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

GC# _____

Request for Augmentative Communication Service

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

CLIENT INFORMATION	
Name: (Surname) (First)	DOB: (DD-MM-YYYY) Gender: **M** ☐ **F** ☐ **O** ☐
Address:	
Health Card Number:	Version Code: Expiry:
Childcare:	
School: ☐ LKDSB ☐ SCCDSB ☐ Providence	Grade:
Diagnosis:	Physician:
CAREGIVER #1 Address Same As Clients ☐ YES ☐ NO (complete fields)	CAREGIVER #2 Address Same As Clients ☐ YES ☐ NO (complete fields)
Relationship to client: Custody:	Relationship to client: Custody:
Name:	Name:
Address:	Address:
Primary #: Alternative #:	Primary #: Alternative #:
Email:	Email:
Language(s) Spoken: Interpreter: Yes ☐ NO ☐	Language(s) Spoken: Interpreter: Yes ☐ NO ☐
French Language Services Required? YES ☐ NO ☐	French Language Services Required? YES ☐ NO ☐

LOCAL TEAM ASSESSMENTS ARE REQUIRED PRIOR TO MAKING A REFERRAL TO A SPECIALTY ASSESSMENT AND CONSULTATION SERVICE.

SERVICE	**REQUIREMENTS** These forms must be completed and included with this referral	
Augmentative Communication Service	☐ Primary SLP and/or OT Name ☐ Guided Assessment- Daily Communication ☐ attached School Speech and /or OT Report	☐ Attached ☐ Attached ☐ Attached

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.

355 Lark Street Chatham Ontario, N7L 5B2
Telephone: 519-354-0520 Fax: 519-354-7355 Toll Free #: 1-833-241-0628

Last Revised: May 4, 2021