



ATC Augmentative & Alternative Communication (AAC) Clinic REFERRAL FORM

Please fax the completed form to 416-784-5600

PATIENT INFORMATION

Name of applicant: _____ M F
First name Last name Gender

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: _____
(Optional)

MEDICAL INFORMATION

Medical diagnosis and date of onset:

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: _____

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: _____

Other information:

- Consult note included (recommended)
- Have AAC services been received in the past? No Yes (list location and when): _____

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: _____

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): _____