Government of **Western Australia**
Department of **Health**
South Metropolitan Health Service

Communication & Assistive Technology
Level 2, State Rehabilitation Service
20 Fiona Wood Road, Murdoch WA 6150
Telephone (08) 6152 7049
FSH.AAC@health.wa.gov.au

Communication & Assistive Technology Referral Form

Reset Form

Form Version: 3.2

Service Information

Referral is required for:

☐ Communication ☐ Call bell ☐ Computer access ☐ Environmental control ☐ Voice banking / cloning

Patient Details

Current Patient Location:

Surname | First Name | UMRN | DOB

Street Address | Suburb | Postcode

Mobile | Telephone | Email

Preferred contact method

☐ I confirm that I have physically assessed the patient and deemed them appropriate for CATS.

☐ I confirm that the patient is aware of, and has consented to this referral to CATS.

Referrer Information

Name | Position | Organisation

Telephone | Email | Best days/times to contact

Initial Appointment

People who will attend initial interview

Funding options

Are Infection Control measures required?

Are there any potential risks to staff health & safety seeing this patient in clinic?

Are there any potential risks to staff health & safety if visiting this clients home in the future?

CATS will endeavour to make contact for all referrals within 7 days to book an assessment appointment. All appropriate outpatient referrals will be offered a clinic appointment at the CATS clinic located at Fiona Stanley Hospital within 8 weeks. If urgent, please contact CATS on (08) 6152 7049.

Medical Information

Primary Diagnosis

Date of Diagnosis

Relevant Secondary Condition

Consultant

Reason for Referral

Current Level of Functioning (Please tick all that apply)

Communication limitations:

- ☐ Apraxia of speech
- ☐ Cognitive communication
- ☐ Non verbal
- ☐ Reading
- ☐ Writing
- ☐ Speech intelligibility
- ☐ Speech volume
- ☐ Expressive language
- ☐ Receptive language

Physical limitations:

- ☐ Upper Limb
- ☐ Lower Limb
- ☐ Vision
- ☐ Hearing
- ☐ Tremor
- ☐ Apraxia
- ☐ Fine motor (Hands)
- ☐ Gross motor (Arms)
- ☐ Manual Wheelchair
- ☐ Power Wheelchair

Any cognitive impairment?

- ☐ None
- ☐ Mild
- ☐ Moderate
- ☐ Severe

Please document any relevant issues pertaining to mobility, upper limb function, sensory impairment, cognition and communication.

Devices or Strategies Trialled

Please document any devices or strategies that have been trialled, related to the reason for referral

List any equipment you would like trialled in the first session

List any phrases you would like included in the trial device

For **WA Health referrers**, please **attach this form to an eReferral**. Other referrers, please email form to FSH.referrals@health.wa.gov.au