Holland Bloorview
Kids Rehabilitation Hospital

Referral Criteria – Communication and Writing Aids (CWAS)

Augmentative and Alternative Communication (AAC)

Please check the box in the category that applies to your client and fax this form WITH the referral.

CWAS's Augmentative and Alternative Communication (AAC) service works with clients who are unable to speak or whose speech does not meet their everyday needs (extremely unclear or limited speech). This includes both face-to-face (conversation) and written communication support.

In order to be eligible for referral, the client must meet **all** of the following criteria:

- Speech does not meet every day needs
- Under the age of 19 (at the time of referral)
- Is working with or has access to speech language pathology consultation; **and**

Falls into one of the following categories and you are developing next steps:

Alternate Access
(Difficult to use fingers to point/push buttons)

Difficult to use fingers to point / push buttons (**AND / OR** a degenerative diagnosis, **AND / OR** significant vision needs such as CVI – cortical visual impairment)

Yes → **Refer to AAC** ☐

No → **Go to Direct Access criteria below**

Direct Access
(Can use fingers to point/push buttons)

Exceptions:
- Lives in Simcoe, York Region → refer to Children's Treatment Network
- Lives in Toronto with a postal code that starts with M with diagnosis of developmental delay → refer to Surrey Place Centre

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

Holland Bloorview Kids Rehabilitation Hospital
150 Kilgour Road, Toronto ON Canada M4G 1R8
T 416 425 6220 **T** 800 363 2440 **F** 416 425 6591
www.hollandbloorview.ca

A teaching hospital fully affiliated with the University of Toronto

Can use fingers to point / push buttons and can use an a communication system to:

- Independently navigate and functionally use 4-6 pages & 8-12 vocabulary items…
  …**AND**
- Functionally use their communications system with at least 2 or more partners & within two or more environments (home must be one)

Yes → **Refer to AAC** (see exceptions) ☐

No → **Refer to community speech language services** (school board, preschool language services)

Direct Access with age appropriate receptive language skills

Exceptions:

- Lives in Simcoe or York Region → refer to Children's Treatment Network

Uses any combination of unintelligible speech, gestures, signs, pointing to express novel messages **AND** whose receptive language skills fall within the average range

Yes → **Refer to AAC** (see exceptions) ☐

No → **Refer to community speech language services** (school board, preschool language services)

*** If the referral is being made on behalf of a client, the client / family must be aware of the referral**

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

PHYSICIAN REFERRAL FORM – OUTPATIENT SERVICES

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: _____
Last Name First Name Middle Initial

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

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

Client Address: _____City:_____

Province: _____ Postal Code: _____ Tel.:_____

Health Card Number: _____ Version Code: _____

☐ Interim Federal Health Program (IFHP) ☐ Health Card In Process

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

PARENT(S) OR GUARDIAN(S): (if different from client address)

Parent/Guardian: _____

Address:_____

Email:_____

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

Parent/Guardian: _____

Address:_____

Email:_____

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

AGENCIES/PROFESSIONALS CURRENTLY INVOLVED:

Agency (eg. Child Protection, Community)	Professional (eg. OT, SLT, 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:

_____

_____

Use check box for referral:

- ❑ Query Autism
- ❑ Acquired Brain Injury Rehabilitation
- ❑ Concussion Clinic
- ❑ Cleft Lip & Palate Speech Language Pathology
- ❑ Infant Development Services
- ❑ Neuromotor (e.g. cerebral palsy, global developmental delay, Retts)
- ❑ Psychopharmacology* (additional forms required)
- ❑ Neuromuscular (e.g. muscular dystrophy)
- ❑ Feeding* (additional forms required)
- ❑ Spina Bifida
- ❑ Spinal Cord Injury
- ❑ Augmentative & Alternative Communication (AAC)
  - ❑ Writing Aids
- ❑ Orthotics (including protective headwear)
- ❑ Prosthetics (including myoelectric & cosmetic)
- ❑ Clinical Seating

Dental Services:

- ❑ Cleft Lip & Palate (general anesthesia available for qualifying clients)
- ❑ Special Needs Dentistry (general anesthesia available for qualifying clients)

***Pre-assessment forms are required with the referral. Click here:**

Feeding: http://hollandbloorview.ca/programsandservices/programsservicesaz/feedingservices
Psychopharmacology: http://hollandbloorview.ca/programsandservices/ProgramsServicesAZ/Psychopharmacologyclinic

REFERRING M.D./D.D.S. Name: _____

OHIP Billing Number: _____

Hospital: _____

Telephone: _____ Fax: _____

Email: _____

Signature: _____

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