Referral Criteria – Communication and Writing Aids Service (CWAS)

Augmentative and Alternative Communication (AAC)

PLEASE READ THROUGH CAREFULLY

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 exceptions:

Exceptions: (please refer to the appropriate agency if either of these apply):

☐ **CLIENT LIVES IN TORONTO** and meets ALL of the following criteria:
- ☐ Can use direct access (can point to pictures or buttons using fingers, hands 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 Disabilities Services

→ Consult Surrey Place's referral criteria

☐ **CLIENT LIVES IN YORK OR SIMCOE** and
- Can use direct access (can point to pictures or buttons using fingers, hands or feet) with or without vision challenges

→ Consult Children's Treatment Network's referral criteria

In order to be eligible for CWAS service, the client must meet ALL of the following criteria:
- ☐ 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 the ones that apply:

☐ 1. Client has vision needs that impacts ability to use pictures or symbols

☐ 2. Client has difficulty using direct access (cannot point to pictures or buttons using their fingers, hands or feet)

☐ 3. *Client is able to use direct access (can point to pictures or buttons using fingers, hands or feet) and can **independently** use **10** symbols on a communication system (i.e. board, book or device) to **initiate** communication 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 that includes the following must be submitted with this referral:
- List of a minimum of **10** symbols that the child can use **independently** (no prompting) to **initiate** a purposeful message
- List of a minimum of **3** topics that the child uses the picture symbols for (e.g. food, toys, places)
- List of all people child currently uses symbols with and all environments symbols are used in

If client DOES NOT meet any of the above referral criteria, please refer to community speech-language services (e.g. pre-school, school board)

Before submitting:
- ☐ Have you checked all the applicable boxes?
- ☐ Have you attached the description of child's current system for #3 above (and any reports if available)
- ☐ Have you attached the referral form?

Please use the referral form online at: hollandbloorview.ca/referrals

Revised December 2020

Holland Bloorview Kids Rehabilitation Hospital

Holland Bloorview
Kids Rehabilitation Hospital

Appointment Services: 150 Kilgour Rd. Toronto, ON, M4G 1R8
Tel: (416) 424-3804 Fax: (416) 422-7036

PHYSICIAN REFERRAL FORM – OUTPATIENT SERVICES

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.

Family is aware of the reason for this referral - Yes · (must be checked) Referral Date:_____(dd/mm/yy)

CLIENT INFORMATION:

Client Name:_____
Last Name First Name Middle Initial

Date of Birth:_____ o Male o Female
Day / Month / Year

Is an interpreter required? o Yes o No Language spoken:_____

If yes, would over-the-phone interpretation be possible for this client (i.e. is hearing/speaking an issue?) o Yes o No

Client Address:_____City:_____

Province:_____Postal Code:_____ Tel.:_____

Health Card Number:_____Version Code: _ o Interim Federal Health Program (IFHP) o Health Card In Process

Client lives with: o Both parents o Father o Mother o Guardian o Independent o Group Home o Other:

PARENT(S) OR GUARDIAN(S): (if different from client address)

Parent/Guardian:_____

Address:_____

Email:_____

Tel. (home):_____Tel. (work):_____Tel. (cell): _____

Parent/Guardian:_____

Address:_____

Email:_____

Tel. (home):_____Tel. (work):_____Tel. (cell): _____

AGENCIES/PROFESSIONALS CURRENTLY INVOLVED:

Agency (eg. Child Protection, Community) Professional (eg. OT, SLT, Psychologist)

1._____ _____

2._____ _____

3._____ _____

MEDICAL INFORMATION:

Primary Diagnosis: **Is this a degenerative condition? Yes No**

_____

Other Diagnoses:

_____

Does this client require any special infectious disease precautions? Yes No

If yes, what for: _____

Medical History/Allergies:

_____

_____

Taking Medication: ☐ Yes ☐No

Risks (i.e. frequent falls)

_____

Reason for Referral/Concern/Goals:

_____

_____

Use check box for referral:

- ❑ Query Autism
- ❑ Acquired Brain Injury Rehabilitation
- ❑ Concussion Clinic
- ❑ Cleft Lip & Palate Speech Language Pathology
- ❑ Clinical Seating
- ❑ Infant Development Services
- ❑ Neuromotor (e.g. cerebral palsy, global developmental delay, Retts)
- ❑ Psychopharmacology* (additional forms required)
- ❑ Neuromuscular (e.g. muscular dystrophy)
- ❑ Feeding* (additional forms required)
- ❑ Spinal Cord Injury
- ❑ Communication & Writing Aids Services
  - ☐ Augmentative & Alternative Communication (AAC)
  - ☐ Writing Aids (WA)
- ❑ Orthotics (including protective headwear)
- ❑ Prosthetics (including myoelectric & cosmetic)
- ❑ Spina Bifida

Dental Services:

- ❑ Cleft Lip & Palate (general anesthesia available for qualifying clients)

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

Feeding: http://hollandbloorview.ca/programsandservices/programsservicesaz/feedingservices

Psychopharmacology: http://hollandbloorview.ca/programsandservices/ProgramsServicesAZ/Psychopharmacologyclinic

REFERRING M.D./D.D.S. Name: _____

OHIP Billing Number: _____

Hospital: _____

Telephone: _____ Fax: _____

Email: _____

Signature: _____

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