KidsAbility Centre for Child Development
APPLICATION – Augmentative Communication Services – Written Communication

To be completed by Occupational Therapist and Parent(s)

☐ **NEW Referral** ☐ **Re-Referral**		**Date Completed:**	
Name of Client:			**Gender:**
Date of Birth:			
Chronological Age:			
Diagnosis:			
Name of Client's Preschool/School:			Grade:
OT Name:		Are you an Individual Authorizer (IA)?	Yes ☐ No ☐
OT Email Address:			
Has the individual received a prescription of face to face communication equipment from an IA? Yes ☐ No ☐			
If yes, device:			
Date dispensed:			

Mother		***Father***	
Name:		Name:	
Address:		Address	
Telephone No.:	Home:	Telephone No.:	Home:
	Work:		Work:
	Cell:		Cell:
Email:		Email:	
Is English a second language for the client/caregiver?		Yes ☐ No ☐	
Language spoken in the home:		Is an interpreter needed for appointments?	Yes ☐ No ☐

SERVICE PROVIDERS: People/agencies involved with the client

Discipline	**Discussed referral**	**Name**	**Agency**	**Telephone/e-mail**
Occupational Therapist	☐			
Teacher	☐			
Special Education Resource	☐			
Board Consultant	☐			
Other	☐			

NEW Referral	**RE-REFERRAL**
Briefly describe your expectations of this referral:	What writing needs have changed since last seen by the ACS team? What are your expectations at this time?

If available, please attach samples of sentence writing, stories, journal entries, etc. which the child/youth has printed or typed, with comments as appropriate.

CLIENT DESCRIPTION		
Mobility **Describe**		
Does your child/ youth:	Walk independently	Yes ☐ No ☐
	Use walking aids	Yes ☐ No ☐
	Use a manual wheelchair Independently	Yes ☐ No ☐ Yes ☐ No ☐
	Use a power wheelchair Switch Joystick	Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐
	Tilt system	Manual ☐ Power ☐

Seating and Positioning – Check				
Does your child/ youth use:	☐ head support	☐ trunk support	☐ pommel	☐ body brace
	☐ strapped foot rest	☐ seatbelt	☐ wheelchair tray	☐ arm positioning
	☐ AFOs	☐ adductor pad	☐ other:	

Sensory Abilities		
Does your child/ youth:	Have visual concerns?	Yes ☐ No ☐ If yes, describe:
	Wear glasses?	Yes ☐ No ☐ If yes, who follows: Optometrist/ ophthalmologist ☐ UW Low Vision Clinic ☐
	Have hearing concerns?	Yes ☐ No ☐ If yes, describe:
	Wear hearing aids?	Yes ☐ No ☐ If yes, which ear(s)? Left ☐ Right ☐ Both ☐

Other Equipment used for positioning in any environment:

This form must be completed in full and returned before the application will be considered.

Current system is ☐ adequate ☐ inadequate Explain:			
Date of last Seating appointment: By whom:			
Motor Abilities			
Does your child/youth:		Examples welcome:	
Yes ☐	No ☐	Sustain arm movement against gravity?	
Yes ☐	No ☐	Reach with accuracy toward a target?	
Yes ☐	No ☐	Lift hand on/off a target?	
Yes ☐	No ☐	Grasp objects?	
Yes ☐	No ☐	Release objects?	
Yes ☐	No ☐	Point with a finger?	
Yes ☐	No ☐	Have voluntary control turning their head?	
Yes ☐	No ☐	Have voluntary control blinking eyes?	
Yes ☐	No ☐	Have voluntary control making facial movements?	
Yes ☐	No ☐	Have voluntary eye gaze control?	
Right ☐	Left ☐	Have hand dominance?	Not established ☐

WRITTEN COMMUNICATION		
Describe written communication needs ***at home***:**		
☐ homework	☐ e-mail	☐ lists
☐ social networking	☐ journaling	☐ other:
How is writing currently completed ***at home***?**		
☐ printing/handwriting	☐ other person scribes	☐ computer

Handwriting skills		
Does your child/youth:		
Yes ☐	No ☐	Have the physical ability to print or handwrite?
Right ☐	Left ☐	If 'yes', which hand does your child/youth use to print or handwrite?
Describe problems that occur with handwriting? (e.g., legibility, pain, fatigue, speed)		

Typing/keyboarding skills			
Does your child/youth:			
Yes ☐	No ☐	Type?	
Right ☐	Left ☐	Both ☐	If 'yes', which hand(s) is/are used?
Describe problems that occur with typing? (e.g., targeting keys, pain, fatigue, speed, vision)			

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Mouse skills and computer adaptations		
Does your child/youth use	☐ A standard mouse?	
	☐ A trackball?	
	☐ An adapted keyboard?	Describe:
	☐ A keyguard?	
	☐ Use software adjustments?	
	☐ Other?	

Home computer	
☐ desktop ☐ laptop	Describe (e.g., Mac/PC, age, number of computers, software, people using, availability to child/youth)

EDUCATION		
Describe the classroom environment (e.g., integrated Grade 2 with educational assistant, special education class)		
How is writing currently completed *<u>at school</u>*?		
☐ printing/handwriting	☐ other person scribes	☐ computer
☐ photocopies of notes	☐ voice recognition software	☐ other:
If these methods do **<u>not</u>** meet the child/youth needs, please explain:		
If using a computer, please describe (e.g., Mac/PC, age, software, location/accessibility)		

Literacy Skills				
Estimated reading level ☐ preschool ☐ kindergarten Grade ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12				
If child/youth cannot read or skills are very limited -				
Does your child/youth:	Give the <u>name</u> of each letter of the alphabet? e.g., "What's this letter called?"	☐ a few	☐ some	☐ all
	Give the <u>sound</u> made by each letter? e.g., "What sound does this letter make?"	☐ a few	☐ some	☐ all
	Give a <u>word</u> that starts with each letter/sound? e.g., Can you tell me a word that starts with this letter?"	☐ a few	☐ some	☐ all
	Need help to spell words?	☐ always	☐ sometimes	☐ never

Check the items that your child/youth is able to write/compose **independently** (without assistance). This could be demonstrated by oral spelling, printing, writing, using a keyboard or an alphabet board.		
☐ first name	☐ consonant-vowel-consonant e.g., cat, Mom	☐ simple sentences e.g., My cat is brown.
☐ last name	☐ 2- & 3-syllable words e.g., teacher, together	

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