**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** |