

GoldCare # _____
(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*

Verbal consent

Verbal consent obtained by: _____

Date (dd/mmm/yyyy): _____

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