THRIVE Child Development Centre
THRIVE Centre de développement de l'enfant
74 Johnson Ave, Sault Ste. Marie, ON, P6C2V5
Tel : 705-759-1131 - Toll Free : 1-855-759-1131
Fax : 705-759-0783 - Toll Free Fax : 1-855-759-0789

ASSISTIVE COMMUNICATION AND WRITING AIDS (ACWA) CLINIC
REFERRAL FORM FOR FACE-TO-FACE COMMUNICATION

This referral form can be completed by any person involved with child/youth (i.e., caregiver, educational support, physician) in consultation with a Speech-Language Pathologist (SLP) or Occupational Therapist (OT).

The referral form MUST BE SIGNED by the child/youth's parent or guardian.

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.

Eligibility Criteria:	
The child/youth is eligible for an AAC evaluation if the following criteria are met:	
☐	Child/youth is 18 years of age or younger
☐	Speech is not sufficient to meet functional face-to-face communication needs (i.e., may be non-speaking or has speech that is difficult to understand to familiar and unfamiliar communication partners)
☐	The child/youth is purposefully using 20+ symbols and understands that symbols can be used to communicate
☐	An AAC system (e.g., signs, communication book/board, visuals, voice output device) has been trialed with the child/youth and the student has demonstrated some level of proficiency
☐	A parent, family member or caregiver has demonstrated an interest and prolonged commitment to using an AAC system with the child/youth
☐	The child/youth and their family are supported by a Speech-Language Pathologist in the community
If you have any questions regarding the eligibility criteria for the ACWA Clinic, please contact (705) 759-1131 ext 257	

PLEASE NOTE:

ALL BOXES IN THE ELIGIBILITY CRITERIA SECTION AT THE TOP OF PAGE 1 MUST BE CHECKED IN ORDER FOR THE REFERRAL TO BE ACCEPTED. REFERRALS WHERE CRITERIA IS NOT MET OR THE FORM IS NOT COMPLETED IN FULL WILL BE RETURNED TO THE REFERRAL SOURCE.

Referral Information		
Client's Name:	Date of Birth:	Sex:
Client ID#:	Health Card #	
Full Address:		
Telephone Number:		
Type of Disability:		
Is the disability considered to be rapidly progressive? ☐ Yes No ☐		
Preferred language of assessment:		

Name of ☐ Parent(s) ☐ Guardian :
Address *(if different from client)*:
Telephone # *(if different from client)*:

Name of person filling out this form:	Telephone #:
Relationship to client:	Date:

Educational Placement	
Please provide the child/youth's educational or daycare placement *(if applicable)*:	
School/Daycare:	Grade:
☐ Regular Classroom ☐ Supported Classroom (please describe):	

Supporting Services
Is the client receiving service in any of the following areas? If so, please list the name of the service provider or agency.
☐ Speech/Language Pathology:
☐ Occupational Therapy:
☐ Physiotherapy:
☐ Seating:
☐ Hearing:
☐ Vision:
☐ Behavior:

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Physical Status			
Does the client walk? ☐ Yes ☐ No			
What mobility aids are used, if any?			
Walker ☐	Crutches ☐	Manual Wheelchair ☐	Power Wheelchair ☐
☐ Other:			
Please give us a general idea of the client's hand function. *(Check all that applies)*.			
Can point finger ☐	Can point using open hand ☐	Can reach ☐	Can grasp ☐
No functional use ☐			
Please provide any pertinent information related to the following:			
☐ Hearing:			
☐ Vision:			
☐ Seating and Mobility:			
☐ Sensory Processing:			

Methods of Communication	
Please describe how the child/youth is currently communicating. Check all that apply.	
☐ Gaze	☐ Reaching
☐ Facial expressions	☐ Pushing items away
☐ Signs and/or gestures	☐ Hand leading
☐ Touching or pointing to pictures	☐ Crying or vocalizing to gain attention

Communication Functions	
Please list all the reasons why the child/youth is communicating. Please list examples of how the child might communicate each function (e.g., refuses by pushing objects away; requests by pointing to a picture)	
☐ Request	☐ Ask/answer questions
☐ Protest	☐ Comment
☐ Refuse/reject	☐ Greet
☐ Label	☐ Express Feelings
☐ Share about themselves	

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Literacy and Symbol Identification
☐ Recognizes and understands picture symbols
☐ Recognizes and understands signs or gestures
☐ Demonstrates comprehension of some written words
☐ Can spell out some high frequency or motivating words (e.g., through writing, with letter magnets/blocks, keyboard)
☐ Recognizes some high frequency or motivating written words
☐ Has age-appropriate literacy skills

Please list 20 symbols (signs, gestures, pictures) the child is currently using to communicate.			
1.	6.	11.	16.
2.	7.	12.	17.
3.	8.	13.	18.
4.	9.	14.	19.
5.	10.	15.	20.

Please describe the communication system the child is currently using.

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Please describe in detail the reason for this referral and the areas you would like our assistance with (e.g. What would you like the client to be able to communicate that he/she is unable to communicate now? Are there situations where the client's current method of communication is not sufficient?).

Dear Parent/Guardian:

This referral is the first step in the process to help your child improve his/her ability to communicate. Our services include assessment and consultation-based intervention. We will make recommendations for enhancing the child's communication in different environments (e.g., home, school, daycare, etc.). Family members and communication partners are expected to participate in both the assessment and intervention processes. For example, communication partners may be asked to provide information about the child's communication skills, to practice specific communication techniques with the child, 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 time-consuming, but they are crucial to the child's success in using augmentative communication. Family participation in this process is essential to the success of the child/youth.

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 (705) 759-1131 ext. 257.

Parent/Guardian's signature:_____ **Date:**_____

Verbal consent provided for submitting referral:

☐ Verbal Consent provided by Parent/Legal Guardian

Parent/Legal Guardian Name: _____ **Date:** _____

Please return this signed form by email to intake@kidsthrive.ca or fax or mail to:

THRIVE Child Development Centre
74 Johnson Avenue, Sault Ste. Marie, ON P6C 2V5
Attention: INTAKE
Fax: 705-759-0783 - TF Fax 1-855-759-0783

"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 THRIVE Child Development Centre, 74 Johnson Avenue, Sault Ste. Marie, Ontario P6C 2V5, Phone (705) 759-1131"