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):

_____

## 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