TECHNOLOGY ACCESS CLINIC
REFERRAL AND BACKGROUND INFORMATION FORM

Thank you for your interest in the Technology Access Clinic. We are an augmentative and alternative communication clinic. Our mandate is to provide the most functional AAC communication system(s) for the individual through assessment and training. We see clients of all ages who live in the greater Hamilton area.

Information Required to Accept Referral:

Section A: To be completed in full
Section B: Client/Legal Guardian Signature approving the referral
Section B: Physician's Signature, Diagnosis and Contact Information

Please fill out the information as completely and accurately as possible. This information assists us in preparing for the assessment process. Other people working with the client may help you complete the form. If there is additional documentation (ie: reports that deal with communication and/or a recent vision assessment) that you are able to attach, please do so.

Pages 1 to 3 This is to be completed for **all** clients.

Page 4 **Face-to-face communication needs** – complete only when clients have trouble making themselves understood using speech.

Page 5 **Written communication needs** – complete only for clients who have physical difficulties with writing.

If a client has **both** face-to-face and written communication needs, please complete all the pages.

If you have any questions, please contact us at (905) 521-2100 ext. 77833.

It is recommended that you copy the completed referral before mailing.
Send the completed referral form by mail to:

Ron Joyce Children's Health Centre
TECHNOLOGY ACCESS CLINIC
237 Barton Street East
Hamilton ON L8L 2X2
Tel: (905) 521-2100 x77833 Fax: (905) 521-4964

Please ensure that the completed referral is legible.

Hamilton Health Sciences
Ron Joyce Children's Health Centre
TECHNOLOGY ACCESS CLINIC
237 Barton Street East
Hamilton ON L8L 2X2
Tel: (905) 521-2100 x77833 Fax: (905) 521-4964
Please return form to above address

Office Use:
Affix identifier

REFERRAL FORM

A. CLIENT INFORMATION

Client Name: _____ ☐ Female ☐ Male
(Last) (First)

Date of Birth: ____/_____/_____ Health Card #: _____ Version Code: _____
(day) (month) (year)

Address: _____ _____ _____
(Street) (City) (Postal Code)

Telephone #: _____/ _____ E-Mail: _____
(home) (work / cell)

Circle to indicate if the client receives funding from the following: ODSP / ACSD / WSIB / DVA / Other

Has client previously used ADP funds for a communication device? ☐ Yes ☐ No
If **Yes**, Name of prescribing clinician/ clinic: _____ When? _____

B. REASON FOR REFERRAL

☐ **Face-to-Face Communication** (i.e. unable to communicate using speech)… *Complete pages 1 – 4*
☐ **Written Communication** (i.e. difficulties with handwriting due to a physical diagnosis)… *Complete pages 1-3 & 5*
☐ **Both**… *Complete pages 1 – 5*

I approve this referral:

Name: _____ **Signature:** _____ **Date:** _____
PRINT Please Circle: Client / Legal Guardian

TO BE COMPLETED BY PHYSICIAN: (this section **must** be completed prior to submission to TAC)

PRIMARY DIAGNOSIS: _____ Date of Onset: _____
(resulting in communication impairment)

Physician's Signature confirming this diagnosis: _____

Physician's Name: (please print legibly or stamp)

Address:

Phone:

FOR OFFICE USE ONLY:	Date Referral Received:
Wait List: ☐ Yes ☐ No	Screened by:
Reason: ☐ Writing ☐ Face-to-Face	Discipline Needed: ☐ SLP ☐ OT
COMMENTS (please use a Working Note for additional comments):	

Client Name:_____

Office Use:
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C. CONTACT INFORMATION

	Name	Relationship to Client	Telephone #
Who is the client's Legal Guardian or Power of Attorney (PoA)?			
Who completed this form? ☐ Same as above, or please specify:			
Who to contact to book appointments: ☐ Same as above, or please specify:			☐ **OK to leave Voicemail?**

- Does the client live independently, with mother/father, group home, etc.?_____
- Is a change of residence anticipated? ☐ Yes ☐ No If **Yes**, please specify_____
- Is English understood by the client? ☐ Yes ☐ No: Language spoken or understood:_____

Other people/agencies (including at Hamilton Health Sciences) who are involved with this client:

Discipline	Name	Agency	Telephone
Occupational Therapist			
Speech Pathologist			
HHS Doctors			
Physiotherapist			
School Contacts			
School Contacts			
Home Support Worker			
Other			

D. MEDICAL INFORMATION

Does the client have any **ALLERGIES:** ☐ Yes ☐ No If **Yes**, please specify:_____

Does the client have an **Antibiotic Resistant Infection** (i.e. MRSA, VRE, or ARO) ☐ Yes ☐ No Specify_____

Does the client have any other communicable diseases (e.g. TB, Hepatitis, etc.) ☐ Yes ☐ No Specify_____

1. RELEVANT MEDICAL CONDITIONS: _____

Anticipated Course of Condition: ☐ Stable ☐ Improving ☐ Deteriorating ☐ Fluctuating

Medications: _____

Medical Precautions (e.g. seizures, respiratory, dislocations, etc.): _____

Describe any relevant medical, surgical, or dental procedures. Include dates if known: _____

_____

2. VISION: Is vision a concern? ☐ No ☐ Yes: (please specify, e.g. acuity, strabismus) _____

Are glasses worn? ☐ No ☐ Yes: ☐ All the time ☐ Reading only

Vision specialist : Name: _____Phone: _____ Date of last assessment: _____

3. HEARING: Is hearing a concern? ☐ No ☐ Yes: (please specify) _____

Are hearing aids worn? ☐ No ☐ Yes: ☐ Left ear ☐ Right ear ☐ Both

Hearing specialist: Name: _____ Phone: _____ Date of last assessment: _____

Client Name:_____

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E. MOTOR ABILITIES

1. MOBILITY: How is the client able to move in their environment? Please describe any other forms of mobility used (i.e. walks independently, manual or power wheel chair, etc.):

_____

_____

2. SEATING AND POSITIONING:
Is current seating and positioning system adequate? ☐ Yes ☐ No: (please describe the problem)

_____

Are there any upcoming seating appointments scheduled? ☐ Yes ☐ No If **Yes,** when: _____

Date of last seating or wheelchair assessment: _____

3. **HAND** Dominance: ☐ Right
☐ Left
☐ Not Established

Is the client able to: (check all that apply)

- Grasp objects ☐ Yes ☐ No
- Release objects ☐ Yes ☐ No
- Point with a finger ☐ Yes ☐ No
- Write with a pen or pencil ☐ Yes ☐ No
- Manage buttons ☐ Yes ☐ No

4. MOVEMENTS: Please indicate **all** movements the client has voluntary control (e.g. arm / leg / other):

_____

Which movements are the best or most reliable? _____

Does the client have any involuntary movements (e.g., reflexes, spasms or body tone) which interfere with his/her control? ☐ No ☐ Yes: (please specify)

_____

F. EDUCATION / EMPLOYMENT / RECREATION

1. School / Preschool / Daycare: _____ Grade Level Achieved: _____

Address:_____ Phone:_____

OR: Current / Previous Employer: _____ Occupation:_____

2. Activities the client enjoys: _____

3. Activities the client dislikes: _____

G. LEARNING AND BEHAVIOUR

1. Can the client:	**YES**	**NO**	**COMMENTS**
Sit quietly and concentrate on a task for more than 10 minutes?	☐	☐	_____
Concentrate within a distracting environment?	☐	☐	_____
Make eye contact with people?	☐	☐	_____
Recognize differences in objects?	☐	☐	_____
Classify or group objects?	☐	☐	_____
Carry out tasks of two or more steps?	☐	☐	_____
Understand the concepts of direction (e.g., up/down, go/stop)?	☐	☐	_____
Know his actions can cause something else to happen?	☐	☐	_____
Make choices when two objects or activities are presented?	☐	☐	_____

2. Does the client have behaviour management needs? ☐ Yes ☐ No; If **Yes**, describe behaviour concerns and how they are managed. Please use a separate page if needed.

_____

_____

Client Name:_____

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FACE-TO-FACE COMMUNICATION INFORMATION

Name of person filling out this section:_____

Relationship to client: _____

1. Please check all the ways the client currently tries to communicate:

a) ☐ Speech: ☐ vocalizations (e.g., laughing, crying)
☐ meaningful vocalizations (i.e., identifiable sounds for specific activities)
☐ single word utterances (Vocabulary size: ☐ 1-10, ☐ 11-20, ☐ over 20 words)
☐ phrases/sentences ☐ 2-3 words ☐ more than 4 words

b) ☐ Eye gaze

c) ☐ Facial expressions

d) ☐ Gestures

e) ☐ Manual signs (How many? _____)

f) ☐ Augmentative communication system:
Briefly describe augmentative communication systems previously and/or currently used including symbol set and method of access: _____
_____

2. Please describe how this client:

a) Asks/answers questions:_____

b) Answers yes/no questions:_____

c) Asks for help, objects, actions, or activities:_____

d) Greets people:_____

e) Makes comments/gives information:_____

f) Expresses feelings:_____

g) Gets your attention:_____

3.

Please ✓ your answers to the following:	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
It's easy for me to understand the client's basic needs/desires					
Familiar people understand this client					
Unfamiliar people have problems understanding this client					
The client wants to communicate with others					
The client participates in conversations					

4. What are some things the client wants to communicate but cannot:

_____

_____

5. Please check the client's current level of understanding:

☐ Does not understand spoken words
☐ Understands single words
☐ Understands simple sentences
☐ Understands 2 and 3 part commands
☐ Understands most conversation

6. Please list formal receptive language testing and test results, if available (ask the client's speech-language pathologist) _____

7. Who is available, on a consistent basis, to follow through on recommendations?_____

Client Name:_____

Office Use:
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WRITTEN COMMUNICATION INFORMATION

Name of person filling out this section:_____

Relationship to client: _____

1. Please indicate what the client needs to be able to write at home (e.g. homework, correspondence, creative stories, etc.)_____

2. Describe any changes anticipated in the need for writing (return to school, change in employment, etc.)

_____

3. How are writing activities currently completed <u>at home</u>?
- ☐ Handwriting/ Tape recording
- ☐ Computer
- ☐ Scribe/Other person writes
- ☐ Other (specify) _____

Do these methods meet the client's writing needs? If not, why not? _____

4. How is writing currently completed <u>at school or work</u>?
- ☐ Handwriting/ Tape recording/Other person writes
- ☐ Computer
- ☐ Other (specify) _____

Do these methods meet the client's written needs? If not, why not? _____

5. Does the client have the physical ability to print / handwrite?
- ☐ Yes…If "Yes", which hand does the client use to print / handwrite? ☐ Left ☐ Right
- ☐ No…**DESCRIBE** problems with handwriting (e.g., legibility, pain, fatigue, speed): _____

6. Does the client have the physical ability to:-

a) Type? ☐ No ☐ Yes If **Yes**, how does the client type? ☐ One hand ☐ Both hands

b) Use a regular mouse? ☐ No ☐ Yes If **No**, any alternative mice_____

c) Require any special adaptations with the computer? ☐ No ☐ Yes (e.g. adapted keyboard, keyguard, etc.) Please specify: _____

7. Describe current problems using a computer e.g., targeting keys/ pain/ fatigue/ speed/ vision _____

8. Can the client read? ☐ Yes ☐ No - If the client cannot read please complete the following:

a) Can he/she recognize letters? ☐ Yes ☐ No ☐ Some

b) Can the client recognize symbols? ☐ Yes ☐ No ☐ Some

c) Does the client need assistance when **composing text?** ☐ Yes ☐ No ☐ Some

If "**Yes**" the client can read - please ✓ the box below to indicate how often the client needs the following **type of assistance** when he/she is trying to write or type their ideas:

	Always	Frequently	Sometimes	Never
a) Prompting to stay on task:	☐	☐	☐	☐
b) Helping them generate ideas:	☐	☐	☐	☐
c) Repeating back their ideas/words to them:	☐	☐	☐	☐
d) Helping to spell a word:	☐	☐	☐	☐

Indicate the client's level (approximate or best guess)**:**

- **Reading level** ☐ preschool ☐ elementary ☐ secondary ☐ post-secondary
- **Spelling level** ☐ preschool ☐ elementary ☐ secondary ☐ post-secondary

NOTE: PLEASE ATTACH A SAMPLE OF WRITTEN WORK (approximately 2 - 3 sentences)

Please make a copy of the completed referral form for your records.