

GoldCare# _____
(For office use)

AUGMENTATIVE COMMUNICATION SERVICES
FACE TO FACE RE-REFERRAL FORM

Last Name: _____ First Name: _____

Date of Birth: _____ Age: _____

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: _____

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

Verbal consent

Verbal consent obtained by: _____

Date (dd/mmm/yyyy): _____

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