



Augmentative Communication Services, Pathways Health Centre for Children
EXTERNAL REFERRAL & BACKGROUND INFORMATION FORM

A. DEMOGRAPHICS

Client Name: _____ (First) _____ (Last)

Date of Birth: ____/____/____ Female Male
(month) (day) (year)

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

B. REASON FOR REFERRAL

EAW (Early Augmentative Workshop)
Children who are non-verbal or have significant difficulty speaking and who are not yet communicating independently with 10 pictures/symbols.

Augmentative and Alternative Communication (AAC) Assessment
Children who are

- Able to communicate with at least 10 symbols, in 2 categories (e.g.food/toys/places) with 2 communication partners (parent, school EA).
OR
- have significant vision and or physical limitations.
AND/OR
- have written or physical limitations.
AND/OR
- have previous involvement with another AAC clinic.

[Click here for more information about the 3 Streams](#)

Consultation
Caregiver/Service Provider/Professional who has questions regarding supporting a child with using AAC

What are your expectations from ACS: _____

C. CONTACT INFORMATION

1. Referral Source:

Name Relationship or Position/Agency Telephone #

2. Who is the primary contact? Same as above Other, please specify:

Name Relationship

Telephone: Home: _____ Work: _____ Cell: _____

Email: _____ I consent to correspond via Email



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

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D. CLIENT INFORMATION

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

2. **DIAGNOSIS:** _____

3. VISION

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

4. 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

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.

Send completed referral form by mail or fax to:

Address: ACS
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