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

Re-Referral to be completed by parent/caregiver

Date Completed:			
Person Completing Form:		**Relationship to Client:**	
Name of Client:		**Gender:**	
Date of Birth:			
Diagnosis:			
Name of Client's School:			

Information about Augmentative Communication Services:

Our team works with you to find an augmentative or alternative communication tool to meet the needs and ability of each child or youth. There are many AAC tools to consider and our team will present options that will support the child's communication development. This clinic can only provide systems your child/youth will use to communicate and will not prescribe a device to be used as a learning tool.

Once you receive the communication tool ACS will offer coaching and consultation so you can learn how to communicate with your child using the system. Our team provides:

- ☑ Technical information about the communication system (e.g., opening the device, recording messages, activating messages, customizing vocabulary, navigating the app, adjusting the volume, access support, etc.)
- ☑ Strategies to create motivating experiences with your child and the AAC system
- ☑ Communication partner skills that build long-term success when communicating with an individual who uses AAC

You may be eligible for financial support when purchasing a system or leasing opportunities (iPads are not available for lease). Please note, in many cases there is a cost associated with a prescription. Our team can provide more information based on the outcome of your child's assessment.

ACS supports communication goals in the home and community environments. If your child/youth has communication goals related to the school environment, please speak with the Speech-Language Pathologist at your school.

I understand the services ACS can provide at KidsAbility. I would like to proceed with a referral to ACS.

Parent/Caregiver Initials: _____

Have you discussed the re-referral with any of the following?

☐ Therapy team	☐ OT	☐ School Team	☐ Other:

Current Therapies and name(s) of therapists (public, private):

If the communication system your child/youth currently uses still meets their communication needs, however, you are experiencing technical difficulties we ask that you contact the manufacturer of the communication system to troubleshoot these issues before re-referring to Augmentative Communication Services.

Re-Referral Contact Information			
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 ☐

Re-Referral Clinical Information
What are you 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. I confirm that I have contacted the manufacturer of my child's device and was directed to follow-up with the AAC clinic.

_____ _____ _____

Signature Relationship to Client Date

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