

***To be completed by Speech-Language Pathologist –
NEW Referrals ONLY***

NEW Referral Parent advised to watch “What to Expect with ACS” at www.kidsability.ca
 Client has a valid health card or is eligible to apply for a health card

Date Completed:		
Name of Client:		Gender:
Date of Birth:		
Chronological Age:		
Diagnosis:		
Name of Client’s School:		
SLP Name:		
SLP Email Address:		

Briefly describe your expectations of this referral:

Identify where the client would use a communication device and who their communication partners are:

Pre-Linguistic Skills

Does the client demonstrate:

Turn taking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Joint attention?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Intentionality?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cause-effect skills?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please elaborate (if necessary):

Receptive Language Skills

Can the client:

Follow directions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Respond to other people’s communication?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Respond to their name?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please elaborate (if necessary):

Communication Modes					
What kind of communication signals does the client currently use? Check all that apply.					
<input type="checkbox"/>	changes in breathing patterns	<input type="checkbox"/>	eye movement	<input type="checkbox"/>	single words (how many)
<input type="checkbox"/>	body position changes	<input type="checkbox"/>	vocalizations (sounds)	<input type="checkbox"/>	two word phrases
<input type="checkbox"/>	eye pointing	<input type="checkbox"/>	vowel sounds	<input type="checkbox"/>	three word phrases
<input type="checkbox"/>	facial expressions	<input type="checkbox"/>	pointing	<input type="checkbox"/>	three or more word phrases
<input type="checkbox"/>	gestures (i.e., reaching, guiding a adult by the hand)	<input type="checkbox"/>	signing	<input type="checkbox"/>	writing or drawing—specify which one
<input type="checkbox"/>	pointing to pictures in a communication book	<input type="checkbox"/>	using a low-tech, light-tech or high-tech communication device		

Communicative Functions		
Does the client intentionally use vocalizations, gestures, words, body language, etc. to:		
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Request items, help and information?
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Express feelings (i.e., likes or dislikes)?
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Make choices?
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Respond to questions?
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Ask questions?
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Make comments?
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Accept or reject things that are offered?
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Get someone’s attention?
Describe how the client indicates:		
“yes”		Is it reliable? <input type="checkbox"/> Yes <input type="checkbox"/> No
“no”		Is it reliable? <input type="checkbox"/> Yes <input type="checkbox"/> No

Motor Abilities	
Does the client have:	
Fine motor difficulties (i.e., difficulty with grasp, finger isolation, isolating a finger to point?)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Gross motor difficulties (i.e., unable to walk independently, use a manual/power wheel chair, etc.)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Occupational therapy or Physical therapy involved?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Please elaborate (if necessary):	

Vision / Hearing	
Is vision a concern? Specify if the client wears glasses	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is hearing a concern? Specify if the client wears hearing aids or has a cochlear implant.	Yes <input type="checkbox"/> No <input type="checkbox"/>

Augmentative Communication		
Has the individual received a prescription of face to face communication equipment from an IA or a SEAiPad? If yes, device:	Yes <input type="checkbox"/> No <input type="checkbox"/> Date Dispensed:	
Have any AAC strategies/devices been used to aid understanding or support expression?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
If a low-tech, light-tech, or high-tech device is used, please describe the name of the device or system and the number of vocabulary items per page:		
Completed by (SLP):		
	Signature	Date

To be completed by parent/legal guardian:

New Referral			
<i>Mother</i>		<i>Father</i>	
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 <input type="checkbox"/> No <input type="checkbox"/>	
Language spoken in the home:		Is an interpreter needed for appointments?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Please add any important information that you would like us to know about how your child/youth communicates:			

Dear 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. This means the ACS team are able to prescribe a wide range of technology to support face to face communication and written communication that can be purchased or leased. Services are provided at our main Waterloo Site, 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 communication skills.

Your commitment will be required throughout our process, including attending assessment and training appointments, as well as home and community practice. The ACS team requires your active participation to help your child/youth reach their full potential. During the ACS care path, you will work alongside the ACS team (SLP, OT, CDA) and together practice strategies for best supporting your child/youth and their communication. The ACS team’s goal is to empower and support families, so they can be their child’s/youth’s best teacher.

*Modified from One Kids Place Referral form

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.

Facilitator Commitment

I agree to act as a facilitator for the child/youth described above, and I accept the responsibilities as outlined.

Signature (Facilitator)

Date

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 being referred to KidsAbility Augmentative Communication Services.

Signature

Relationship to Client

Date