

# Referral Criteria – Communication and Writing Aids Service (CWAS)

## Augmentative and Alternative Communication (AAC)

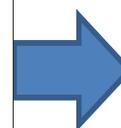
### PLEASE COMPLETE AND SUBMIT THIS CHECKLIST WITH THE REFERRAL FORM

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:**

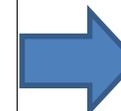
- **Can** physically point to pictures and/or press buttons using fingers, hands and/or feet with or without vision challenges
- Has a diagnosis of Developmental Disability or Intellectual Disability and/or is a current client of Surrey Place Developmental Services



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 all 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?



# Referral Criteria – Communication and Writing Aids Service (CWAS)

## Augmentative and Alternative Communication (AAC)

- 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.)

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5. Comments/additional information:

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**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:**

<p><b>Specialized Services:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Aquatic Therapy</li> <li>Communication &amp; Writing Aids Services: <ul style="list-style-type: none"> <li><input type="checkbox"/> Augmentative &amp; Alternative Communication (AAC)</li> <li><input type="checkbox"/> Writing Aids (WA)</li> </ul> </li> <li><input type="checkbox"/> Clinical Seating</li> <li><input type="checkbox"/> Infant Development Services</li> <li><input type="checkbox"/> Music Therapy</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Nursery Schools (Holland Bloorview)</li> <li><input type="checkbox"/> Orthotics (including protective headwear)</li> <li><input type="checkbox"/> Prosthetics (including myoelectric &amp; cosmetic)</li> </ul> <p><b>Transitions, Recreation &amp; Life skills:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Employment &amp; Volunteering</li> <li><input type="checkbox"/> Life Skills Coaching</li> <li><input type="checkbox"/> Post-Secondary Transition Service</li> <li><input type="checkbox"/> Therapeutic Recreation Services</li> <li><input type="checkbox"/> Transitions to Adult Services</li> </ul>	<p><b>Dental Services:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Cleft Lip &amp; Palate (general anesthesia available for qualifying clients)</li> <li><input type="checkbox"/> Special Needs Dentistry (general anesthesia available for qualifying clients)</li> </ul>
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**REFERRING PROFESSIONAL/CLIENT OR FAMILY:**

Name: \_\_\_\_\_

Organization: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Signature: \_\_\_\_\_

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

**Holland Bloorview**  
Kids Rehabilitation Hospital

Appointment Services: 150 Kilgour Rd. Toronto, ON, M4G 1R8

Tel: (416) 424-3804 Fax: (416) 422-7036

