**ELIGIBILITY**

Our Augmentative Communication Clinic accepts referrals for individuals residing within Windsor-Essex County who are intentionally communicating AND meeting 1 or more of the following criteria:

Using more than 10 pictures, signs or words independently

Is speaking, but spoken language is difficult to understand

Is intentionally communicating for more than simple requests.

**AAC Full Referral Form– Augmentative Communication Clinic**

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| Client Name: | |
| DOB: | |
| Primary Caregiver Name: | Family consented to referral? |
| Current Speech-Language Pathologist:  Is SLP aware of this referral? | |
| What are your main concerns regarding communication for this person? | |
| Is the person interested in communicating with others? | |
| Is there a gap between receptive and expressive language skills? | |
| Can the individual:  Follow directions?  Respond to communication from others?  Respond to their name?  Please elaborate (if applicable): | |
| What are some things the person is interested in communicating about? | |
| Are there any sensory or motor difficulties (e.g., can the individual point to small pictures in books directly with their finger)? | |
| **COMMUNICATION** | |
| Approximately how many words/signs/pictures does the person use?  1-10  20-50  50+  Please provide some examples: | |
| What is their primary mode of communication? (e.g., verbal, picture-based, signs, gestures): | |
| Do they combine words/gestures or pictures? (e.g., you go, don’t like, etc.): | |
| Does the individual demonstrate:  Turn-taking?  Joint attention?  Cause-effect skills?  Please elaborate (if applicable): | |
| Are they easily understood by others? | |
| What types of communicative functions are they currently using:  Requesting  Commenting  Protesting  Greeting | |
| How often does the individual initiate communication with others?  Frequently  Occasionally  Never | |
| Describe strategies that the individual uses if not understood (e.g., keeps trying, changes message, use of gestures): | |
| Please indicate any behavioural concerns that may impact assessment: | |
| SPEECH/LANGUAGE THERAPY HISTORY | |
| Is the person receiving SLP services? If yes, for how long? | |
| What augmentative strategies have been introduced and how successful were they? (please indicate type/size of core board if applicable). | |
| Frequency of present treatment (i.e., weekly, monthly, block): | |
| ADDITIONAL COMMENTS | |
|  | |
| **Please submit along with the JMCC Referral Form to JMCC Intake Team** | |