Assistive Technology Service
G.F. Strong Rehab Centre
4255 Laurel Street
Vancouver, B.C. V5Z 2G9
Phone: 604-737-6263
Fax: 604-734-1363

Assistive Technology Service Consultation Request

CLINICIAN INFORMATION

Name: _____ **Designation: (e.g., OT, SLP):** _____

Address: _____ **Telephone/Local:** _____

OR _____ **Fax:** _____

GFS Program _____ **Email:** _____

How and when is it easiest to contact you? _____

REQUEST TYPE

☐ **Alternate Access Assessment (Check ALL that apply)**

- ☐ **AAC device**
- ☐ **Mac Computer**
- ☐ **Windows Computer**
- ☐ **Tablet (model):** _____
- ☐ **Smart Phone (model):** _____

☐ **Adapted Gaming**

☐ **Augmentative and Alternative Communication (AAC)**

☐ **Custom 3D printed adaptation**

☐ **Device Mounting**

☐ **Environmental Controls**

☐ **Other:** _____

CLIENT INFORMATION (PCIS Label OK for GFS Clients)

Name: _____ **DOB:** _____

Telephone #: _____ **Email:** _____

Address: _____ **Postal Code:** _____

Diagnosis: _____ **Date of Onset:** _____

Current Treatment Setting: ☐**Acute** ☐ **GFS Inpatient** ☐ **GFS Outpatient** ☐ **Other Outpatient** ☐ **Community** ☐ **Other:** _____

☐ **PHN:** _____ **OR** ☐ **MRN (GFS ONLY):** _____ **Estimated Discharge Date:** _____

☐ **Consent received for the client or client representative to consult with ATS**

Describe your client's abilities relative to this request, and any additional information you feel is relevant:

Signature: _____ **Date:** _____

For Office Use Only:

Date Received	PIC	Entered in Database: ☐	Receipt Acknowledged (Community Referrals): ☐