

REFERRAL FOR COMMUNICATION AID ASSESSMENT

Name of Client: _____ Date of Birth: _____.

Please complete the Specialist Disability Service referral form and return it with this form.

Reason for referral. For what specific purposes will the client use a communication aid and what impact will that have?

Why has the referral been made at this time?

Has the client had an AAC assessment before? Yes/No
If yes, please provide details, including copies of any reports.

Describe how the client communicates at present (include full details of low-tech AAC used. If low tech has not been tried please contact the SLT on the above number before proceeding with the referral)

Does the client have a reliable yes/no response? Yes/No
Please provide details of how client indicates yes/no

Please circle one choice from 1-7 on the following charts for each of skills A-J.

COMPREHENSION

	A	B	C	D
	Clinical – verbal	Clinical – non-verbal	Clinical written	Functional (supported by social context)
7.	Able to follow group conversation	Fluent comprehension of a sign or gesture system	Able to read short stories	Follows “abstract” conversation
6.	Able to follow long complex commands	Able to follow a wide range of integrated gestures/symbols	Able to read newspaper articles	Follows complex/ concrete conversation
5.	Able to follow short complex commands	Able to follow short combinations of gesture/symbols	Able to read paragraphs for meaning	Follows “everyday” conversations without difficulty
4.	Able to follow 3 + word commands	Able to follow limited less common gestures, eg. hairdryer	Able to read sentences for meaning.	Able to “get the gist” of conversation
3.	Able to follow 2 word commands	Able to follow a limited range of “everyday” gestures/symbols, eg. drink, bye	Able to read short phrases for meaning	Responds appropriately to utterances of 2-3 word level in a single interaction
2.	Follows only 1 word commands	Unable to comprehend any gestures/symbols	Able to read single words for meaning	Responds appropriately to single word utterances
1.	Unable to follow single word commands	Unwilling or unable to engage	Unable to read single words for meaning	Unable to follow spoken output at all

EXPRESSION

	E	F	G	H	J
	Clinical verbal	Spelling	Articulation	Word finding	Functional verbal/ non verbal (inc. use of AAC/gesture)
7.	Able to produce complex connected speech	Able to use sentences/ paragraphs	No difficulties	No difficulties	Showing full range of pragmatic skills (no problems)
6.	Able to produce simple sentences	Able to convey short phrases	Nearly all/all of output is intelligible to listeners	Able to retrieve words correctly over 75% of time.	Able to express needs, wishes and desires to any audience
5.	Able to produce short clauses	Able to spell single words	75% + of output is intelligible/ acceptable, save specific parameters eg: articulatory postures or intonation	Able to retrieve words correctly 50-74% of time	Able to engage in social interaction with unfamiliar people
4.	Able to produce 2 –3 word phrases	Able to spell part of words	Approx 50-74% of output is intelligible to listener	Able to retrieve words correctly 25-49% of time	Able to engage in social interaction with familiar people
3.	Able to produce single word utterances	Unable to spell	Approx 25-49% of output is intelligible to listener.	Able to retrieve words appropriately < 25% of time	Able to convey basic needs only (to (a) familiar / (b) unfamiliar people).
2.	Able to verbalise Yes / No		Less than approx 25% is intelligible to listener.		Maintains eye contact/smiles in response
1.			Occasional word only is intelligible to listener		Unable to convey even basic needs/poor eye contact.

MEDICAL INFORMATION

Is the clients medical condition changing quickly? **Yes/No**
Describe:

Does the client have any hearing loss? **Yes/No**
Describe:

Does the client have visual problems? **Yes/No**
Describe:

Does the client have any memory difficulties? **Yes/No**
Describe:

Does the client have reduced concentration/ attention span? **Yes/ No**
Describe:

Please describe the client's physical ability:

- **Ambulant Power wheelchair Manual Wheelchair**
- **Sitting ability**
- **Hand function**
- **Head Control**
- **Best movement**

Does the client have an environmental control system? **Yes/No**
Type:

Does the client know how to use a computer? **Yes/No**

CONTACTS

Who does the client live with?

Contact details:

Contact Details for college/day centre

Who will attend the appointment?

Please include addresses if not given above.

Days SLT/referrer available to attend appointment

Mon/Tues/Wed/Thurs/Fri

Email address for SLT/referrer

Contact details for next of kin:

Has the client consented to the referral?

Yes/No

How will any equipment recommended be funded?

Who will provide support for any practise required and programming for a high tech system?

Signed: _____

Date: _____.

Name: _____

Profession: _____.