COMMUNICATION TECHNOLOGY CLINIC (CTC)

Grand River Hospital - Freeport Campus
P.O. Box 9056, Kitchener, ON N2G 1G3 - 3570 King Street E., Kitchener, ON N2A 2W1
Telephone 519-749-4300 ext 7278 Fax 519-893-6007

To Persons Completing the Referral Form:

Thank you for your interest in the Communication Technology Clinic (CTC). As this service operates as an Expanded Level Clinic through the Ministry of Health’s Assistive Devices Program (ADP), we provide the following services.

- consultation and collaboration with your referral source and/or Speech-Language Pathologist or Occupational Therapist
- comprehensive AAC assessment
- prescription or recommendation of appropriate systems or devices
- training and support as appropriate
- referral for additional services as appropriate

There is no charge for the assessment, prescription, or initial training. Costs of devices and equipment, beyond the contribution which ADP provides (if eligible), are the responsibility of the client.

Please note that page one inquires about the client’s need for face-to-face communication and/or written communication supports.

**Face-to-face** communication options are indicated for only those clients who lack functional speech to meet their everyday communication needs. Clients referred for this service REQUIRE a primary Speech-Language Pathologist (SLP) who will verify the client is able to use “low-tech” methods or strategies to communicate (e.g., communication book, alphabet board). ***The primary SLP will also provide support with the integration of any new system as needed in collaboration with our consulting CTC SLP.***

**Written** communication options are indicated for only those clients who lack functional handwriting to meet their everyday written communication needs.

A physician’s signature is required for all referrals. Incomplete forms will be returned to the sender for completion. If there are any additional documents or reports (e.g. vision, hearing, communication, seating, behaviour reports) that you are able to attach to this application, please do so. Requests for further information and reports may be made by members of the CTC team.
**Referral will not be processed unless form is completed in FULL.**

**Client Identification**

Client Name: __________________________ Date of Birth: ________________ □Male □Female

Health Card #: __________________________ Version Code _______ Exp Date ________________

Address: __________________________________________ City: _______________________

Postal Code ___________ Telephone: _______________ Fax: ___________________

Email Address ___________________________ Today’s Date: _________________

Referring Physician’s name: __________________________ Telephone: _________________

Physician Signature (REQUIRED) __________________________ Date: ________________

May we contact the client directly by phone? □Yes □No □Please call person listed below

May we leave a message on voice mail □Yes □No

**Next-Of-Kin / Caregiver / Contact Person**

Name: __________________________ Relationship to client: ______________

Address: __________________________________________ Home Telephone ________________

_____________________________ Business Telephone _____________________

If client is unable to sign documents, please identify the POA or designated guardian with signing authority. Same as above □Yes □No

Name: __________________________ Relationship to client: ______________

Address: __________________________________________ Telephone: ________________

Please check any applicable boxes below to help us to identify your needs.

**Communication Needs and AAC History**

□ Assessment for a Speech Generating Device (SGD) for face-to-face communication

□ Applicant is a former client of another AAC Clinic (name of clinic) __________________

□ Applicant has previously accessed ADP funding for a Communication Aid

□ Applicant lacks functional speech

□ Client has a primary SLP (page 3)

□ Client has a facilitator (page 4)

□ Client has a low tech system (paper based)

□ Applicant has a physical disability

□ Applicant lacks functional handwriting

□ Client has a facilitator (page 4)

□ Client is literate

**Client meets CTC eligibility requirements (select as many as apply):**

For a Speech Generating Device referral:

□ Applicant lacks functional speech

□ Client has a primary SLP (page 3)

□ Client has a facilitator (page 4)

□ Client has a low tech system (paper based)

For a Writing Aid referral:

□ Applicant has a physical disability

□ Applicant lacks functional handwriting

□ Client has a facilitator (page 4)

□ Client is literate
**Message and Voice Banking:** If applicant is interested in message or voice banking we will mail or email instructions to you or your Speech-Language Pathologist so that you may complete any recordings or pursue a voice banking service prior to your visit to us.

Name of person completing form __________________________ Telephone __________________

Has the client been referred to another AAC clinic?  ☐ Yes  Name of clinic ___________  ☐ No

Is the client capable of giving consent?  ☐ Yes  ☐ No

Has the client contributed to the filling out of this form?  ☐ Yes  ☐ No

If not, identify the highest-ranking substitute decision maker (this is usually a family member or designated caregiver):

Name: __________________________ Relationship to client: __________________________

Address: __________________________ Telephone #: __________________________

<table>
<thead>
<tr>
<th>Current Medical History</th>
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<tbody>
<tr>
<td>Primary diagnosis which has resulted in the communication impairment</td>
</tr>
<tr>
<td>__________________________</td>
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</tbody>
</table>

Other secondary diagnoses __________________________ __________________________

Does the client have any communicable diseases (e.g. hepatitis, MRSA, tuberculosis, etc.)?
If yes, please identify: __________________________

Please attach medication profile including dosage and frequency of administration if available.

Please list any allergies: __________________________

<table>
<thead>
<tr>
<th>Background Information and Reports</th>
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<tbody>
<tr>
<td>Client is in receipt of  ☐ ODSP  ☐ WSIB  ☐ Ontario Works (OW)  ☐ Veteran’s Affairs</td>
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</table>

*IF COPIES OF VISION/HEARING REPORTS ARE CURRENTLY AVAILABLE PLEASE ATTACH DIRECTLY TO REFERRAL PACKAGE. IF NOT IMMEDIATELY AVAILABLE, PLEASE SEND ASAP.*

Has the client seen an **Audiologist**?  ☐ Yes  ☐ No

Hearing aids?  ☐ Yes  ☐ No

Does the client have any trouble hearing what is said in a normal conversation? (with hearing aid if applicable)  ☐ Yes  ☐ No

Has the client seen a **Vision Specialist**?  ☐ Yes  ☐ No

Glasses?  ☐ Yes  ☐ No

Do you have any concerns or comments about the client’s vision?  ☐ Yes  ☐ No

If yes, please specify in brief __________________________
Has the client seen a **Speech-Language Pathologist**?  □ Yes  □ No

**Applicants who have not previously accessed ADP funding for a communication aid through an AAC Clinic MUST have a primary Speech-Language Pathologist to be eligible for our face-to-face communication service. A current report MUST accompany this referral request.**

SLP name: __________________________ (SLP available to support recommendations)
SLP email: __________________________  Hospital/Agency: __________________________

Date most recently seen (if known): _______  Telephone: __________________________

For applicants with an ABI (TBI, CVA or other) diagnosis please contact our clinic directly by telephone for more information about eligibility for service. We do not accept referrals for applicants having any dementia diagnosis.

Has the client seen an **Occupational Therapist**? If so, please describe:

Name: __________________________  Hospital/Agency: __________________________

Date most recently seen (if known): _______  Telephone: __________________________

Concerns or comments: __________________________

***Does the client use a mobility aid and/or specialized seating and positioning equipment?***  □ Yes  □ No

***Does the client have difficulty using their arms or hands?***  □ Yes  □ No

(for example: a seating insert, special cushion, headrest, etc.)

If yes, please describe and give date when this was last reviewed: __________________________

________________________________________________________________________________

Has the client seen another related health professional? (example: behavioural specialist, psychometrist, etc.) If so, please describe:

Name: __________________________  Hospital/Agency: __________________________

Discipline/Specialty: __________________________  Telephone: __________________________

Date most recently seen (if known): _______  Concerns or comments: __________________________

________________________________________________________________________________

**Other Information**

Client □ speaks □ understands □ reads □ writes in English?  Other? __________________________

Education: __________________________

Occupation: __________________________

**Transportation**

Clients are required to travel to our clinic for service. Medically fragile clients within LHIN3 may be eligible for a home/hospital visit. Medically fragile clients outside LHIN3 may be eligible for OTN service.
COMMUNICATION TECHNOLOGY CLINIC (CTC) – GRAND RIVER HOSPITAL - FREEPORT CAMPUS REFERRAL CRITERIA

<table>
<thead>
<tr>
<th>Speech Generating Device Service (SGD)</th>
<th>Writing Aids Service (WA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clients whose speech does not meet their everyday needs for face-to-face (conversation) communication.</td>
<td>Clients with physical disabilities who require tools to assist them to complete written work.</td>
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</tbody>
</table>

ALL of the following criteria must be met:
- Client’s speech is not sufficient to meet communication needs
- Client is 18 years of age or older at time of referral
- Has a primary Speech-Language Pathologist (SLP) whose report will accompany referral and will be available to support the client during the implementation of an SGD (*exception for clients who have previously accessed ADP funding for a communication aid through another AAC clinic*)
  AND referring SLP must select one of the criteria below

☐ Client has literacy skills that allow him/her to manage daily living tasks

OR

☐ Client uses an aided communication system which may be either direct (touch) access of a communication book, theme display and/or light tech SGD and is able to
  1. Independently navigate to and functionally use 4-6 pages (e.g. theme based or category pages)
  2. Independently use at least 8-12 vocabulary items or messages on each page
  3. Functionally use their communication book, theme displays, light tech SGD and/or partner facilitated system with at least 2 or more partners and within 2 or more environments. We are unable to prescribe an SGD for therapy purposes
  4. Express at least one communicative function (eg. Make a request, comment, greet etc) with consistency

OR

☐ Client uses an unaided communication system (any combination of unintelligible speech, gestures, signs, pointing to express novel messages and whose receptive language skills fall within the average range/WNL)

*For clients who do not presently meet these criteria, consultation services are available for community SLPs who are supporting a client’s development of AAC communication skills. Referral to an Individual Authorizer level SLP may be recommended.

ALL of the following criteria must be met:
- Client is 18 years of age or older at time of referral
- Has difficulty with handwriting because of a physical condition
- Has regular writing needs at home
- Is able to compose ideas in writing (traditional orthography or symbol writing)
- Does not have a writing aid that is meeting his/her needs at home
- Has the ability/potential to use a writing aid to increase speed and/or legibility of writing
Facilitator Form for (Client Name): _____________________________

The FACILITATOR is a family member/friend/caregiver/other person with regular and long-term involvement with the client named above. The FACILITATOR will:

a) attend the interview and assessment sessions at Grand River Hospital - Freeport Campus
b) provide regular client support to ensure the client is competent in the use of his/her system(s)
c) teach others about the client’s communication system(s)
d) receive training to update and maintain the client’s communication system(s), and
e) serve as a liaison between the client and Freeport CTC for the scheduling of appointments, troubleshooting of equipment and discussion of issues regarding leasing and use of device
f) notify the Communication Technology Clinic if/when involvement/employment with the client ends

Who is the main person who will function as the facilitator?
Name: _____________________________ Relationship to client: __________
Agency: _____________________________ Telephone: _____________________________
Address: _____________________________ Fax: _____________________________
__________________________________ Email: _____________________________

Comfort level with computers and technology:

☐ I know how to “surf” the internet and send email.
☐ I have very limited or no experience with computers but am willing to learn to provide basic support of the communication system and/or device.
☐ I am comfortable /familiar with computers and/or electronics.

Does the client have internet access at home?  ☐ Yes ☐ No

How much time do you spend with the client?  In an average week: _______ hours

ATTENTION: The information communicated between the Freeport CTC and facilitators is confidential and legally privileged. The Freeport CTC will not disclose or discuss information relating to the client with anyone other than identified facilitators.

FACILITATOR COMMITMENT

I agree to act as a facilitator for the client described above, and I accept the responsibilities as outlined.

______________________________ _____________________________
Signature (Facilitator) Date