KidsAbility™

AUGMENTATIVE COMMUNICATION SERVICES (ACS)
Writing Aids
Application form

Client Name:		Date of birth:	

To be completed by Occupational Therapist 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 or Email: csa-acs@kidsability.ca

☐ **Client has a valid health card or is eligible to apply for a health card**			
Date Completed:			
Gender/Pronouns:			
Diagnosis:			
Name of Client's School:		**Grade:**	
OT Name:			
OT Email Address:			

New Referrals	
Parent / Guardian Acknowledgement (this must be completed before referral is accepted)	
☐ I declare that this referral was completed in collaboration with a parent/guardian. The parent/guardian is aware of the referral and has agreed that the information shared below is correct ☐ I have confirmed consent from the parent to share information between board and/or referring SLP and ACS clinicians	
Name of parent/guardian involved:	

Mobility and posture:			
Does the client:			
Walk independently?	Yes ☐	No ☐	
Use a manual wheelchair?	Yes ☐	No ☐	
Independently?	Yes ☐	No ☐	
Use a power wheelchair?	Yes ☐	No ☐	
Drive Control:	Joystick ☐	Switch ☐	Other ☐ (Describe):
Require supportive seating?	Yes ☐	No ☐	

Fine Motor/other:		
Yes ☐	No ☐	Isolate a finger to point?
Yes ☐	No ☐	Sustain arm movement against gravity?
Yes ☐	No ☐	Have voluntary control of head movement?
Yes ☐	No ☐	Have voluntary control of eye movement?

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Vision / Hearing / Speech	
Is vision a concern? Specify if the client wears glasses	Yes ☐ No ☐
Is hearing a concern? Specify if the client wears hearing aids or has a cochlear implant.	Yes ☐ No ☐
Is speech a concern? Specify if the client uses a communication device	Yes ☐ No ☐

Literacy Skills			
Does the client:			
Name letters of the alphabet?	☐ All	☐ Some	☐ Few
Know the sounds of each letter?	☐ All	☐ Some	☐ Few
Identify a word that starts with each letter/sound?	☐ All	☐ Some	☐ Few

Composition		
Select all items that the client is able to do independently (without assistance) through either oral spelling, printing, or typing:		
☐ First name ☐ Last name	☐ 3-letter words (e.g., cat, mom) ☐ 2-3 syllable word (e.g., teacher, together)	☐ Simple sentences (e.g., My cat is brown.)

Writing needs at home:					
What are the client's current writing needs **at home?**					
☐	homework	☐	email	☐	lists
☐	social networking	☐	journaling	☐	Other:
How is writing currently completed **at home?**					
☐	printing/handwriting	☐	scribing	☐	Computer
☐	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 ☐ Yes ☐ No (describe system and age)			Is it dedicated to this client only (i.e., not shared)? ☐ Yes ☐ No		
At school ☐ Yes ☐ No at school (describe system and age)			Is it dedicated to this client only (i.e., SEA funded)? ☐ Yes ☐ No		
Does the client use:					

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☐ Standard computer, laptop or Chromebook:	
☐ trackball or joystick ☐ adapted keyboard ☐ keyguard ☐ alternate access (e.g., switches, eye gaze) ☐ specialized software	Please describe:
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:

To be completed by parent/legal guardian:

☐ **This is an internal referral and demographic information is up to date in the client file.**

Note: Clinician does not need to fill out the information below.

Parent/Guardian 1		***Parent/Guardian 2***	
Relationship to Client:		Relationship to Client:	
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 ☐

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