KidsAbility

AUGMENTATIVE COMMUNICATION SERVICES (ACS)
Face to Face communication
Application form

Client Name:		Date of birth:	

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

KidsAbility Centre for Child Development
Fax to: 519-886-7292
Email using KidsAbility ACS Internal Portal-PHIPA compliant: https://acs.kidsability.org
Questions? Call: 519-886-8886 or 1-888-372-2259 x 2222 Email: csa-acs@kidsability.ca

☐ **Client has a valid health card or is eligible to apply for a health card**	
☐ **Client has accessed ADP funding for a communication device (Kidsability or other clinic in the province)**	
Date Completed:	
Gender and/or Pronouns:	
Diagnosis:	
Name of client's school:	
SLP Name:	
SLP Email Address:	
Briefly describe the client's communication challenges and your expectations of this referral:	
Identify where the client would use a communication device and who their communication partners are:	

Pre-Linguistic Skills		
Indicate if the client demonstrates the following skills:		
Turn taking	☐**Yes**	☐**No**
Joint attention	☐**Yes**	☐**No**
Intentionality	☐**Yes**	☐**No**
Cause-effect skills	☐**Yes**	☐**No**
Additional information (if necessary):		

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Receptive Language Skills		
Indicate if the client demonstrates the following skills:		
Follow directions	☐Yes	☐No
Respond to other people's communication	☐Yes	☐No
Respond to their name	☐Yes	☐No
Briefly describe the child's understanding of concepts, vocabulary and picture/symbols		
Additional information (optional):		

Communication Modes		
What kind of communication signals does the client currently use? Check all that apply.		
☐changes in breathing patterns	☐vocalizations (sounds)	☐single words (how many)
☐body position changes	☐vowel sounds	☐two-word phrases
☐eye pointing	☐pointing	☐three-word phrases
☐facial expressions	☐signing	☐three or more-word phrases
☐gestures (i.e., reaching, guiding adult by the hand)	☐using a low-tech, light-tech or high-tech communication device	☐writing or drawing – specify which one
Does the client use at least 10 words, signs, symbols, or gestures to communicate? Yes ☐ No ☐ Please Describe:		
Additional information (optional):		

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Communicative Functions	
Indicate whether the child/youth is able to communicate for the following reasons:	
☒Yes ☐No	Express feelings (i.e., likes or dislikes)
☐Yes ☐No	Accept or reject things that are offered
☐Yes ☐No	Request items, help and information
☐Yes ☐No	Get someone's attention
☐Yes ☐No	Make choices
☐Yes ☐No	Make comments
☐Yes ☐No	Respond to questions
☐Yes ☐No	Ask questions
Describe how the client indicates:	
"yes" ☐	Is it reliable? ☐Yes ☐No
"no" ☐	Is it reliable? ☐Yes ☐No

Motor Abilities		
Indicate if the client has any of the following:		
Fine motor difficulties	☐Yes	☐No
Experience with tablet	☐Yes	☐No
Ability to isolate a finger	☐Yes	☐No
Gross motor difficulties (i.e., unable to walk independently, use a manual/power wheelchair, etc.)	☐Yes	☐No
Difficulties walking independently	☐Yes	☐No
A manual or power wheelchair	☐Yes	☐No
Occupational therapy or Physiotherapy involved	☐Yes	☐No
Additional information (optional):		

Vision / Hearing		
Does the client have challenges with vision?	☐Yes	☐No
Does the client wear glasses?	☐Yes	☐No
Does the client have hearing challenges?	☐Yes	☐No

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Augmentative Communication	
Has the individual received a prescription of face to face communication equipment from an IA or a SEA iPad? If yes, which device:	☐Yes ☐No Date Dispensed:
Have any AAC strategies/devices been used to aid understanding or support expression?	☐Yes ☐No
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*:*	

Parent/Guardian Information

☐**This is an internal referral and demographic information is up to date in the client file. Note: If this box is checked, clinician does not need to fill out the information below.**

Parent/Guardian 1		*Parent/Guardian 2*	
Name:		Name:	
Address:		Address	
Telephone No.:	Home:	Telephone No.:	Home:
	Work:		Work:
	Cell:		Cell:
Email:		Email:	

*Consent for use of email to receive information about referral, and/or to schedule appointments. Email will only be used if Parent/Guardian can't be reached for the initial contact. Consent can be withdrawn at any time. Further consent for other types of communication, will be obtained at a later date.

Is English a second language for the client/caregiver? ☐Yes ☐No	
Language spoken in the home:	Is an interpreter needed for appointments? ☐Yes ☐No

Is there any additional information that you would like to share regarding this referral?

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Please review the following information with Parent/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. 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.
Referring SLP Responsibilities:
I have confirmed with the parent guardian that the child/youth will have a facilitator who will support use of the device in the home environment I have confirmed that the parent/guardian is in agreement with the information provided and has provided consent for their child/youth to be referred to KidsAbility's Augmentative Communication Services. I have confirmed consent from the parent to share information between board and/or referring SLP and ACS clinicians

SLP Signature (digital accepted)	**Date**

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