**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:** (NOTE: Incomplete referrals will be returned)
**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 complete the referral as listed below and ensure the referral is legible.** The information you provide will assist us in preparing for the assessment process. Other people working with the client may help you complete the form. If able please attach additional documentation (i.e. reports that deal with communication and/or a recent vision assessment).

| | |
|---|---|
| **Pages 1 to 4** | this is to be completed for **all** clients. |
| **Page 1 to 5** | **face-to-face communication needs:** complete **only** for clients have trouble making themselves understood using speech |
| **Page 1 to 4 & 6** | **written communication needs:** complete **only** for clients who have physical difficulties with writing |
| **Pages 1 to 6** | **both** face-to-face and written communication needs: complete all pages |

**It is recommended that you copy the completed referral before mailing.**

**Following Intake, if the referral is appropriate, an information letter will be sent to the client.**

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

## Send completed referral form by mail 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
F a x : (905) 521-4964

**TECHNOLOGY ACCESS CLINIC**
**Ron Joyce Children's Health Centre**
**Hamilton Health Sciences- General Site**
**237 Barton St. East**
**Hamilton, ON**
**Telephone: 905-521-2100 ext. 77833**
**Fax: 905-521-4964**

*Office Use: Affix Patient 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: home: _____ work: _____ cell: _____

E-Mail: _____ ☐ I consent to correspond E-Mail

Does client receive funding from: ☐ODSP ☐ACSD ☐WSIB ☐DVA ☐ MVA ☐ 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 – 5*
☐ **Written Communication** (i.e. difficulties with handwriting due to a physical diagnosis)… *Complete pages 1-4 & 6*
☐ **Both**… *Complete pages 1 – 6*

**TO BE COMPLETED BY CLIENT** (I approve this referral.)

**Name:** _____ **Signature:** _____ **Date:** _____
Print Please Circle One: 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**: _____

**Please Print Legibly Physician's Contact Information**:

**Office Use Only: Date Referral Received** _____

**WAITLIST: ☐ Yes ☐ No REASON: ☐ Writing ☐ Face to Face DISCIPLINE: ☐ SLP ☐ OT SCREENED BY:** _____

**Comments:**

Client Name:_____

*Office Use: Affix Patient Identifier*

| C. CONTACT INFORMATION | | | |
|---|---|---|---|
| | **Name** | **Relationship** | **Telephone #** |
| **Who is the client's Legal Guardian or Power of Attorney (P.O.A.)?** | | | Home:<br>Cell:<br>Work: |
| **Address if Different from Client's** | | | |
| **Who completed this form?**<br>☐Same as above, or please specify: | | | |
| **Who to contact to book appointments:**<br>☐Same as above, or please specify: | | | ☐**Okay 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 |
|---|---|---|---|
| HHS Doctors | | | |
| Home Support Worker | | | |
| Occupational Therapist | | | |
| Physiotherapist | | | |
| School Board SLP | | | |
| School Contacts | | | |
| Speech Pathologist | | | |
| Other | | | |
| Other | | | |

Client Name:_____

*Office Use: Affix Patient Identifier*

## 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 Specify: _____ ☐ No

Does the client have any other **communicable diseases**(i.e. TB, Hepatitis, etc.)

☐ Yes Specify: _____ ☐ No

**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:_____

Vision Report Attached: ☐

**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:_____

*Office Use: Affix Patient Identifier*

## 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: _____

*Office Use: Affix Patient Identifier*

## 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 simple sentences
☐ Understands most conversation
☐ Understands single words
☐ Understands 2 and 3 part commands

**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: Affix Patient Identifier*

## 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)**