KidsAbility Centre for Child Development
APPLICATION – Augmentative Communication Services (ACS) – Face to Face Communication

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

☐ **NEW Referral** ☐ **Parent advised to watch "What to Expect with ACS" at www.kidsability.ca**
☐ **Client has a valid health card or is eligible to apply for a health card**

Date Completed:			
Name of Client:		**Gender:**	
Date of Birth:			
Chronological Age:			
Diagnosis:			
Name of Client's School:			
SLP Name:			
SLP Email Address:			

Briefly describe your expectations of this referral:

Identify where the client would use a communication device and who their communication partners are:

Pre-Linguistic Skills

Does the client demonstrate:		
Turn taking?	☐ Yes	☐ No
Joint attention?	☐ Yes	☐ No
Intentionality?	☐ Yes	☐ No
Cause-effect skills?	☐ Yes	☐ No

Please elaborate (if necessary):

Receptive Language Skills

Can the client:		
Follow directions?	☐ Yes	☐ No
Respond to other people's communication?	☐ Yes	☐ No
Respond to their name?	☐ Yes	☐ No

Please elaborate (if necessary):

Communication Modes

What kind of communication signals does the client currently use? Check all that apply.

☐	changes in breathing patterns	☐	eye movement	☐	single words (how many)
☐	body position changes	☐	vocalizations (sounds)	☐	two word phrases
☐	eye pointing	☐	vowel sounds	☐	three word phrases
☐	facial expressions	☐	pointing	☐	three or more word phrases
☐	gestures (i.e., reaching, guiding adult by the hand)	☐	signing	☐	writing or drawing – specify which one
☐	pointing to pictures in a communication book	☐	using a low-tech, light-tech or high-tech communication device		

Communicative Functions

Does the client intentionally use vocalizations, gestures, words, body language, etc. to:

Yes ☐	No ☐	Request items, help and information?
Yes ☐	No ☐	Express feelings (i.e., likes or dislikes)?
Yes ☐	No ☐	Make choices?
Yes ☐	No ☐	Respond to questions?
Yes ☐	No ☐	Ask questions?
Yes ☐	No ☐	Make comments?
Yes ☐	No ☐	Accept or reject things that are offered?
Yes ☐	No ☐	Get someone's attention?

Describe how the client indicates:

"yes"	Is it reliable? ☐ Yes ☐ No
"no"	Is it reliable? ☐ Yes ☐ No

Motor Abilities

Does the client have:

Fine motor difficulties (i.e., difficulty with grasp, finger isolation, isolating a finger to point?)	Yes ☐ No ☐
Gross motor difficulties (i.e., unable to walk independently, use a manual/power wheelchair, etc.)	Yes ☐ No ☐
Occupational therapy or Physical therapy involved?	Yes ☐ No ☐

Please elaborate (if necessary):

Vision / Hearing

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 ☐

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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, 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:	

Completed by (SLP):			
	Signature		**Date**

To be completed by parent/legal guardian:

New Referral			
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 ☐

Please add any important information that you would like us to know about how your child/youth communicates:

This form must be completed in full and returned before the application will be considered.

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Dear Legal 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.

This referral is the first step to further enhance your child's/youth's communication skills.

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.

*Modified from One Kids Place Referral form

ATTENTION: The information communicated between KidsAbility's Augmentative Communication Service and facilitators is confidential and legally privileged. KidsAbility's Augmentative Communication Service will not disclose or discuss information relating to the client with anyone other than identified facilitators and legal guardians.

Facilitator Commitment

I agree to act as a facilitator for the child/youth described above, and I accept the responsibilities as outlined.

______________________________	______________________________
Signature (Facilitator)	**Date**

NEW Referrals

Family / Guardian Acknowledgement (this must be completed before referral is accepted)

I am aware of and in agreement with the information provided in this questionnaire. I consent to my child/youth being referred to KidsAbility Augmentative Communication Services.

____________________	____________________	____________________
Signature	**Relationship to Client**	**Date**

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