UNF Adaptive Toy Project Referral Form

____
Date

Patient Name | Age | Health Condition/Diagnosis

Parents Names | Parent's Phone #

Therapist Name | Email | Therapist's Phone #

Name of Therapist's Agency | If agency is a school district, attended school name

How long have you been treating this child? _____ Does the parent know about the referral? ______

Reason for Referral to the UNF Adaptive Toy Project:

A. **Cognition/language/Communication** *(therapist impression or levels if known, can the child follow directions, hearing, vision, understand cause and effect, primary language in home, school placement)*

B. **Neuromuscular/Musculoskeletal** *(muscle tone, coordination, strength and joint range of motion, assistive devices, orthotics/prosthetics, seizures, developmental levels for fine & gross motor skills)*

Child's Measurements (*These can be approximate*)

Height: ______ Weight: ________

C. **Gait, Locomotion, and Balance** *(Independent mobility level: rolling over, sitting independently when placed, protective reactions, crawling, standing, walking)*

D. **Family/Patient/Therapist Goals:**

D. Assistive Technology Specifications Therapist may want to recommend *(these are examples of some of the modifications we have done: high seatback, head supports, chest straps, pelvic straps, pelvic lap belt, lateral trunk supports, knee pads, type of switch, controls)*

Anything else you'd like for us to know?

Can we contact the parents? And how much do they know about this project?