Serving people with disabilities since 1964

Specialised Assistive Technology Centre
20 Lengkok Bahru #01-06
Tech Able, Enabling Village
Singapore 159053

AT ASSESSMENT – REFERRAL FORM

Please ensure that applicable sections of the form are completed.

SATC Contact Information
Phone / WhatsApp: 6473 0446
Email: SATC@spd.org.sg

REFERRAL SOURCE (IF APPLICABLE)

Name: _____ Designation: _____

Organisation: _____ Contact No.: _____

Email Address: _____ Referral Date: _____

REASON FOR REFERRAL / MAIN CONCERNS (PLEASE ATTACH REPORTS IF APPLICABLE)

Please tick √ the services needed:

☐ Powered Mobility (Wheelchair / Scooter / Power Add-On) ☐ Computer Access

☐ Alternative & Augmentative Communication (AAC) ☐ Environmental Control

☐ Others: _____

For Official Use

Referral received by: _____ _____
Name of staff, designation Signature & date

First contact by: _____ _____
Name of staff, designation Signature & date

Updated January 2026

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CONSENT AND DECLARATION

I acknowledge that I have read SPD's Privacy Policy (https://www.spd.org.sg/useful-links/privacy-policy/) and consent to SPD collecting, using and disclosing the personal data provided in the Referral Form and all its completed Parts for the following purposes in accordance with the Personal Data Protection Act 2012 and SPD's Privacy Policy:

a) Assessing my application, for the services, programmes and/or assistance offered and/or administered by SPD;
b) Providing me with the services, programmes and/or assistance for which I am admitted or granted if my application is successful;
c) Facilitating training for SPD's professional team;
d) For submission to relevant ministries and statutory boards, to satisfy regulatory requirements; and

Please tick applicable:

☐ I further agree to SPD disclosing the personal data for professional referral to other agencies for assessing my eligibility for their services.
☐ If my application to SPD be unsuccessful, I agree for the personal data to be disclosed for the further purpose of professional referral by SPD to other agencies for their services.

Where I have not agreed to disclosure by ticking any of the above, I have been notified and/or am aware that SPD may not be in a position to continue providing me with the services I am seeking.

I declare that all information in the Referral Form and its Parts (and attached documents, if any) are true to the best of my knowledge and belief, and I have not wilfully suppressed any material facts. I agree that the services, programmes and/or assistance to which I am admitted or granted may be withdrawn/terminated without any notice if any information is found to be untrue or material facts have been wilfully suppressed.

In addition, I further give my consent to the collection, use and disclosure of my personal data for:

☐ Contacting me regarding use and disclosure for SPD's annual reports, newsletters and sharing of human interest stories
☐ For training, workshops and outreach
☐ For research by SPD or in collaboration with its partners (As far as possible, data used will be anonymised)
☐ None of the above

and acknowledge that if I do not consent to any of the above, I may still receive services, programmes and assistance.

SPD uses digital tools for data processing and analysis. The data will be available to and used only by SPD. For example, to help us with service delivery, we will be using a new digital tool to help with note-taking.

Your participation is completely voluntary. If you agree for us to proceed with our services to you using digital tools, please sign and date the form below.

If applicable: This information has been translated to me in _____ (language) by _____ (staff's name, designation/organisation) on _____ (date).

_____ _____
Name of Client* / Caregiver / Parent Signature / Thumbprint & Date

** For clients under 21 years of age, or for clients over 21 who lack mental capacity, consent must be provided by a parent or legal guardian. If you are submitting this form on behalf of a family member who is over 21, has mental capacity, but is unable to handle the submission themselves, you confirm that you are duly authorised by that family member to consent to and affirm the matters set out in this form.*

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REFERRAL FORM
(Specialised ATC)

PARTICULARS OF APPLICANT

Name: _____ Gender: ☐ Male ☐ Female

NRIC / FIN / Birth Cert No.: _____ IC Type: ☐ Pink ☐ Blue ☐ NA

Date of Birth: _____(dd/mm/yyyy) Nationality: _____

Race: ☐ Chinese ☐ Malay ☐ Indian ☐ Eurasian ☐ Others: _____

Language Spoken: ☐ English ☐ Mandarin ☐ Malay ☐ Tamil ☐ Dialect / Others: _____

Address: _____ Singapore (_____)

Contact No.: _____ (Home) _____ (Mobile) _____ (Office)

Email Address: _____

School (Grade) / Work (Designation): _____

PARTICULARS OF CAREGIVER

Name: _____ Relationship to Applicant: _____

Contact No.: _____ Email Address: _____

NATURE OF DISABILITY (TICK √ WHERE APPLICABLE)

Medical Diagnosis: _____

☐ Physical Disability: _____ ☐ Intellectual Disability: _____

☐ Hearing Impairment: _____ ☐ Visual Impairment: _____

☐ Developmental Disability: _____ ☐ Others: _____

Other Considerations:

☐ History of Seizures ☐ Frequent Ear Infections ☐ Fatigues Easily

☐ Degenerative Medical Condition ☐ Others: _____

☐ Uses Mobility / Visual / Hearing / Communication Device(s): _____

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REFERRAL FORM
(Specialised ATC)

Please fill up the following according to the services selected.

SECTION A: ALTERNATIVE & AUGMENTATIVE COMMUNICATION (AAC)

1. Have any recent speech-language assessments been completed with the individual?

   ☐ No ☐ Yes (what were the results? _____)
   Note: Please attach ST report along with this form if available.

2. Describe how does the individual answer yes/no questions:

3. Who best understands the individual and why?

4. What is your estimate of the individual's ability to:
   a. Understand directions / commands: _____
   b. Make choices: _____
   c. Express general ideas: _____

5. Is the individual able to read/spell/write?

   ☐ No ☐ Yes (describe: _____)

6. Does the individual already use a communication device to communicate?

   ☐ No ☐ Yes (what device and who owns it: _____)
   Note: Please bring along any existing communication devices / books for the AT assessment.

7. What activities/items/interests does the individual like/have?

8. How would you describe the individual's general physical abilities and/or behavioural challenges?

9. Does the individual have:
   a. Wheelchair (manual / power) ☐ Yes ☐ No Describe: _____
   b. Lap tray on wheelchair ☐ Yes ☐ No Describe: _____
   c. Braces (hands/feet/body) ☐ Yes ☐ No Describe: _____
   d. Glasses ☐ Yes ☐ No Describe: _____
   e. Hearing aid(s) ☐ Yes ☐ No Describe: _____
   Note: Please bring the above mentioned for the AT assessment session (if applicable)

10. Circle parts of the body the individual can voluntarily control:

    Head / arm / fingers / elbow / foot / toe / fist / eye / others: _____

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SECTION B: POWERED MOBILITY

1. Is the individual able to follow one to two-step instructions consistently?

   ☐ No ☐ Yes

2. Does the individual have any loss of sensation?

   ☐ No ☐ Yes (Please elaborate: _____)

3. Does the individual have any current/history of pressure sore?

   ☐ No ☐ Yes (Please elaborate: _____)

4. Does the individual have any deformity that may require specialised seating?

   ☐ No ☐ Yes (Please elaborate: _____)

5. Does the individual need any assistance or special equipment (e.g. hoist) in transfers?

   ☐ No ☐ Yes (Please elaborate: _____)

6. Where does the individual intend to use the device?

   ☐ Indoor ☐ Outdoor

7. What mobility device(s) is the individual currently using?

   ☐ Motorised Wheelchair ☐ Motorised Scooter ☐ Manual Wheelchair ☐ Others: _____

8. How long has the individual been using the above device?

9. Circle parts of the body the individual can voluntarily control:

   Head / arm / fingers / elbow / foot / toe / fist / eye / others: _____

SECTION C: COMPUTER ACCESS

1. Is the individual able to follow one to two-step instructions consistently?

   ☐ No ☐ Yes

2. Does the individual have any loss of sensation?

   ☐ No ☐ Yes (Please elaborate: _____)

3. Circle parts of the body the individual can voluntarily control:

   Head / arm / fingers / elbow / foot / toe / fist / eye / others: _____

4. Circle the devices that the individual is currently using:

   Desktop / laptop / tablet / iPad / smartphone / others: _____

5. How long has the individual been using the above device?

6. Is the individual currently using any specialised keyboard/mouse/software?

   ☐ No ☐ Yes (Specify: _____)

7. How long has the individual been using the above device?

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SECTION D: ENVIRONMENTAL CONTROL / ACCESS

1. Is the individual able to follow one to two-step instructions consistently?

   ☐ No ☐ Yes

2. Does the individual have any loss of sensation?

   ☐ No ☐ Yes (Please elaborate: _____)

3. Circle parts of the body the individual can voluntarily control:

   Head / arm / fingers / elbow / foot / toe / fist / eye / others: _____

4. Circle the devices that the individual is currently using:

   Desktop / laptop / tablet / iPad / smartphone / others: _____

5. Where does the individual spend a greater portion of his/her time in?

   ☐ Bed ☐ Wheelchair ☐ Others: _____

6. Is the individual currently using any device to control appliances?

   ☐ No ☐ Yes (Specify: _____)

Thank you for completing this form. Please refer to the following checklist for the supporting documents needed for submission along with the referral form:

- ☐ NRIC / Birth Certificate
- ☐ Medical memos (if any)
- ☐ Proof of disability (for funding purposes)
- ☐ Previous therapist / assessment reports (if any)

To help us schedule your appointment promptly, please indicate your available timeslots:

Available Timeslots	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
	☐ **AM**	☐ **AM**	☐ **AM**	☐ **AM**	☐ **AM**
	☐ **PM**	☐ **PM**	☐ **PM**	☐ **PM**	☐ **PM**

Please email the Referral Form and relevant documents to SATC@spd.org.sg or call us at 64730446 if you have further enquires.