.2016).

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Essential Contacts				
Field / Clinician	**Name**	**Actively Involved (Yes / No)**	**Mobile No.**	**E-mail**
Occupational therapy				
Speech & language therapy				
Psychology (Clinical)				
Specialist Consultant				
Visiting Teacher Service (Visual)				
Visiting Teacher Service (Hearing)				
Behavioural Support				
School Liaison				
Voluntary Agencies				
[¥]Other (1)				
Other (2)				

[¥]Add all relevant Professional / Clinical team members currently involved with the child / YP and who are not detailed above, under the 'Other' fields.

School / Educational setting			
School Name		**Contact No.**	
Address		**Eircode**	

Contacts Please ✓ to indicate the primary contact				
Role	**Name**	**✓**	**Contact No.**	**Email**
Teacher		☐		
S.E.T.		☐		
S.N.A.		☐		
Other		☐		
Is the school team aware of this referral?		**Yes** ○	**No** ○	
If **No**, please detail why?				

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National Consent of Child Service User to Data Processing, Services and Direct Marketing

Re: _____ **DOB:** _____
(name of your child)

I/We _____
(name of parents/legal guardians)

acknowledge the following:

1. Personal information relating to me/us and my/our child will be processed by Enable Ireland Disability Services (Enable Ireland) and/or its partners and service providers which may include children's services teams to include members of the Progressing Disability Services ("PDS") teams, the HSE, Medical Consultants to include Dental care providers, GPs, speech and language therapists, occupational therapists, physiotherapists and any other medical treatment services/practitioners, Principals and staff of local Mainstream and Special Schools in accordance with the General Data Protection Regulation (GDPR). Enable Ireland provides full details of our data protection rights including the right to withdraw consent to data processing in the **attached** Data Protection Notice (which is also available to view online via the Privacy Policy section on Enable Ireland's website).

2. The personal information relating to me/us and my/our child will be processed for the purposes of planning and provision of services by Enable Ireland for my/our child which will include processing my/our information using online platforms (to include but not limited to: Microsoft Teams, Attend Anywhere, Webex) where there is need. My/our child's personal information will also be processed to ensure compliance with legal and regulatory obligations;

3. The processing of me/our and my/our child's personal information may include disclosure of such personal information to third parties, for example, Assessment Officers and/or Liaison Officers as part of the assessment of need process. It may also include the need to obtain relevant professional reports about my/our child from third parties.

4. The content of telephone calls that Enable Ireland makes to, and receive from me/us or about my/our child may be transcribed, as appropriate and relevant in my/our child's service user file. Enable Ireland will, where possible, contact me by text to advise me of appointments and reminders about these appointments.

5. I/We also are aware that we need to advise Enable Ireland of any changes to my/our personal information relevant to the provision of its services to me/us/our child to ensure that it holds accurate and updated information e.g. change of address or GP details.

I/We hereby **EXPLICITLY CONSENT** for the purposes of the GDPR to the processing of personal information relating to me as outlined above

Signed: ..... Date: .....
Mother/Legal Guardian (please circle as appropriate)

Print Name: _____

Signed: ..... Date: .....
Father/Legal Guardian (please circle as appropriate)

Print Name: _____

Consent Form to Enable Ireland Services

I/We _____
(**name of parents/ Legal guardians)**

of _____(**address)**

Child's name: _____ **Child's DOB:** _____/_____/_____

hereby consent to an assessment being carried out on _____
(**name of child)** by the Enable Ireland Disabilty Services (Enable Ireland) and, where appropriate, for intervention to commence.

I/We consent for Enable Ireland to access relevant information/reports from the HSE and other relevant Service Providers where necessary. Where there is a need for a referral[(1)] to another service provider (e.g. Education, Social Welfare, HSE) I/we consent to the sharing of the assessment findings and reports with these service providers.
[(1)] *Any such referral will only be made with my/our permission.*

Please note: the consent of both guardians is required when there are two.

1) Guardian Signature: _____
   Relationship to child: _____

   Date: _____/_____/_____

2) Guardian Signature: _____
   Relationship to child: _____

   Date: _____/_____/_____

Should your child be accepted into the Enable Ireland services, it would be useful to inform your local GP in order to maintain links with primary care services.

I/We consent to Enable Ireland informing our GP of our child's referral to Enable Ireland:

Yes ☐ No ☐

GP's name and address:_____

National Consent of Child Service User over 16 years to Data Processing, Services and Direct Marketing

I_____ (**name of service user**) of

_____ **(address of service user)**

DOB: _____/_____/_____

acknowledge and consent to the following:

1. Personal information relating to me will be processed by Enable Ireland Disability Services (Enable Ireland) and/or its partners and service providers which may include children's services teams to include members of the Progressing Disability Services ("PDS") teams, the HSE, Medical Consultants to include, GPs, speech and language therapists, occupational therapists, physiotherapists, dental care providers and any other medical treatment services/practitioners, Principals and staff of local Mainstream and Special Schools in accordance with the General Data Protection Regulation (GDPR). Enable Ireland provides full details of my data protection rights including the right to withdraw consent to data processing in the attached Data Protection Notice (which is also available to view online via the Privacy Policy section on Enable Ireland's website).

2. The personal information relating to me will be processed for the purposes of planning and provision of services by Enable Ireland to me which will include processing my information using online platforms (to include but not limited to: Microsoft Teams, Attend Anywhere, Webex) where there is need. My personal information will also be processed to ensure compliance with legal and regulatory obligations. This will also include processing personal information of my parents or legal guardians as these details will be recorded in my service user file.

3. The processing of my personal information may include the disclosure of such information to third parties, for example, Assessment Officers and/or Liaison Officers as part of the assessment of need process. It may also include the need to obtain relevant professional reports about me from third parties.

4. The content of telephone calls that Enable Ireland staff make about me and receive about me may be transcribed, as appropriate and relevant, onto my service user file. Enable Ireland will, where possible, contact me by text to advise me of appointments and reminders about these appointments.

5. I also am aware that I need to advise Enable Ireland of any changes to my personal information relevant to the provision services to me to ensure that Enable Ireland holds accurate and updated information about me e.g. change of address or GP details.

I hereby **EXPLICITLY CONSENT** for the purposes of the GDPR to the processing of personal information relating to me as outlined above.

This form must be signed by the service user named on this form (if over 16 years of age)

Signed: …… Date: ……
Service User

Print Name _____

This form may alternatively be signed by the parent(s)/Legal guardian(s) the child service user over 16, if appropriate.

Signed: ..... Date: .....
Mother/ Legal Guardian (please circle as appropriate)

Print Name: _____

Signed: ..... Date: .....
Father/ Legal Guardian (please circle as appropriate)

Print Name: _____

Consent Form to Enable Ireland Services

I, _____ (**name of service user**)

of_____ (**address of service user**)

DOB: _____/_____/_____

hereby consent to an assessment being carried out on me by the Enable Ireland Disabilty Services (Enable Ireland) and, where appropriate, for intervention to commence.

I consent for Enable Ireland to access relevant information/reports from the HSE and other relevant Service Providers where necessary. Where there is a need for a referral[1] to another service provider (e.g. Education, Social Welfare, HSE) I consent to the sharing of the assessment findings and reports with these service providers. [1] Any such referral will only be made with my permission.

This form must be signed by the service user named on this form (if over 16 years of age)

Signed: ..... Date: .....

Service User

Print Name _____

This form may alternatively be signed by the parent(s)/ legal guardian(s) of the child service user over age 16 if appropriate.

Signed: ..... Date: .....
Mother/ Legal Guardian (please circle as appropriate)

Print Name: _____

Signed: ..... Date: .....
Father/Legal Guardian (please circle as appropriate)

Print Name: _____

Should you be accepted into the Enable Ireland services, it would be useful to inform your local GP in order to maintain links with primary care services.

I/ We consent to Enable Ireland informing my GP of my referral to Enable Ireland:

Yes ☐ No ☐

GP's name and address:_____

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Private and Confidential -

If this booklet is misplaced, please return to;

A.T. Regional Service,

Seamus Quirke Road,

Galway H91 E8P4

Tel: 091 545 800

Email: atwest@enableireland.ie

Enable Ireland is committed to protecting your privacy and the personal information you and others provide to us. Full details about how we handle your information is available from **Enable Ireland's Privacy Statement** This is available online at **www.enableireland.ie/privacy_policy.**

If you are under 16 years of age, please read this statement with a parent or guardian and ensure you understand it. This statement outlines our approach to Data Protection to fulfil our obligations under the General Data Protection Regulation (GDPR).