ONE KIDS PLACE
LA PLACE DES ENFANTS
CHILDREN'S TREATMENT CENTRE
CENTRE DE TRAITEMENT POUR ENFANTS

AUGMENTATIVE AND ALTERNATIVE COMMUNICATION CLINIC

FACE-TO-FACE COMMUNICATION REFERRAL

This Referral form can be completed by anybody involved with child/youth educational, health and/or personal care but **MUST BE SIGNED** by the child's parents or guardians.

This form is used to determine eligibility for AAC services (i.e., augmentative and alternative communication) and to gather information about the child/youth for the purposes of completing an AAC evaluation.

Has the child been referred to OKP AAC Clinic in the past? ☐ YES ☐ NO

The child is eligible for an AAC evaluation if the following four conditions are met:

- ❑ Child is non-verbal or has speech but it is not sufficient to meet functional face-to-face communication needs (i.e., speech is difficult to understand)
- ❑ 18 years of age or younger or, older than 18 AND attending school at time of referral
- ❑ Child has access to a speech-language pathology consultant
- ❑ Team can identify a primary facilitator (i.e., SLP, parent teacher, educational assistant) for ongoing program support

CLIENT INFORMATION		
Client's name:	DOB::__/___/____ D M Y	Sex: ☐M ☐F
Address:	City:	Postal Code:
Home phone:	Diagnosis:	
Is the disability considered to be rapidly progressive?	☐Yes	☐ No
Preferred language for assessment? ☐ English	☐ French	☐ Other:
Would like an interpreter who speaks:		

REFERRAL SOURCE INFORMATION		
Name of person filling out this form:		
Adresss:		
Relationship with client:	Phone:	Date:

PARENT OR GUARDIAN INFORMATION	
Name of: ☐ parent(s) ☐ guardian:	
Address (*if different from client):*	
Home telephone *(if different from client)*:	Mobile phone:
Email:	

CLIENT PROFILE		
1. What is your child's current placement (check all that apply):		
☐ regular class: Grade:	☐ special education class	☐ partial inclusion
☐ full inclusion	☐ daycare full time	☐ daycare part time

Name of school: _____ School board: _____
Name of daycare:

2. Please describe any problems relating to:
   - ☐ Hearing: _____
   - ☐ Vision: _____
   - ☐ Behaviour: _____
   - ☐ General Health:

3. Is the client on waitlist or receiving services in any of the following areas? If so, please list the name of the agency and, if available, the frequency of services (e.g., once per week, 9:00-12:00 3x per week etc):
   - ☐ Speech/Language Therapy:: _____
   - ☐ Occupational Therapy: _____
   - ☐ Physiotherapy: _____
   - ☐ Hearing: _____
   - ☐ Vision: _____
   - ☐ Behaviour: _____
   - ☐ IBI services: _____
   - ☐ ABA services

4. Please list the child's most preferred and non-preferred things (i.e., Activities, Places, People, Food etc)
   Preferred: _____
   Non preferred:

5. Does the child intentionally use signals (vocalizations, gestures, movements, words etc.) to:
   - ☐ express likes and dislikes
   - ☐ get people's attention
   - ☐ accept or reject things that are offered
   - ☐ request help
   - ☐ request something that he/she wants
   - ☐ answer questions
   - ☐ ask questions
   - ☐ make comments
   - ☐ tell about things that happened in the past or that will happen in the future

6. What kind of communication signals does the child currently use? (check all that apply)
   - ☐ Verbal speech: ☐ single words ☐ two-word phrases ☐ 3+ word sentences
   - ☐ Emotional responses: ☐ crying ☐ fussing ☐ facial expressions
   - ☐ Gestures and Behaviours: ☐ looking ☐ reaching ☐ grabbing ☐ pointing ☐ guiding adult by the hand
   - ☐ Vocalizations or non-speech sounds
   - ☐ PECS (i.e., handing photo or picture symbol of desired items to an adult)
   - ☐ Pointing to photos or pictures on a communication board, a book, or pictures in the environment
   - ☐ Manual Signs or personalized signs
   - ☐ Drawings
   - ☐ Electronic device with voice output (e.g., talking switches, iPad) Describe:
   - ☐ Special communication software used on a computer Name of software:

7. How does the child communicate YES and NO? Check all that apply
   - ☐ Body movements, facial expressions, emotions
   - ☐ Pushing things away or looking away to reject things
   - ☐ Smiling to accept things
   - ☐ Clear Head shakes/nods

☐ Clear verbal signals (words or word approximations) ☐ Picture pointing or touching
☐ Other: _____

8. Does the client walk independently? ☐ Yes ☐ No
What mobility aids are used, if any?
☐ walkers ☐ crutches ☐ stroller
☐ manual wheelchair ☐ power wheelchair ☐ other:

9. Please give us a general idea of the client's hand function:

RIGHT HAND	LEFT HAND
☐ can reach	☐ can reach
☐ can point using index finger	☐ can point using index finger
☐ can isolate all finger movements	☐ can isolate all finger movements
☐ can isolate some finger movements	☐ can isolate some finger movements
☐ no functional use of right hand	☐ no functional use of left hand

10. Can the child…
☐ target icons on a tablet with their fingers ☐ use a mouse

11. Does the child use…
☐ computer ☐ tablet ☐ smart phone ☐ iPod ☐ Hand-held video consoles
What apps or software does the child use?: _____

12. The child uses technology to:
☐ Do Google searches ☐ Search YouTube videos ☐ Play games
☐ Take photos and/or videos ☐ Write or read emails or text messages ☐ Write journal
☐ Other:

REASON FOR REFERRAL

Please describe in detail the **reason for this referral** and the areas you would like our assistance with:

Dear Parent/Guardian:

This referral is the first step in a process to help your child improve his/her ability to communicate. This process requires a commitment from you in order to bring results.

Our services include assessment and consultation-based intervention. Your primary therapist will be an occupational therapist or a speech language pathologist. We will make recommendations for enhancing the child's communication in different environments (e.g. home, school, daycare, etc), Family members and communication partners that are familiar to the child are expected to participate in both the assessment and intervention processes. For example, they may be asked to provide information about the child's communication skills, to practice specific communication techniques with the child, to make symbol boards, to program words into a communication device, or to teach others how to use the child's communication system.

We will provide the tools and the training needed to complete the required tasks. We understand that they may be very time-consuming, but they are crucial to the child's success in using augmentative communication.

If you feel that you can make this commitment, and you agree to the referral, please sign below. If you have any questions about the referral, please call the OKP Intake Coordinator at (705) 476-5437 ext. 3882.

Parent/Guardian's signature: _____ Date: _____

OR

Verbal consent ☐ Obtained by _____ Date: _____

Please return this signed Referral Form, along with the signed Consent form to:

One Kids Place. Attention: Intake
400 McKeown Ave
North Bay, ON P1B 0B2
OR
FAX: 705-789-1115

Please attach recent therapy reports (e.g. Speech Pathology, Occupational Therapy, Psychology, IBI, etc). After we receive this form we will call the parents to complete an INTAKE INTERVIEW over the phone. Once this is completed, we will place the child's name on our waiting list.

"The personal information being collected on this form is collected under the authority of the Health Protection and Promotion Act, the Municipal Freedom of Information and Protection of Privacy Act & Personal Information Protection & Electronic Documents Act. This information shall be used to ensure necessary health care measures are attained." Questions covering the collection of this information may be directed to One Kids Place, 400 McKeown Ave., North Bay, Ontario, P1B 0B2 Phone (705) 476-5437