Referral Criteria – Communication and Writing Aids Service (CWAS)

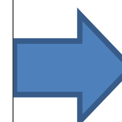
Augmentative and Alternative Communication (AAC)

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.

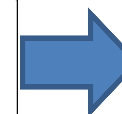
CWAS services the Toronto, Durham, York and Simcoe regions with the following two exceptions (please refer to the appropriate agency if either of these apply):

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?

Referral Criteria – Communication and Writing Aids Service (CWAS)

Augmentative and Alternative Communication (AAC)

1. **List a minimum of <u>10</u> 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 <u>3</u> topics the child uses the above symbols for: (example: food, toys, people, etc.)**
   1.
   2.
   3.

   List additional topics:

3. **List a minimum of <u>2</u> 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 / NURSE PRACTITIONER REFERRAL FORM – OUTPATIENT SERVICES

Family is aware of this referral: ❑**Yes** ❑**No (must be checked)** **Referral Date:**____________________(dd/mm/yy)

CLIENT INFORMATION:

Client Name: ____
Last Name First Name Middle Initial

Chosen Name:________________________ Preferred Pronoun:________________________

Date of Birth:________________________ Gender: ☐ Male ☐ Female ________________
Day / Month / Year

Client Address:____

Apt/Unit #: ________________ City:________________ Province:________________

Postal Code:________________________ Tel.:________________________

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

Health Card Number:________________________**Version Code:** ____

Interim Federal Health Program (IFHP) ☐Yes ☐No Health Card In Process ☐ Self-Pay ☐ 3rd Party ☐

Client lives with: ☐Both Parents ☐ Father ☐ Mother ☐ Guardian ☐ Independent ☐ Group Home ☐ Other________________

Does the child have a sibling that receives/received services at Holland Bloorview? ☐**Yes** ☐**No**

Are there custody or access arrangements that the health care team should be aware of? ☐**Yes** ☐**No**

Are child welfare services involved with the child? E.g. CAS, JF&CS, CFS, etc.? ☐**Yes** ☐**No**

Preferred Contact

Name: ________________________________**Relationship to Child:** ________________

Address (if different from child):____

Email:____

Tel. (home):________________Tel. (cell):________________Tel. (work): ________________

Secondary Contact

Name: ________________________________ **Relationship to Child:** ________________

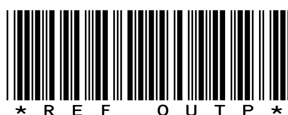
Address (if different from child):____

Email:____

Tel. (home):________________Tel. (cell):________________Tel. (work): ________________

AGENCIES/PROFESSIONALS CURRENTLY INVOLVED:

Agency (e.g., Child Protection, Community)	Professional (e.g., OT, SLP, Psychologist)
1.________________________	________________________
2.________________________	________________________
3.________________________	________________________



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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
Please include PRN medications and provide details related to frequency, dose, effectiveness/response, side effects, etc.)

____

Other information/Risks (i.e. frequent falls)

____

Reason for Referral/Concern/Goals:

____

____

Use check box for referral:

- ☐ Query Autism
  - ☐ **Client does not already have a diagnosis of autism spectrum disorder** (must be checked to be accepted)
  - ☐ **Client has not been assessed for ASD in the past 12 months** (must be checked to be accepted)
  - ☐ **Description of child's current presentation and/or issues that led to this question** (most recent relevant consult note must be attached to be accepted)

  ____

  ____
- ☐ Acquired Brain Injury Rehabilitation
- ☐ Baby CIMT
- ☐ Concussion Clinic* (additional forms required)
- ☐ Cleft Lip & Palate Speech Language Pathology
- ☐ Family Centred Intervention Services for Children (0-5)
- ☐ 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
- ☐ Orthotics (including protective headwear)
- ☐ Prosthetics (including myoelectric & cosmetic)
- ☐ Clinical Seating
- ☐ Communication & Writing Aids Services
  - ☐ Augmentative & Alternative Communication (AAC)
  - ☐ Writing Aids
- ☐ Extensive Needs* (additional forms required)
- ☐ Motion Analysis Centre

Transitions, Recreation & Life skills:

- ☐ Employment & Volunteering
- ☐ Life Skills Coaching
- ☐ Post-Secondary Transition Service
- ☐ Therapeutic Recreation Services

Dental Services:

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

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

Feeding: http://hollandbloorview.ca/programsandservices/programsservicesaz/feedingservices
Psychopharmacology: http://hollandbloorview.ca/programsandservices/ProgramsServicesAZ/Psychopharmacologyclinic
Augmentative & Alternative Communication (AAC): https://hollandbloorview.ca/services/programs-services/augmentative-and-alternative-communication
Extensive Needs: https://hollandbloorview.ca/services/programs-services/extensive-needs-service
Special Needs Dentistry: https://hollandbloorview.ca/services/programs-services/dental-services
Concussion Service: https://hollandbloorview.ca/services/programs-services/concussion-centre/concussion-services/clinical-services

REFERRING MD/NP/DDS Name: ______________________________
OHIP Billing Number: ______________________________
Referring provider is not the client's Primary Care Provider ☐

Hospital: ______________________________
Telephone: ______________________ Fax: ______________________
Email: ______________________________
Signature: ______________________________

*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.**

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