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APPLICATION – Augmentative Communication Services (ACS) – Writing Aids

To be completed by Occupational Therapist and family– NEW Referrals ONLY

☐ Client has a valid health card or is eligible to apply for a health card			
Date Completed:			
Name of Client:		**Gender:**	
Date of Birth:		**Age:**	
Diagnosis:			
Name of Client's School:		**Grade:**	
OT Name:			
OT Email Address:			

Mobility and posture:	
Does the client:	
Walk independently?	Yes ☐ No ☐
Use a manual wheelchair?	Yes ☐ No ☐
Independently?	Yes ☐ No ☐
Use a power wheelchair?	Yes ☐ No ☐
Drive Control:	Joystick ☐ Switch ☐ Other ☐ (Describe):
Require supportive seating?	Yes ☐ No ☐

Fine Motor/other:		
Yes ☐	No ☐	Isolate a finger to point?
Yes ☐	No ☐	Sustain arm movement against gravity?
Yes ☐	No ☐	Have voluntary control of head movement?
Yes ☐	No ☐	Have voluntary control of eye movement?

Vision / Hearing / Speech	
Is vision a concern? Specify if the client wears glasses	Yes ☐ No ☐
Is hearing a concern? Specify if the client wears hearing aids or has a cochlear implant.	Yes ☐ No ☐
Is speech a concern? Specify if the client uses a communication device	Yes ☐ No ☐

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Literacy Skills			
Does the client:			
Name letters of the alphabet?	☐ All	☐ Some	☐ Few
Know the sounds of each letter?	☐ All	☐ Some	☐ Few
Identify a word that starts with each letter/sound?	☐ All	☐ Some	☐ Few

Composition		
Select all items that the client is able to do independently (without assistance) through either oral spelling, printing, or typing:		
☐ First name ☐ Last name	☐ 3-letter words (e.g., cat, mom) ☐ 2-3 syllable word (e.g., teacher, together)	☐ Simple sentences (e.g., My cat is brown.)

Writing needs at home:		
What are the client's current writing needs **at home?**		
☐ homework	☐ email	☐ lists
☐ social networking	☐ journaling	☐ Other:
How is writing currently completed **at home?**		
☐ printing/handwriting	☐ scribing	☐ Computer
☐ Voice recognition (dictation)		
Describe problems that occur with handwriting (e.g., Holding a pencil, legibility, pain, fatigue, speed)		
Does the client have access to a computer?		
At home ☐ Yes ☐ No (describe system and age)	Is it dedicated to this client only (i.e., not shared)? ☐ Yes ☐ No	
At school ☐ Yes ☐ No at school (describe system and age)	Is it dedicated to this client only (i.e., SEA funded)? ☐ Yes ☐ No	
Does the client use:		
☐ Standard computer, laptop or Chromebook		
☐ trackball or joystick ☐ adapted keyboard ☐ keyguard ☐ alternate access (e.g., switches, eye gaze) ☐ specialized software	Please describe:	
Describe problems that occur with computer use (e.g., difficulty controlling a mouse, targeting keys, pain, fatigue, speed)		

Please add any important information that you would like us to know about your child/youth's writing needs:

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New Referrals
Family / Guardian Acknowledgement (this must be completed before referral is accepted)
I am aware of and in agreement with the information provided in this questionnaire. I consent to my child/youth's referral to Augmentative Communication Services at KidsAbility.

____________________________ ____________________________ ____________________________

Signature **Relationship to Client** **Date**

To be completed by parent/legal guardian:

Parent/Guardian		***Parent/Guardian***	
Relationship to client		Relationship to client	
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 ☐

Dear Parent/Legal Guardian:

The Augmentative Communication Services (ACS) clinic is an Expanded Level Clinic with the Assistive Devices Program (ADP) of the Ontario Ministry of Health and Ministry of Long-Term Care. Services are provided at our Waterloo Site (500 Hallmark Drive), and as appropriate, in the client's home, school or community.

This referral is the first step to further enhance your child's/youth's written communication skills.

Your commitment will be required throughout our process, including:

- ☑ Attending assessment and training appointments
- ☑ Providing opportunities for your child to practice in the home
- ☑ Working with the ACS team (SLP, OT, CDA) to learn strategies so you can be your child/youth's best teacher
- ☑ Your active participation to help your child/youth reach their full potential

I understand my role and will support my child/youth and the ACS team: ____________________________________
(Signature)

ATTENTION: The information communicated between KidsAbility's Augmentative Communication Service and facilitators is confidential and legally privileged. KidsAbility's Augmentative Communication Service will not disclose or discuss information relating to the client with anyone other than identified facilitators and legal guardians.

If you have any questions, please contact the Client Support Assistant
1-888-372-2259 ext. 1351 | csa-acs@kidsability.ca.