

APPLICATION – Augmentative Communication Services (ACS) – Writing Aids

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

<input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/>
Use a manual wheelchair?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Independently?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Use a power wheelchair?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Drive Control:	Joystick <input type="checkbox"/> Switch <input type="checkbox"/> Other <input type="checkbox"/> (Describe):
Require supportive seating?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Fine Motor/other:	
Yes <input type="checkbox"/> No <input type="checkbox"/>	Isolate a finger to point?
Yes <input type="checkbox"/> No <input type="checkbox"/>	Sustain arm movement against gravity?
Yes <input type="checkbox"/> No <input type="checkbox"/>	Have voluntary control of head movement?
Yes <input type="checkbox"/> No <input type="checkbox"/>	Have voluntary control of eye movement?

Vision / Hearing / Speech	
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"/>
Is speech a concern? Specify if the client uses a communication device	Yes <input type="checkbox"/> No <input type="checkbox"/>

Literacy Skills			
Does the client:			
Name letters of the alphabet?	<input type="checkbox"/> All	<input type="checkbox"/> Some	<input type="checkbox"/> Few
Know the sounds of each letter?	<input type="checkbox"/> All	<input type="checkbox"/> Some	<input type="checkbox"/> Few
Identify a word that starts with each letter/sound?	<input type="checkbox"/> All	<input type="checkbox"/> Some	<input type="checkbox"/> Few
Composition			
Select all items that the client is able to do independently (without assistance) through either oral spelling, printing, or typing:			
<input type="checkbox"/> First name	<input type="checkbox"/> 3-letter words (e.g., cat, mom)	<input type="checkbox"/> Simple sentences (e.g., My cat is brown.)	
<input type="checkbox"/> Last name	<input type="checkbox"/> 2-3 syllable word (e.g., teacher, together)		

Writing needs at home:			
What are the client's current writing needs at home ?			
<input type="checkbox"/> homework	<input type="checkbox"/> email	<input type="checkbox"/> lists	
<input type="checkbox"/> social networking	<input type="checkbox"/> journaling	<input type="checkbox"/> Other:	
How is writing currently completed at home ?			
<input type="checkbox"/> printing/handwriting	<input type="checkbox"/> scribing	<input type="checkbox"/> Computer	
<input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No (describe system and age)		Is it dedicated to this client only (i.e., not shared)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
At school <input type="checkbox"/> Yes <input type="checkbox"/> No at school (describe system and age)		Is it dedicated to this client only (i.e., SEA funded)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the client use:			
<input type="checkbox"/> Standard computer, laptop or Chromebook			
<input type="checkbox"/> trackball or joystick	Please describe:		
<input type="checkbox"/> adapted keyboard			
<input type="checkbox"/> keyguard			
<input type="checkbox"/> alternate access (e.g., switches, eye gaze)			
<input type="checkbox"/> specialized software			
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:

<i>Parent/Guardian</i>		<i>Parent/Guardian</i>	
Relationship to client		Relationship to client	
Name:		Name:	
Address:		Address	
Telephone No.:		Telephone No.:	
	Home:		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"/>

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.