**AAC WEST Specialist Service Bristol/Plymouth Expectations**

**Triage Loan Referral Form**

**Triage Loan Referral** – Please complete this form if you are requesting to borrow an AAC WEST triage iPad to either ascertain if someone has the potential to use an AAC device ahead of making a full referral to the service or to borrow an iPad before making an Accredited Referral (AR).

**What is expected from the person using the service?**

* To take care of the device which is loaned
* To functionally use the device during the loan
* To cooperate with any conditions / requests made by AAC WEST regarding the use/safety of equipment on loan.

**What is expected of the local Therapist?**

* To request a device for one of the two reasons/purpose named above
* To request a loan device at a time when they are able to support a trial - ie complete any personalisation that is required, to demonstrate the device to the regular communication partners, to review the use of the device during loan period
* To return the device in the timescales agreed with AAC WEST
* To provide AAC WEST with feedback of the loan and give clear next steps using the form provided

**What you can expect from AAC WEST**

* The service will loan the device as requested in this referral form
* The device will be safety checked and ready to use

**Please complete all sections of this form as fully as possible**

| **Patient Details** | **Referring SLT Details** |
| --- | --- |
| Name: Pronouns: He/Him [ ]  She/Her [ ]  They/Them [ ] Date of Birth: Address (including postcode):  | Name:Address (including postcode): |
| Telephone:(This number will be used for text message reminders about appointments) | Telephone: |
| Email: | Email: |
| NHS number (Mandatory): | Details of SLT employment: (school, NHS trust etc.)*Please note referrals can only be accepted from SLTs employed by a statutory body e.g. NHS, School, Local Authority.* |
| **Next of kin name**: | **School/Pre-school:** |
| Address(es): (if different from above)  | Address: |
| Telephone: | Telephone: |
| Email: | Email: |

| **Ethnicity code** *(please ask the patient to indicate which code best matches their heritage/identity. See list at the end of this form)* | Code (A-Z):  |
| --- | --- |
| **Language:** Is the patient’s home language English? | Yes [ ]  No[ ]  |
| If no, what languages are spoken at home? *(Please add relevant details)* |  |
| Does the patient or family require an interpreter? | Yes [ ]  No[ ]  |
| If yes, what language? |  |

**Other professionals involved relevant to referral (please include GP, Paediatrician, OT, Physio, Advisory Teachers). Please ensure consent is gained for sharing information with these professionals (see consent section).**

**PLEASE NOTE: REFERRALS CANNOT BE ACCEPTED WITHOUT PATIENTS NHS NUMBER OR GP DETAILS**

| Name | Professional | Address | Tel Number |
| --- | --- | --- | --- |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

| **Medical Diagnosis/History**: |
| --- |
| **SLT Diagnosis**: |

|  |
| --- |
| **Reason for triage loan request:**  |

|  |  |
| --- | --- |
| Equipment requested |  |
| Hardware ; iPad / iPad mini |  |
| App; Grid for iPad Predictable |  |
| Vocabulary: Super core 30, Supercore 50, VocoChat, Text Talker Other please specify |  |
| Case/ Strap Please give details |  |

**PLEASE NOTE: REFERRALS CANNOT BE ACCEPTED UNLESS THE CONSENT SECTION BELOW IS COMPLETED IN FULL**

|  |  |
| --- | --- |
| **Consent to the referral:** Can the patient consent to the referral?*N.B. if unclear whether a patient is able to consent to this referral, a capacity assessment should be undertaken written/visual supports appropriate to the patient’s needs.*  | Yes [ ]  No [ ]  |
| If **YES** has the patient consented to this referral?*Please detail how the patient gave their consent (verbally, using AAC, gesture etc.)*  | Yes [ ]  No [ ] How consented: |
| If **NO and patient 16 or over** - has the referral be discussed with relevant parties and agreed to be in the patient’s best interest?Discussed with/name:Relationship to patient:Reason consent not gained from patient: | Yes [ ]  No [ ] N/A [ ]   |
| If **NO and patient under 16** - has someone consented on behalf of the patient? Name:Relationship to patient:Reason consent not gained from patient: | Yes [ ]  No [ ] N/A [ ]   |
| **Consent to emailing:** Does the patient/their NOK if patient is under 16, consent to be contacted by email?*Please be aware that confidentiality cannot be guaranteed, and the NHS is not liable for the confidentiality or security of any message once it’s been sent*. | Yes [ ]  No [ ]  |
| **Consent to information sharing:** Can the patient consent to information sharing?*Examples of symbols to support this conversation can be downloaded at* [*https://www.nbt.nhs.uk/bristol-centre-enablement/referral-centre/aac-west-referral*](https://www.nbt.nhs.uk/bristol-centre-enablement/referral-centre/aac-west-referral) | Yes [ ]  No [ ] (see below) |
| [ ]  If **YES**, discuss information sharing consent with patient and indicate decisions below.[ ]  If **NO and patient 16 or over** - discuss information sharing consent with relevant parties/individuals and indicate best interest decisions below.**Discussed with**:[ ]  If **NO and patient under 16** - discuss information sharing consent with parent/guardian and indicate decisions below.**Discussed with**:  |  |
| *Please indicate who AAC WEST can share information with (as per patient’s consent, parental consent or best interests decision) and provide contact details on page 3 in “Other professionals involved relevant to referral” section.*[ ]  Other members of AAC WEST team (SLT, OT, Teacher, Assistant, Clinical Technologist, technical team, admin team)[ ]  GP [ ]  Local SLT [ ]  School staff (if relevant)[ ]  Carers / Support Workers [ ]  Day centre staff [ ]  Occupational Therapist [ ]  Physiotherapist[ ]  Advisory Teachers, e.g. Qualified Teacher of VI or HI.[ ]  Wheelchair service (needed for mounting)[ ]  Environmental Controls[ ]  Other: [ ]  Other AAC Specialised Service (if patient moves out of the South West)[ ]  Family/friends (specify who and provide contact details):[ ]  DON’T SHARE INFO WITH:  |  |
| **Expectations**As the referring therapist, are you able to meet the expectations outlined on page one? | Yes [ ]  No [ ]  |

Signed:

Name:

Date of Completion:

**Ethnicity code:**

|  |  |  |  |
| --- | --- | --- | --- |
| A | White – British  | K | Asian or Asian British – Bangladeshi |
| B | White – Irish  | L | Asian or Asian British - any other Asian background |
| C | White – Any other white background | M | Black or Black British – Caribbean |
| D | Mixed – White and Black Caribbean | N | Black or Black British – African |
| E | Mixed – White and Black African | P | Black or Black British – Any other Black background |
| F | Mixed – White and Asian | R | Chinese |
| G | Mixed – Any other mixed background | S | Any other ethnic group |
| H | Asian or Asian British – Indian  | Z | Does not wish to disclose |
| J | Asian or Asian British – Pakistani |  |  |