ATC Augmentative & Alternative Communication (AAC) Clinic
REFERRAL FORM

Please fax the completed form to 416-784-5600

PATIENT INFORMATION

Name of applicant: _____ ◯ M ◯ F ◯ Single ◯ Married
First name Last name Gender Marital Status

Date of Birth: _____ Health Card Number: _____ Version: _____ Expiry Date: _____
(YYYY/MM/DD) (YYYY/MM/DD)

Address: _____ ON
Street Apt City Postal Code Province

Phone number: _____ E-mail address: _____
Home Mobile (Optional)

Primary language(s) (written and spoken): _____

PRIMARY CONTACT (if different from applicant)

Full name: _____ Relationship to applicant: _____

Phone number: _____ E-mail address: _____

TECHNOLOGY FACILITATOR

A facilitator is mandatory for clients who are unable to speak, and/or have a physical disability (need physical assistance to handle the communication system). A facilitator is a support person in the client's home environment, and can be a family, trained volunteer, neighbor, friend, or healthcare professional who can regularly and reliably provide support to the client and their communication system. The facilitator should be someone who the client interacts with regularly and on a long- term basis. The facilitator is expected to do the following:

1. Provide ongoing support to the client and their communication device to ensure that the client is able to use their communication system.
2. Attend the assessment and all training session(s) OR be able to arrange another facilitator in their place if unable to attend follow-up training sessions.
3. Serve as the contact person between the client and the Assistive Technology Clinic for scheduling, troubleshooting of equipment, and discussion of issues regarding the lease and use of the equipment.
4. Assist with the equipment transportation between the client and the clinic.

Full name: _____ Relationship to applicant: _____

Phone number: _____ E-mail address: _____

Assistive Technology Clinic
assistivetechnologyclinic.ca

Toronto Grace Health Centre
650 Church Street, Toronto, ON, M4Y 2G5
P: 416-784-3600 | F: 416-784-5600

ATC
Assistive Technology Clinic

MEDICAL INFORMATION

Primary medical diagnosis, and date of onset, as well as any secondary medical diagnoses:

REFERRAL SOURCE

Date of referral: _____
(YYYY/MM/DD)

Full name: _____ Relationship to applicant: _____

Address: _____ ON
Street Apt City Postal Code Province

Phone number: _____ Fax Number: _____

E-mail address: _____ Signature: _____

PHYSICIAN INFORMATION: (*required*)

☐ Same as above

Physician name: _____

Address: _____ ON
Street Apt City Postal Code Province

Phone number: _____ Fax Number: _____

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AAC GOALS

☐ Face-to-face communication (difficulty speaking or being understood)
☐ Written communication (adapted computer access for basic writing)
☐ Integrated (communication device to meet both face-to-to face and adapted computer access)
☐ Other: _____

COMMUNICATION & WRITING STATUS (*check all that apply*)

☐ Functional verbal communication – fully intelligible or early speech changes
☐ Impaired verbal communication – significant difficulty getting messages out or being understood by others
☐ Non-verbal communication method(s): _____

Describe applicant's cognition and comprehension:

Describe applicant's mobility and movements:

OTHER INFORMATION

☐ Consult note included (recommended)
☐ Medication list (recommended)

Have AAC services been received in the past? ○ No ○ Yes (list location and when): _____

FUNDING SOURCES

☐ Ontario Disability Support Program (ODSP)
☐ Ontario Works Program (OWP)
☐ Veterans Affairs Canada (VAC) – Group A
☐ Workplace Safety & Insurance Board (WSIB)
☐ Private insurance (company): _____
☐ Other (specify): _____

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