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?

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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:**

   _____

   _____

   _____

Holland Bloorview
Kids Rehabilitation Hospital

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:_____

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) ☐ 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._____	_____

REF OUTP

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

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