AUGMENTATIVE COMMUNICATION SERVICES (ACS)
Face to Face Communication
Re-Referral Application form

Client Name:		**Date of birth:**	

Re-Referral to be completed by parent/caregiver

KidsAbility Centre for Child Development
Fax to: 519-886-7292
Email using KidsAbility ACS Internal Portal-PHIPA compliant: https://acs.kidsability.org
If you have any questions, please contact the Client Support Assistant: 519-886-8886 or 1-888-372-2259 x 2222, or email: csa-acs@kidsability.ca

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

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 ☐

AUGMENTATIVE COMMUNICATION SERVICES (ACS)
Face to Face Communication
Re-Referral Application form

Client Name:		Date of birth:	

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