Referral Criteria – Communication and Writing Aids Service (CWAS)

Augmentative and Alternative Communication (AAC)

PLEASE READ THROUGH CAREFULLY

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 exceptions:

CLIENT LIVES IN TORONTO and meets both of the following criteria • Can use fingers to point/press button • Has a diagnosis of Developmental Disability (DD) or an associated syndrome	Consult Surrey Place's referral criteria
CLIENT LIVES IN YORK OR SIMCOE and • Can use fingers to point/press buttons	Consult Children's Treatment Network's referral criteria

In order to be eligible for CWAS' AAC Referral, the client must meet ALL of the following criteria:

- 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:

Client has significant vision needs

Client has difficulty using fingers to point/press buttons

Client is able to use fingers to point / press buttons

AND

Can **independently** and **functionally** use **10** symbols *within or across* word classes (e.g. verbs, nouns, adjectives, pronouns) on a communication system (i.e. board, book or device) to express at least 3 different topics (e.g. food, toys, places) with 2 or more partners

OR

Can use any combination of gestures and/or signs to express novel messages and whose receptive language is within normal limits

If client DOES NOT meet any of the above CWAS' AAC referral criteria, please refer to community speech-language services (e.g. preschool, school board)

Please use the referral form online at: hollandbloorview.ca/referrals

Holland Bloorview
Kids Rehabilitation Hospital

Revised September 2018

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:_____ o Male o Female
Day / Month / Year

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

If yes, would over-the-phone interpretation be possible for this client (i.e. is hearing/speaking an issue?) o Yes o 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: o Both parents o Father o Mother o Guardians o Independent o Group Home o 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: _____

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
- ❑ Life Skills Services
- ❑ Music Therapy
- ❑ Nursery Schools (Holland Bloorview)
- ❑ Orthotics (including protective headwear)
- ❑ Post-Secondary Transition Service
- ❑ Prosthetics (including myoelectric & cosmetic)
- ❑ Therapeutic Recreation 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