

PART A: ComTEC CLIENT INFORMATION FORM

Please fill in **all relevant sections of the form** and attach any recent therapy reports if applicable. Please provide **as much detail** as possible to enable us to provide the best service for you.

Who referred you to ComTEC

- | | | |
|---|--|---|
| <input type="checkbox"/> Family member/friend | <input type="checkbox"/> Speech Pathologist | <input type="checkbox"/> Occupational Therapist |
| <input type="checkbox"/> Self | <input type="checkbox"/> Integration Teacher/Teacher | <input type="checkbox"/> Integration Aide |
| <input type="checkbox"/> Physiotherapist | <input type="checkbox"/> Adult Educator | <input type="checkbox"/> Nurse |
| <input type="checkbox"/> Rehabilitation Coordinator | <input type="checkbox"/> Support Worker | <input type="checkbox"/> Case Manager |
| <input type="checkbox"/> Doctor | <input type="checkbox"/> Other, please specify | |

PERSON REFERRING:

Name:
Organisation:
Address: Postcode:
Phone: Mobile:

Information from your file may be used in gathering data for research that will assist in service development and evaluation. No information that could identify you will be included in any reports or presentations of the research. **I/we give consent** (circle if consent given) for my information to be included in research conducted by ComTEC.

Signature:(Client/Parent/Guardian)

Name:(Please Print)

If you have any queries about completing this form or about the services of ComTEC, please contact the phone enquiry line on (03) 9362 6111 or Freecall 1300 885 886 for Victorian country callers.

SComTEC04 – R10-2009

CONTACT INFORMATION

CLIENT NAME.....

Address.....

.....**Postcode**.....

Phone () **Mobile**.....

Date of Birth **Female** **Male**

MEDICAL DIAGNOSIS.....

.....

CENTRE/SCHOOL in attendance (if applicable)

.....

Do you receive support services? Please tick.

- | | | |
|---|---|--|
| <input type="checkbox"/> Speech therapy | <input type="checkbox"/> Occupational therapy | <input type="checkbox"/> Physiotherapy |
| <input type="checkbox"/> Psychology | <input type="checkbox"/> Integration Teacher/Aide | <input type="checkbox"/> Other, please specify |
| <input type="checkbox"/> No current support | | |

It is strongly recommended that the main people who support you attend the advisory session.

Who will you invite to the advisory session? Please tick:

- | | | |
|--|---|---|
| <input type="checkbox"/> Parent/guardian | <input type="checkbox"/> Speech Pathologist | <input type="checkbox"/> Occupational Therapist |
| <input type="checkbox"/> Support Worker | <input type="checkbox"/> Integration Teacher/Aide | <input type="checkbox"/> Case Manager |
| <input type="checkbox"/> Physiotherapist | <input type="checkbox"/> Adult Educator | <input type="checkbox"/> Other, please specify |
| | | |

CONTACT PERSON No 1:

(This person will be contacted to arrange and coordinate team attendance at the appointment)

NAME..... **RELATIONSHIP to CLIENT**.....

Address..... **Postcode**.....

Phone () **Mobile**.....

CONTACT PERSON No 2: (If contact No1 is unavailable, this person will be contacted)

NAME..... **RELATIONSHIP to CLIENT**.....

Address..... **Postcode**.....

Phone () **Mobile**.....

Language spoken at home

Is an interpreter needed for an appointment? **Yes** **No**

If yes, which language?.....

DATE RECEIVED...../...../.....**Office Use Only**

If another client cancels could you attend at short notice? Yes No

How much notice is required?(eg 24hrs).....

HAVE YOU BEEN TO ComTEC BEFORE? Yes No

WHY DO YOU WANT TO COME TO ComTEC?

(Please place a **Number 1** in the box next to your **main** reason for attending, and then a tick next to your other reasons)

I want to find out about :

- Speech generating device** (a device to help me "talk" in a variety of situations)
- Computer hardware to support...**
 - Reading
 - Writing
 - Learning
 - Leisure
 - Vocational/job skills
- Computer Software to support...**
 - Reading
 - Writing
 - Learning
 - Leisure
 - Vocational/job skills
- Environmental Control Units** (a device which will allow me to control my environment)
- Use of switches to access toys, a speech generating device, a computer or environmental controls**
- Fixing/mounting** (how to attach a speech generating device, switch or computer to my wheelchair) **Specific details of wheelchair make and model, including photographs of the chair/equipment to which device is to be mounted are required to process this referral.**

Main Issue :

.....
.....
.....

What has already been tried:

.....
.....

Relevant Considerations:

.....
.....

PLEASE NOTE : If you wish to look at *more* than one of the above areas, it is often necessary to have more than one appointment.

MOBILITY

Which of the following statements best describes your mobility most of the time

- I walk independently
- I walk independently with the following aid/s
 - Walking aid
 - Manual wheelchair – push myself
 - Manual wheelchair – pushed by another
 - Motorised wheelchair
 - Motorised scooter

Make and model of your wheelchair _____

Comments _____

If you use a wheelchair does it have adaptations?

- Yes No No, but they are needed Not applicable

SEATING

Do you use a special chair?

- Yes No No, but needed Not applicable

If possible bring your SPECIALISED SEATING to your ComTEC ADVISORY SESSION

ACCESSING ABILITY

Can you press keys?

(eg. on a telephone, keyboard, TV remote control)

- Yes No

If **yes**, how do you do it? (please tick)

- | | | |
|--|-------------------------------------|------------------------------------|
| <input type="checkbox"/> Fingers..... | <input type="checkbox"/> right hand | <input type="checkbox"/> left hand |
| <input type="checkbox"/> Whole hand or fist..... | <input type="checkbox"/> right hand | <input type="checkbox"/> left hand |
| <input type="checkbox"/> Hand held pointer | | |
| <input type="checkbox"/> Mouthstick | | |
| <input type="checkbox"/> Other (please describe) _____ | | |

SWITCHES

Do you use a switch?

- Yes No

What type of switch do you use? _____

Please describe how you activate your switch

- | | | |
|---|--|------------------------------------|
| <input type="checkbox"/> Fingers..... | <input type="checkbox"/> right hand | <input type="checkbox"/> left hand |
| <input type="checkbox"/> Whole hand or fist..... | <input type="checkbox"/> right hand | <input type="checkbox"/> left hand |
| <input type="checkbox"/> Head <input type="checkbox"/> Foot | <input type="checkbox"/> Other (please describe) _____ | |

What equipment do you use your switch with/for? _____

COMPUTER SKILLS

Have you used a computer before?

Yes

No

Are you currently using a computer?

Yes

No

If **yes**, please indicate the type of computer

Desktop

Laptop

If **yes**, please indicate the make of the computer

PC

Mac

Please describe any modifications and/or additions you have.

.....
Please list the reasons for using the computer (including any software that are currently using).
.....
.....

Do you use a standard computer keyboard?

Yes

I miss keys or hit keys I don't want

I sometimes hold keys down for too long

I have difficulty seeing the keys

I'm not familiar with the keys

I experience pain/discomfort

No

I use a different type of keyboard

How do you use your keyboard?

Fingers

Hand held pointer

Mouthstick

Right hand

Left hand

Other _____

Do you use a standard computer mouse?

Yes

I cannot control the mouse movement

I have trouble using the mouse buttons

I can't see the pointer on the screen

I experience pain/discomfort

I'm not familiar with using a mouse

No

I use a different type of mouse

HEARING

Do you have a hearing loss?

Yes

No

If **yes**, please describe _____

VISION

Do you have vision impairment?

Yes

No

If **yes**, please describe _____

COGNITION (please tick all that are relevant)

- | | | |
|--|--|--|
| <input type="checkbox"/> Difficulty processing auditory/visual information | <input type="checkbox"/> Difficulty maintaining concentration | <input type="checkbox"/> Difficulty with retaining information |
| <input type="checkbox"/> Difficulty learning new skills | <input type="checkbox"/> Difficulty adapting to novel situations | <input type="checkbox"/> Difficulty understanding and using language |

READING / SPELLING SKILLS

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> No difficulty reading or spelling | <input type="checkbox"/> Can read / write some words but makes lots of mistakes
(below level expected for age) | <input type="checkbox"/> Learning to read / write
(level expected for age) | <input type="checkbox"/> Cannot read/spell at all |
|--|---|---|---|

Comments:.....
.....

WRITING SKILLS

How do you complete 'written' work? (please tick all that are relevant)

- | | | | | |
|---|---|--|---|-----------------------------------|
| <input type="checkbox"/> Pen/pencil and paper | <input type="checkbox"/> Pen/pencil grips | <input type="checkbox"/> Slant board | <input type="checkbox"/> Electronic notetaker | <input type="checkbox"/> Computer |
| <input type="checkbox"/> Assistant/Scribe | <input type="checkbox"/> I cannot write | <input type="checkbox"/> Not Applicable
(child under 5) | | |

Other (please specify)

.....
.....
.....

I have the following difficulties when handwriting (please tick all that are relevant)

- | | | | |
|----------------------------------|--------------------------------|--|-------------------------------------|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Speed | <input type="checkbox"/> Coordinating hand movements | <input type="checkbox"/> Legibility |
| <input type="checkbox"/> Posture | <input type="checkbox"/> Pain | <input type="checkbox"/> Literacy (eg spelling, thinking of what to write etc) | |

Other (please specify)

.....
.....
.....

BEHAVIOUR

Do you have any challenging behaviours?

- Yes Yes, but only occasionally No

If YES, please describe potential situations and triggers for this behaviour

.....
.....
.....

(If appropriate please attach a behaviour management plan when returning this form.)

COMMUNICATION SKILLS

Which of the following best describes your speech

- I don't use speech, or only very little
 Most/all people find me very difficult to understand
 People who know me well can understand me
 Most/all people can understand me most/all of the time

Do you use methods other than speech as your main way of communicating? Yes No

Which of the following do you use to communicate? (please tick **all** that apply)

- | | |
|--|--|
| <input type="checkbox"/> Vocalisations | <input type="checkbox"/> Facial Expression |
| <input type="checkbox"/> Eye movement | <input type="checkbox"/> Pointing |
| <input type="checkbox"/> Gesture | <input type="checkbox"/> Signs |
| <input type="checkbox"/> Communication Board or book | <input type="checkbox"/> Electronic Communication Device |
| <input type="checkbox"/> Writing | Name of the device |

.....
.....

Note: Please bring your current communication system (book, board and/or device) to the appointment.

How do you usually indicate **yes**?

- | | | |
|--|---|--|
| <input type="checkbox"/> My own speech | <input type="checkbox"/> Speech from my electronic communication device | <input type="checkbox"/> Head movement |
| <input type="checkbox"/> Other gesture | <input type="checkbox"/> Vocalisation | <input type="checkbox"/> Sign |
| <input type="checkbox"/> Written word | <input type="checkbox"/> Picture or other symbol | <input type="checkbox"/> Facial expression |

How do you usually indicate **no**?

- | | | |
|--|---|--|
| <input type="checkbox"/> My own speech | <input type="checkbox"/> Speech from my electronic communication device | <input type="checkbox"/> Head movement |
| <input type="checkbox"/> Other gesture | <input type="checkbox"/> Vocalisation | <input type="checkbox"/> Sign |
| <input type="checkbox"/> Written word | <input type="checkbox"/> Picture or other symbol | <input type="checkbox"/> Facial expression |

DO YOU REQUIRE A QUOTE OUTLINING ANTICIPATED COSTS OF THE SESSION?

Yes No (specifically relevant for school aged clients)

PLEASE INDICATE WHICH CARD / BENEFIT YOU RECEIVE (if any):

Department of Social Security Department of Veteran’s Affairs
Card / Benefit Number.....

If you receive funding through a package, case management, TAC or WorkCover we require their written approval for funding of the advisory session/s prior to processing this referral. Please also provide contact details below.

Case Manager or Package (eg Slow to Recover) Contact Details

Package/ Funding.....
Contact Name
Agency.....
Address.....
.....Postcode.....Phone ().....
Email.....

TAC Details

Claim No.....Date of accident.....
Rehabilitation Co-ordinator.....
Address.....
.....Postcode.....Phone ().....
Hospital attended after accident.....
Region.....

Workcare Details

Client Claim No.....Date of Injury.....
Name of Employer.....
Address of Employer.....
.....Postcode.....Phone ().....
Name of Claim Agent.....
Address of Claim Agent.....
.....Postcode.....Phone ().....
Contact.....

Photographs may need to be taken to provide the assessment, follow up and/or training that you require.

Authorisation to be Photographed (may be completed at session, if required)

I (Client/Client advocate) :

Of (Address) :

Hereby give permission **to be photographed / for client to be photographed** (please circle) and for these images to be placed in the file. Please document any additional uses of photos.

Additional uses of photos:

Signed : **Date:**

Where consumer is unable to give explicit permission to be photographed a relative/advocate may give permission on their behalf. Please note the relationship to the client.