KidsAbility™

AUGMENTATIVE COMMUNICATION SERVICES (ACS)
Writing Aids
Re-Referral Application form

Client Name:		Date of birth:	

Re-Referral to be completed by parent/guardian

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
csa-acs@kidsability.ca

☐ **Client has a valid health card or is eligible to apply for a health card**			
☐ **Client has been seen by the ACS clinic before**			
Date Completed:			
Name of Client:		**Gender/Pronouns:**	
Date of Birth:		**Age:**	
Diagnosis:			
Name of Client's School:		**Grade:**	

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 specialized 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?

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 ☐

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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:	
☐ 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)	

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Please add any important information that you would like us to know about your child/youth's writing needs:

Contact information:			
Parent/Guardian		***Parent/Guardian***	
Relationship:		Relationship:	
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 ☐