Hamilton Health Sciences

TECHNOLOGY ACCESS CLINIC

REFERRAL AND BACKGROUND INFORMATION FORM

The Technology Access Clinic (TAC) is 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.

Virtual Care
Many clinics at Hamilton Health Sciences are offering telephone and video appointments. Sometimes when we call families, the number shows up as a private number. If you receive a call from a private number, especially at a time when you have a scheduled TAC appointment, consider answering as it may be your care team calling.

Privacy and Security
All virtual video appointments at TAC are done using secure, encrypted telehealth networks. Due to privacy legislation, the session will not be recorded by your TAC clinician and should not be recorded by you.

TAC uses a Zoom license and TeamViewer license that is secure and compliant with the Patient Health Information Protection ACT (PHIPA). Our staff take additional steps to increase security, including making sure we are using the most up-to-date version, are conducting meetings in private rooms and not sharing the teleconference link with anyone else.

Referral Submission
The information you provide will assist us in preparing for the assessment process. Other people working with you or your client may assist in completing the form. If able please attach additional documentation (i.e. reports that deal with communication and/or a *recent vision assessment).*

Please complete all required sections so not to delay the screening process.

Following Intake, if the referral is appropriate, a confirmation letter is mailed directly to the client. If you wish to receive a copy of the letter please indicate this next to your name and address on the referral.

It is recommended that you save or copy the completed referral before mailing

Send completed referral form by mail, email or fax to:

Ron Joyce Children's Health Centre
TECHNOLOGY ACCESS CLINIC
237 Barton Street East
Hamilton ON L8L 2X2

Tel: (905) 521-2100 ext. 77833
Fax: (905) 521-4964
Email: tacinfo@hhsc.ca

Hamilton Health Sciences

TECHNOLOGY ACCESS CLINIC
Ron Joyce Children's Health Centre
Hamilton Health Sciences- General Site
237 Barton St. East
Hamilton, ON

Office Use: Affix Patient Identifier

Telephone: 905-521-2100 ext. 77833 **Fax: 905-521-4964** **Email: tacinfo@hhsc.ca**

REFERRAL FORM

CLIENT INFORMATION (*are required fields – please print clearly)

*Last Name	*First Name:	Middle Initial:	
*HIN: (10 digits)	*VERSION CODE	*Date of Birth (DD/MM/YYYY	*Gender (specify)

ADDRESS

Name of Long Term Care Home or Inpatient Hospital Unit (if applicable)		
Unit Number:	*Street Number:	*Street Name:

Lot/Concession/Rural Route	*City/Town	**ONTARIO**	*Postal Code:
Home Telephone:	Cell/Mobile	Work & Ext. Telephone	

I consent to correspond by email:	Email:

May we leave a message on voicemail?	Yes	No

*REASON FOR REFERRAL (check all that apply)

	Face to Face (unable to communicate using speech)
	Written Communication (unable to use a pen and paper to write due to a physical disability)

*REFERRAL CONSENT (check one)

*I approve this referral

Client	Parent	Spouse	Legal Guardian	POA	Other

*Signature	*Date:

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

Other Medical Conditions:

PHYSICIAN INFORMATION REQUIRED

*Physician's Name	*Telephone	Address

CLIENT NAME:	*Office Use: Affix Patient Identifier*

*CONFIRMATION OF BENEFITS

*Do you receive social assistance?	YES	NO	If **Yes**, check the one that applies

ACSD	ODSP	ONTARIO WORKS	WSIB
Department of Veterans Affairs (DVA)		Motor Vehicle Accident Insurance (MVA)	

*Has the client previously used ADP funds for communication aid?	Yes	NO
If yes, name the AAC clinic and clinician name:	Date:	

*LEGAL GUARDIAN INFORMATION

First Name:	Last Name:	Home Phone:	Cell:	Work
Address:				

Relationship:

Parent	Spouse	Next of Kin	Power of Attorney

I consent to correspond by email	Yes	No	Email Address:

Who to contact to book appointments?	Relationship:

*Who does the client live with?

Self	Spouse	Parents	Mother	Father	Next of Kin	Group Home

Does the client understand English?	Yes	No	Is the client bilingual?	Yes	No

Office Use Only:			Date Referral Received:		
Reason	Face to Face	Writing	**Waitlist**	YES	NO

Discipline	SLP	OT	SLP & OT	Screened By:
Comments:				
CWS	Patient Link	Sovera	Access	Initials

CLIENT NAME:	*Office Use: Affix Patient Identifier*

1. Is **vision** a concern?	Yes (specify) i.e. acuity, strabismus	No

Does the client wear glasses?	Yes	All the time	Reading Only	No

Vision Specialist's Name:	Telephone:

2. Is **hearing** a concern?	Yes (specify)	No

Are hearing aids worn?	Yes	NO	Left ear	Right Ear	Both

Hearing Specialist's Name:	Telephone:
Date of Last Assessment:	Hearing Report Attached

***OTHER HEALTH CARE PROVIDERS, AGENCIES, SCHOOL involved with this client**

Role/Discipline	**Name**	**Agency**	**Telephone/Email Contact**
Home Support Worker			Work
			Cell
			Email
Occupational Therapist			Work
			Cell
			Email
Physician			Work
			Cell
			Email
Physiotherapist			Work
			Cell
			Email
School Board SLP			Work
			Cell
			Email
School Contact			Work
			Cell
			Email
Speech Language Pathologist			Work
			Cell
			Email
Other			Work
			Cell
			Email

CLIENT NAME:	*Office Use: Affix Patient Identifier*

MOTOR ABILITIES

Name of person completing this section	Relationship/Role	Telephone

1. **Mobility:** Can the client walk independently: Yes ☐ No ☐

If **No**, what mobility aid is used? Specify make and model:

2. **Seating and positioning:** Is current seating and positioning system adequate:

Yes	No (describe why)

Are they upcoming seating appointments scheduled?	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 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 (i.e.)	Leg	Other

Which movements are the best or most reliable?

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

EDUCATION/EMPLOYMENT/RECREATION

1. Name of School/Preschool/Daycare	Telephone	Address

2. Current/Previous Employer	Occupation
3. Activities the client enjoys:	
4. Activities the client dislikes:	

LEARNING and BEHAVIOUR

1. Can the client	Yes	No	Comments
sit quietly and concentrate on a task for more than 10 min?			
concentrate within a distracting environment?			
make eye contact with people?			
recognize differences in objects?			
classify or group objects?			
understand the concepts of direction (i.e. up/down, go/stop)?			
know their actions can cause something else to happen?			
make choices when two objects or activities are presented?			

2. Does the client have behavior management needs?	Yes	No
If **yes,** describe behavior concerns and how they are managed. Please use a separate page if necessary.		

CLIENT NAME:	*Office Use: Affix Patient Identifier*

FACE TO FACE COMMUNICATION

Name of person completing this section	Relationship/Role	Telephone

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

a) Speech		Vocalization (i.e. laughing, crying			
		Meaningful vocalization (i.e. identifiable sounds for specific activities)			
		Single word utterances (Vocabulary size)	1-10	11-20	Over 20
		Phrases/Sentences	2-3 words	more than 4 words	

b) Eye Gaze	d) Gestures
e) Facial Expressions	e) Manual signs (how many)?
f) Augmentative communication system. Briefly describe augmentative communication systems previously and/or currently used including symbol set and method access.	

2. Please describe how the 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 check your answers to the following questions	Agree	Strongly Agree	Neutral	Disagree	Strongly Disagree
a) It's easy for me to understand the client's basic needs/desires					
b) Familiar people understand this client					
c) Unfamiliar people have problems understanding this client					
d) The client wants to communicate with others					
e) 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 the client understand spoken words?	
Understands simple sentences	
Understands most conversation	
Understands single words	
Understands 2 and 3 part commands	

6. **Please list formal receptive language testing and testing results if available.** The client's Speech-Language Pathologist may have this information.

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

CLIENT NAME:	*Office Use: Affix Patient Identifier*

WRITTEN COMMUNICATION

Name of person completing this section	Relationship/Role	Telephone

1. What writing tasks does the client need today? (i.e. homework, email, journaling etc.)

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

3. How many writing activities are currently completed at **home?**

Handwriting		Scribe/other person writes		Computer		Other	

Do these methods meet the client's writing needs?	Yes	No
If No, why not?		

4. How is writing currently completed at **school or work? (**Please check all that apply)

Handwriting/tape recording		Scribe/other person writes		Computer		Other	
Do these methods meet the client's writing needs?						Yes	No
If No, why not?							

5. Does the client have the physical ability to print/handwrite?

Yes	Which hand does the client use to print/handwrite	Left		Right	

No	Describe problems with handwriting (i.e. legibility, pain, fatigue, speed)

6. Does the client have the physical ability to:

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

b) Use of regular mouse?	Yes	No	If **no**, any alternative mice?

7. Describe current problems using a computer (i.e. targeting keys, pain, fatigue, speed vision)

8. Can the client read? ☐ **YES** ☐ **NO**

If **yes**, the client **can read**, please check the box below to indicate how often the client needs the following **type of assistance** when the client 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				

If **no**, the **client cannot** read, please check the box below	Yes	No	Sometimes	Never
a) Can the client recognize letters?				
b) Can the client recognize symbols?				
c) Does the client need assistance when composing text?				

Indicate the client's reading and spelling level (approximate guess)

Reading Level	Preschool		Elementary		Secondary		Post-Secondary	
Spelling Level	Preschool		Elementary		Secondary		Post-Secondary	

IMPORTANT NOTE: Please attach a sample of written work (approximately 2- 3 sentences)