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: _____ (d/m/y) ☐Male ☐Female

Health Card #: _____ Version Code _____ (if applicable) Exp Date _____ (if applicable)

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

☐ Assessment for a writing aid

☐ Applicant is a former client of another AAC Clinic (name of clinic) _____

☐ Applicant has previously accessed ADP funding for a Communication Aid

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

<u>Message and Voice Banking:</u> 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 #: _____

Current Medical History

Primary diagnosis which has resulted in the communication impairment Date of onset

_____ _____

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: _____

Background Information and Reports

Client is in receipt of ☐ODSP ☐WSIB ☐Ontario Works (OW) ☐ Veteran's Affairs

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

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

Grand River Hospital – Freeport Campus – Communication Technology Clinic (CTC)

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

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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