Children's TREATMENT CENTRE OF CHATHAM-KENT
Celebrating Abilities, Developing Potential

GC# __________

Request for Augmentative and Alternative Communication (AAC) Clinic

Date of Referral: ____________________________ (DD-MM-YYYY)

<table>
<tr><td colspan="4">CLIENT INFORMATION</td></tr>
<tr><td colspan="4">Name: (Surname) (First) DOB: (DD-MM-YYYY) Gender: M ☐ F ☐ O ☐</td></tr>
<tr><td colspan="4">Address:</td></tr>
<tr><td colspan="4">Health Card Number: Version Code: Expiry:</td></tr>
<tr><td colspan="4">Childcare:</td></tr>
<tr><td colspan="4">School: ☐ LKDSB ☐ SCCDSB ☐ Providence Grade:</td></tr>
<tr><td colspan="4">Diagnosis: Physician:</td></tr>
<tr><td colspan="2">CAREGIVER #1 Address Same As Clients ☐ YES ☐ NO (complete fields)</td><td colspan="2">CAREGIVER #2 Address Same As Clients ☐ YES ☐ NO (complete fields)</td></tr>
<tr><td colspan="2">Relationship to client: Custody:</td><td colspan="2">Relationship to client: Custody:</td></tr>
<tr><td colspan="2">Name:</td><td colspan="2">Name:</td></tr>
<tr><td colspan="2">Address:</td><td colspan="2">Address:</td></tr>
<tr><td colspan="2">Primary #: Alternative #:</td><td colspan="2">Primary #: Alternative #:</td></tr>
<tr><td colspan="2">Email:</td><td colspan="2">Email:</td></tr>
<tr><td colspan="2">Language(s) Spoken:
Interpreter: Yes ☐ NO ☐</td><td colspan="2">Language(s) Spoken:
Interpreter: Yes ☐ NO ☐</td></tr>
<tr><td colspan="2">French Language Services Required? YES ☐ NO ☐</td><td colspan="2">French Language Services Required? YES ☐ NO ☐</td></tr>
<tr><td colspan="4">LOCAL TEAM ASSESSMENTS ARE REQUIRED PRIOR TO MAKING A REFERRAL TO A SPECIALTY ASSESSMENT AND CONSULTATION SERVICE.</td></tr>
<tr><td>SERVICE</td><td colspan="2">REQUIREMENTS These forms must be completed and included with this referral</td><td></td></tr>
<tr><td>Augmentative and Alternative Communication (AAC Clinic)</td><td colspan="2">☐ Primary SLP Name
☐ Guided Assessment- Daily Communication attached
☐ School Speech and Language Report</td><td>☐ Attached
☐ Attached
☐ Attached</td></tr>
</table>

Youth/Family agree with this Referral including the collection and sharing of information for the purposes of processing Referral. ☐ YES ☐ NO

______________________________	______________________________	______________________________
Signature of Referring Person	Print Name of Professional Designation	Date (DD-MM-YYYY)
______________________________	______________________________	______________________________
Name of Referring Agency	Email Address	Referrer's Telephone #

Once completed, please send by mail, courier, fax (519-354-7355) or email to tmassender@ctc-ck.com. For more information on referral process, please contact 519-354-0520.