Referral Criteria – Communication and Writing Aids Service (CWAS)

Augmentative and Alternative Communication (AAC)

PLEASE COMPLETE AND SUBMIT THIS CHECKLIST WITH THE REFERRAL FORM

CWAS' **Augmentative and Alternative Communication (AAC)** service **provides support for both face-to-face and written communication** for clients whose speech does not meet their everyday needs. As an Assistive Device Program (ADP) clinic, CWAS can authorize ADP funding when clinically recommended.

CWAS services the Toronto, Durham, York and Simcoe regions with the following two exceptions (please refer to the appropriate agency if either of these apply):

1. If client lives in Toronto AND meets all of the following criteria:

- **Can** physically point to pictures and/or press buttons using fingers, hands and/or feet with or without vision challenges
- Has a diagnosis of Developmental Disability or Intellectual Disability and/or is a current client of Surrey Place Developmental Services

→ Consult the criteria for the Augmentative Communication and Writing Aids Service at Surrey Place

2. ***If client lives in York or Simcoe AND***:

- **Can** physically point to pictures and/or press buttons using fingers, hands and/or feet with or without vision challenges

→ Consult the criteria for the Augmentative Communication Consultative Service at The Children's Treatment Network

In order to be eligible for CWAS the client must meet <u>all</u> of the following criteria (please check all that apply)

- ☐ Unable to speak or whose speech is unclear or limited
- ☐ Under the age of 19 (at the time of referral)
- ☐ Is working with or has access to speech language pathology consultation

AND one or more of the following: (please check all that apply):

- ☐ 1. Client has vision needs that impact ability to use symbols
- ☐ 2. Client **cannot** physically point to pictures or press buttons using fingers, hands and/or feet
- ☐ 3. *Client **can** physically point to pictures and/or press buttons using fingers, hands and/or feet **AND** can **independently** use **10** symbols on a communication system (i.e. board, book or device) to communicate about a minimum of **3** different topics (e.g., food, toys, places) with **2** or more partners across both structured and unstructured tasks
  - * A thorough description of the child's current communication system must be submitted with this referral (**see page 2**)

Before submitting:

- ☐ Have you checked all the applicable boxes?
- ☐ Have you attached the description(page 2) of child's current system for #3 above (and any reports if available)
- ☐ Have you attached the referral form?

* R E F O U T P *

- Page 2 -

1. **List a minimum of 10 symbols that the child can use independently to communicate a purposeful message:**

   1. 6.
   2. 7.
   3. 8.
   4. 9.
   5. 10.

   List additional symbols:

2. **List a minimum of 3 topics the child uses the above symbols for: (example: food, toys, people, etc.)**

   1.
   2.
   3.

   List additional topics:

3. **List a minimum of 2 communication partners the child is using symbols with (example: mom, aunt, teacher, etc.)**

   1.
   2.

   List additional partners:

4. **List all the structured and/or unstructured tasks in which child is using the symbols: (example: therapy activities, school curriculum, requesting items, greetings, etc.)**

   _____

   _____

5. **Comments/additional information:**

   _____

   _____

   _____

REF OUTP

Holland Bloorview
Kids Rehabilitation Hospital

Appointment Services: 150 Kilgour Rd. Toronto, ON, M4G 1R8
Tel: (416) 424-3804 Fax: (416) 422-7036

HEALTH PROFESSIONAL REFERRAL FORM – OUTPATIENT SERVICES

Referral Source: ☐ **Health Care Professional** ☐ **Client and Family** ☐ **Other**

Please complete all sections of this form as incomplete forms will result in processing delays.

NOTE: This information will be shared with Holland Bloorview staff as required

Family is aware of this referral: Yes • **(must be checked)** **Referral Date:**_____(dd/mm/yy)

CLIENT INFORMATION:

Client Name: _____
Surname First Name Middle Initial

Date of Birth:_____ ☐ Male ☐Female
Day / Month / Year

Is an interpreter required? ☐ Yes ☐ No Languages spoken: _____

If yes, would over-the-phone interpretation be possible for this client (i.e. is hearing/speaking an issue?) ☐ Yes ☐ No

Client Address:_____City:_____

Province:_____Postal Code:_____

Tel.: _____

Health Card Number:_____**Version Code:**_____

Interim Federal Health Program (IFHP) ☐Yes ☐No Health Card In Process ☐

Client lives with: ☐ Both parents ☐ Father ☐ Mother ☐ Guardians ☐ Independent ☐ Group Home ☐ Other:

Primary Contact(s) – Parent/Legal Guardian:

_____

Address:_____

Email:_____

Tel. (home):_____Tel. (work):_____Tel. (cell): _____

Secondary Contact(s) – Parent/Legal Guardian:

_____

Address:_____

Email:_____

Tel. (home):_____Tel. (work):_____Tel. (cell): _____

PRIMARY CARE PHYSICIAN:

Name: _____

Address:_____

Tel.:_____Fax: _____

REF OUTP

COMMUNITY AGENCIES/PROFESSIONALS CURRENTLY INVOLVED:

Agency(s) (e.g. Child Protection, Community)	Professional (e.g. OT, Psychologist)
1.	
2.	
3.	

MEDICAL INFORMATION:

Primary Diagnosis:

Other Diagnoses:

Does this client require any special infectious disease precautions? ☐ **Yes** ☐ **No**

If yes, what for:

Medical History/Allergies:

Taking Medication: ☐ Yes ☐No

Risks (i.e. frequent falls)

Reason for Referral/Concern/Goals:

Specialized Services: ❑ Aquatic Therapy Communication & Writing Aids Services: ❑ Augmentative & Alternative Communication (AAC) ❑ Writing Aids (WA) ❑ Clinical Seating ❑ Infant Development Services ❑ Music Therapy	❑ Nursery Schools (Holland Bloorview) ❑ Orthotics (including protective headwear) ❑ Prosthetics (including myoelectric & cosmetic) **Transitions, Recreation & Life skills:** ❑ Employment & Volunteering ❑ Life Skills Coaching ❑ Post-Secondary Transition Service ❑ Therapeutic Recreation Services ❑ Transitions to Adult Services	**Dental Services:** ❑ Cleft Lip & Palate (general anesthesia available for qualifying clients) ❑ Special Needs Dentistry (general anesthesia available for qualifying clients)

REFERRING PROFESSIONAL/CLIENT OR FAMILY:

Name:

Organization:

Telephone: Fax:

Email:

Signature:

Please fax your completed Referral Form to Appointment Services: (416) 422-7036

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