Augmentative Communication Services

EXTERNAL REFERRAL & BACKGROUND INFORMATION FORM

Thank you for your interest in Augmentative Communication Services (ACS), serving residents of Sarnia-Lambton. ACS may be appropriate when speaking or writing is physically difficult or limited.

Our Service offers:

- Assessment
- Recommendations
- Support of Augmentative and Alternative Communication Systems.

Our ACS Team consists of:

- Speech-Language Pathologist
- Occupational Therapist
- Communicative Disorders Assistant
- IT Technician
- Administrative Assistant

We are registered with the **Assistive Devices Program (ADP)** of the Ministry of Health as an Expanded Level Clinic that allows prescriptions and funding for equipment for those who qualify.

If you have any questions, please contact us at (519) 542-3471 ext. 1273

Please complete the referral as listed below and ensure the referral is legible.
The information you provide will assist us in preparing for the assessment process. Other people working with the client may help you complete the form. If able, please attach additional documentation (i.e. reports that deal with communication and/or a recent vision assessment).

Send completed referral form by mail or fax to:

ACS
Pathways Health Centre for Children
1240 Murphy Road,
Sarnia, ON N7S 2Y6

Telephone: (519) 542-3471
Toll Free: 1-855-542-3471
Fax: (519) 542-4115

Augmentative Communication Services, Pathways Health Centre for Children

EXTERNAL REFERRAL & BACKGROUND INFORMATION FORM

A. DEMOGRAPHICS

Client Name: _____ _____ ☐ Female ☐ Male
(Last) (First)

Date of Birth: _____/_____/_____ Health Card #: _____ Version Code: _____
(month) (day) (year)

Address: _____ _____ _____
(Street) (City) (Postal Code)

Telephone: Home: _____ Work: _____ Cell: _____

Email: _____ ☐ I consent to correspond via Email

B. REASON FOR REFERRAL

☐ **Face-to-Face Communication** (i.e. unable to functionally communicate using speech)

☐ **Written Communication** (i.e. difficulties with handwriting must be due to a physical diagnosis)

☐ **Both** (exploring support for both face-to-face and written communication, i.e. alternate access to a communication system)

What are your expectations from an assessment by ACS: _____
_____
_____
_____

C. CONTACT INFORMATION

1. Who completed this form? ☐ Same as above ☐ Other, please specify:

_____ _____ _____
Name Relationship Telephone #

2. Who will be contacted to book appointments and obtain more information regarding client's current communication skills and medical information ? ☐ Same as above ☐ Other, please specify:

_____ _____ _____
Name Relationship Telephone #

3. Does the client live: ☐ Independently ☐ With Mother/Father ☐ Group Home ☐ Other (please specify):

_____

Pathways Health Centre for Children
1240 Murphy Road
Sarnia, ON N7S 2Y6
Tel: (519) 542-3471
Fax: (519) 542-4115
/PathwaysHealthCentreForChildren
PathwaysCentre.org

D. CLIENT INFORMATION

1. Client's primary language: _____ Is English Understood? ☐ Yes ☐ No

2. Other people/agencies who are involved with this client:

Discipline	Name	Agency	Telephone
Doctor			
Home Support Worker			
Therapist (PT/OT/SLP)			
Other			

3. DIAGNOSIS: _____

4. MEDICAL PRECAUTIONS: _____
(i.e. seizures, respiratory, dislocations, etc.)

5. VISION

Is vision a concern? ☐ Yes ☐ No If yes, please specify _____

Vision Report Attached: ☐ (check if yes)

6. HEARING

Is hearing a concern? ☐ Yes ☐ No If yes, please specify) _____

E. MOTOR ABILITIES

1. MOBILITY: How is the client able to move in their environment? Please describe any other forms of mobility used (i.e. walks independently, with a walker, manual or power wheel chair, etc.)

_____

2. MOVEMENTS:

Which movements are the best or most reliable? _____

Does the client have any involuntary movements (i.e. reflexes, spasms or body tone) which interfere with his/her control? ☐ Yes ☐ No If yes, please specify _____

REPORTS ATTACHED? ☐ Yes ☐ No

If there are any additional documents or reports (i.e. clinic report, vision, hearing, PT, OT, SLP, etc.) that you are able to attach to this referral PLEASE do so. Requests for further information and reports may be made by the ACS team.

Client has given consent for this referral? ☐ Yes ☐ No

Pathways Health Centre for Children
1240 Murphy Road
Sarnia, ON N7S 2Y6
Tel: (519) 542-3471
Fax: (519) 542-4115
/PathwaysHealthCentreForChildren
PathwaysCentre.org