KidsAbility Centre for Child Development

APPLICATION – Re-Referral - Augmentative Communication Services (ACS) – Face to Face Communication

Re-referral (To be completed and submitted by Parent)

AUGMENTATIVE COMMUNICATION SERVICES **Application-Face to Face**			
Date:			
Person completing form:		**Relationship to client:**	
☐ Yes, I have watched the video "What to Expect with ACS" at the KidsAbility website.			
Re-Referrals			
Child/Youth's Name:		Male ☐	Female ☐
Date of Birth:			
Diagnosis:			
Briefly describe your expectations of this re-referral:			
Have you discussed the re-referral with any of the following?			
☐ Therapy team	☐ OT	☐ School Team	☐ Other:
Current therapies (public, private):			

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 ☐

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

Re-Referrals – To be completed for re-referrals only
What are your child/youth's communication needs at this time? Please specify what system your child/youth uses and what your priority is for coming back to the Augmentative Communication Services Clinic.

Re-referral Family / Guardian Acknowledgement (this must be completed before re-referral is accepted)
I am aware of and in agreement with the information provided in this questionnaire. I consent to my child/youth being re-referred to KidsAbility Augmentative Communication Services.

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

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