

Clinic for Augmentative Communication (CAC) Telephone: (613) 737-7600 ext. 4346

## CAC REFERRAL FORM FOR WRITTEN COMMUNICATION

Client's name:	Date	of Birth: //	_ Sex:	M :	F
Address:	City:	D M Y	Postal Code:		
Home Tel. #:	Health Card #	<u>'</u> :	_Exp. Date:		-
Type of disability:					
Is the disability considered	d to be rapidly progressiv	ve?	Yes	□No	
Is the client presently an inp	atient (admitted to a ward)	at CHEO?		□Yes	$\square$ No
Preferred language for assess	sment: □English □Frei	nch □Would like	an interpreter	who spea	ks:
Name of: parent(s) gu	ardian:				
Address (if different from cli	ent):				
Home Tel. # (if different from	,				
Name of person completing				Tal #:	
Relationship to client:		Date:		_	
1. Client's Educational Pla	cement (if annlicable):	regular class (g	rade· )	snec	ial class
	cement (ij applicable).		,	_	
School		School B	oard		
agency:	rvice in any of the following:				rvice provider or
Speech/Language P	athology:		_		
Behaviour:					

3.	Does the client	walk?	Yes No				
	What mobility	aids are used, if any?		crutches		manual wheelchair	power wheelchair
4.		any problems relating					
	- behaviour:						
		th:					
5.	What are the cl	ient's writing needs a	t home?				
	homework other:	letters lists			project	ts email	
6.	How are the cl keyboarding / a) At home:	ient's writing needs m computer access, if ap	et at preser plicable:	nt? Please inc	clude infor		nt's current method of
	b) At school:						
7.	Please give us	a general idea of the c	lient's hand	d function:			
8	a) Right Hand:	Can reach			Please de		
		Can point using inde	ex finger				
		Can isolate some fin	iger moven	nents			
		Can isolate all finge	r movemen	t			
		No functional use of	f right hand				
					Please des	scribe:	
b	) Left Hand:	Can reach					
		Can point using inde	ex finger		-		
		Can isolate some fin	ger movem	ents			
		Can isolate all finger	r movemen	ts no			
		No functional use of	left hand				
8.	Please describ	oe in detail the reaso	n for this r	eferral and	the areas	you would like our	assistance with:

## Dear Parent/Guardian,

This referral is the first step in a process that can bring many exciting rewards as your child improves his/her ability to produce written work. It is also a process that requires a commitment from you in order to bring results.

You may be asked to attend multiple appointments over a period of several weeks or months, so that we can complete our assessment and provide the necessary training for any equipment that we may recommend. Not all clients will receive a writing aid following our assessment, but if we recommend one for your child, you may be asked to assist in the process of trying out, selecting and ordering equipment. As well, we may ask you to supervise or assist your child with ongoing training and practice once the equipment is received.

If you feel that you can make this commitment, and you agree to the referral, please sign below. If you have any questions about the referral, please call the CHEO ACCESS Team at (613) 737-2757.

Parent/Guardian's signature:	Date:
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Please return the completed Referral Form, signed by the parent/guardian, and the Writing Aids Screening, completed by the occupational therapist, to:

CHEO ACCESS Team 395 Smyth Road Ottawa, Ontario K1H 8L2

Phone: (613) 737-2757 Fax: (613) 738-4841

Please attach recent therapy reports if applicable (e.g. Occupational Therapy, Psychology).

Updated March 2023