KidsInclusive
EnfantsInclus
Centre for Child & Youth Development
Centre du développement des enfants et des adolescents

HÔPITAL
Hotel Dieu
HOSPITAL

KidsInclusive# ________
(For office use)

AUGMENTATIVE COMMUNICATION SERVICES

WRITING AID RE-REFERRAL FORM

Last Name: ___________________________________ First Name: _________________________________

Date of Birth: _________________________________ Age: _______________________________________

Address: ____ City: ______________________________

Postal Code: ______________________________ Home Phone #: _________________________________

HC #: ______________________________________ VC: ______ Expiry Date: ________________________

School: ____ Grade: ________________________

Information provided by: ____

Relationship to client : ______________________________ Telephone #: __________________________

Parent/s or Guardian/s: ____

Cell Phone#: __________________________ (mom/dad) Work # _______________________ (mom/dad)

Mailing Address (if not the same as child's): ____

How has your previous writing aid/computer helped you with your daily writing needs? ________________

____

____

Approximate date last computer was received: *(if applicable)* _________________________________

Describe any computer system technical breakdown/failures: ______________________________________

____

See over.......

Why is the present system not meeting your needs? ____

____

____

ADP states that individuals must have home writing needs, please state what these needs are:

Homework ☐ Creative writing ☐ Communicating with friends and family (e.g. email) ☐

Letters/cards ☐

Please describe current writing needs: ____

____

____

Additional Comments: ____

____

____

I am aware of and consent to this referral:

____ ________________________

Parent/Guardian/Client Signature *Date*

Please return to: Augmentative Communication Services
KidsInclusive
Attention: Intake Coordinator