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

Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

KidsInclusive# _____
(For office use)

AUGMENTATIVE COMMUNICATION SERVICES
FACE TO FACE RE-REFERRAL FORM

Last Name: _____ First Name: _____

Date of Birth: _____ Age: _____ Diagnosis: _____

Address: _____ City: _____

Postal Code: _____ Home Phone #: _____

HC#: _____ VC: _____ Expiry Date: _____

School: _____ Grade: _____

Information is 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) _____

Please describe how your child/student is currently communicating. Please add examples in the spaces provided. _____

Speech: Yes ☐ No ☐ _____
If your child/student has some speech, how many words on average are they using (e.g. 1 word only vs. 3-4 word sentences)? _____

Who can understand your child's speech and how well?	Always	Sometimes	Never
Close family members			
Teachers			
Peers/friends			
Unfamiliar persons			

Gestures: Yes ☐ No ☐ _____
Pointing to desired object: Yes ☐ No ☐ _____
Pointing to pictures: Yes ☐ No ☐ _____
Leading caregiver by the hand to desired object: Yes ☐ No ☐ _____
Facial expression: Yes ☐ No ☐ _____
Other: _____

Does your child/student respond to questions that can be answered with 'yes' or 'no' (e.g. "are you hungry")? Yes ☐ No ☐ How does he/she express 'yes' or 'no'? _____

What does your child/student do when his/her message is not understood? Please explain (e.g. repeats same message, modifies message, stops trying to communicate, gets frustrated, cries etc .) _____

_____

Does your child/student use a computer/tablet independently? Please describe. _____

_____

What type of alternative/augmentative communication intervention has been tried?
Sign Language ☐ Approximate number of signs _____
Picture Symbols (e.g. communication books or boards) ☐ _____
Picture Exchange Communication System (PECS) ☐ Specify phase of PECS: _____
Communication Device (e.g. Big Mac, GoTalk) ☐ _____
Other _____
Was this successful? Yes ☐ No ☐ If not, why? _____

What are your goals in terms of your child's/student's communication? _____

_____

_____

How has the communication aid helped you with your day to day communication needs? _____

_____

_____

_____

Approximate date last system was received (*if applicable)* _____

Describe any system technical breakdown/failures: _____

_____

_____

_____

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Hôpital Hotel Dieu Hospital | KGH Hôpital Général de Kingston General Hospital

Why is the present system not meeting your basic needs? _____

_____

_____

_____

_____

How do you believe your needs have changed since your last assessment? _____

_____

_____

_____

_____

Additional Comments: _____

_____

_____

_____

I am aware and consent to this referral:

_____ _____

Parent/Guardian/Client Signature *Date*

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