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: ____________ (YYYY/MM/DD) Health Card Number: ____________ Version: ______ Expiry Date: ____________ (YYYY/MM/DD)

Address: ________________________________ ON
\# Street Apt City Postal Code Province

Phone number: ________________________
Home Mobile

E-mail address: ____________________
(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: ____________________

Assistive Technology Clinic
assistivetechnologyclinic.ca

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

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):________________________________

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