

**Augmentative Communication Service Referral Form**

NHS Specialised AAC Service

**Date of Completion:** Click here to enter a date.

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| **Patient & Referrer Details** | | | |
| **Child’s Name:** | Click here to enter text. | **Referrer Name:** | Click here to enter text. |
| **Date of Birth:** | Click here to enter text. | **Profession:** | Click here to enter text. |
| **Home Address:** | Click here to enter text. | **Referrer’s Address:** | Click here to enter text. |
|  | Click here to enter text. |  | Click here to enter text. |
|  | Click here to enter text. |  | Click here to enter text. |
| **Postcode:** | Click here to enter text. | **Postcode:** | Click here to enter text. |
| **Telephone Number:** | Click here to enter text. | **Telephone Number:** | Click here to enter text. |
| **Email:** | Click here to enter text. | **Email:** | Click here to enter text. |
| **NHS Number:** | Click here to enter text. | **GOSH Number:** | Leave blank if child is not known to GOSH |
| **Child’s GP Name:** | Click here to enter text. | **Child’s Consultant Paediatrician:** | Please include where possible. |
| **GP’s Address:** | Click here to enter text. | **Paediatrician’s Address:** | Click here to enter text. |
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| **Postcode:** | Click here to enter text. | **Postcode:** | Click here to enter text. |
| **Child’s Ethnicity:** | Please select |  |  |

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| **Diagnosis / Medical Details** | | | |
| **Diagnosis:** | * Click here to enter text. | | |
| **Previous Investigations (if known):** | Please give details of any previous / on-going medical investigations, including brain imaging where relevant. Please attach copies of correspondence relating to these investigations. | **Current Medications (if known):** | Please give details of any current / previous medications. |
| **Prioritisation Criteria (where relevant):** | Please select | | |
| **Vision / Visual Behaviour:** | Please give details of any known concerns around the child’s vision. Where possible, include details of ophthalmological assessments and any measures of visual acuity. Please include details of glasses / contact lenses. | | |
| **Hearing / Hearing Behaviour:** | Please give details of any known concerns around the child’s hearing. Where possible, include details of any hearing test results. Please also include details of any hearing supports (e.g. hearing aids, cochlear implants etc.) | | |

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| **Other Professionals Involved** | | | | |
| **Name** | **Profession** | **Address** | **Telephone** | **Email** |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
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| **School / Education Details**  *Please include a copy of the child’s current IEP report* | | | |
| **Name of School:** | Click here to enter text. | **School Designation:** | Click here to enter text. |
| **School Address:** | Click here to enter text. | **Description of school environment / support** | Click here to enter text. |
|  | Click here to enter text. |
|  | Click here to enter text. |
| **Postcode:** | Click here to enter text. |
| **Telephone Number:** | Click here to enter text. |
| **Child’s Levels of Educational Achievement** | Please give details of the child’s current National Curriculum levels, P Levels or other equivalent levels of educational achievement. | | |
| **Other comments on education / school** | Click here to enter text. | | |

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| **Language & Communication**  *Please include a copy of the most recent speech and language therapy report, detailing current targets & strategies* | |
| **Level of Language Comprehension** | Please include dates of formal / informal assessment(s), descriptions of tests and methods used, scores obtained… |
| **Current Methods of Communication** | Describe how the child currently communicates (speech, vocalisations, signing, gestures, communication board / book, communication aid). Please include details of any techniques, devices or strategies already in place to support expressive communication. |
| **Communicative Functions** | Describe what the child communicates about. |

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| **Motor Ability, Posture & Seating** | |
| **Level of Gross Motor Function** | Please describe the child’s mobility. Where available, please include the child’s GMFCS level. |
| **Level of Fine Motor Function** | Please describe child’s fine motor ability. Are they able to isolate a finger point? What is the smallest item they can press / point to? Where available, please include the child’s MACS level. |
| **Mobility and Positioning Equipment** | Please describe child’s fine motor ability. Are they able to isolate a finger point? What is the smallest item they can press / point to? Where available, please include the child’s MACS level. |

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| **Cognitive & Behavioural** | |
| **Developmental / Cognitive Assessments** | Please give details of any previous developmental/cognitive assessments |
| **Attention / Behaviour** | Please describe child’s attention and concentration levels. Please give details of any challenging behaviours. |

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| **Current Use of Technology** | |
| **Communication** | Please include a brief summary (which should be expanded upon in the assessment section below) of any communication technology currently being used. |
| **Learning** | Please include details of any technology currently being used in the classroom or to support the child’s learning and access to the curriculum. |
| **Play & Leisure** | Please detail any technology currently being used to support play and leisure activities wither at home or in school. |

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| **Details of Previous AAC Assessment** |
| **Who Conducted the Assessment?**  Please provide details of the professionals who have been involved in any previous assessment for an AAC system. Have members of your local AAC team been involved in this assessment?  Click here to enter text. |
| **Where Did the Assessment Take Place?**  Please describe the environment in which the child was assessed. Where possible, please give details of any different modes of AAC and their effectiveness in different environments or with different communication partners.  Click here to enter text. |
| **Assessment Summary**  Please provide details of the assessment. This summary should include details of:   * Form of representation (objects, photos, pictures, symbols, text…) * Symbol set where relevant (PCS, Widget, Symbol Stix…) * Devices or equipment trialled * Access method (touchscreen, switches, eye-gaze…), including details of which method(s) were successful and whether any other access methods have been considered but not yet trialled * Vocabulary organisation (single words, phrase-based, combining elements…), including information about whether any pre-made vocabularies have been considered or trialled. Where appropriate and available, please provide details of any compare and contrast process * Integration with other technologies (environmental control, email, phone, internet…) trialled or considered * Portability and practical management   Click here to enter text. |
| **Assessment Recommendations**  Please detail the conclusions drawn from the assessment process. If a specific piece of equipment has been requested or recommended, please summarise how the required features have been identified through assessment. Please provide a rationale for the final choice of vocabulary and / or symbol set. Information should be included in this section about what an AAC device will allow the child to do that they currently cannot achieve.  Click here to enter text. |
| **Equipment Requested**  If a specific piece of equipment is being requested, please provide details of this here. If appropriate, please indicate if you would prefer equipment from a specific supplier or manufacturer. Please include any peripherals that have been identified by your assessment process. Ensure any requirements of mounting and specialist access equipment are also detailed in this section.  Click here to enter text. |
| **Roles & Responsibilities**  Please provide details in this section of the roles and responsibilities that have been agreed within your team. This may include but is not restricted to:   * Overall responsibility for monitoring the system and the child’s use thereof * Day to day maintenance of the system (recharging, cleaning, software updates…) * Target setting * Everyday implementation of the AAC system and device * Training new staff members * Updating or editing vocabulary (where this is required) * Recording progress * Identifying regular, timely reviews * Solving technical issues * Liaising with Specialist Service as appropriate   Click here to enter text. |
| **Any Other Information**  Please use this section to provide any other information that may be relevant to the request or the assessment process.  Click here to enter text. |

**Please return completed copies of this form to:**

Service Administrator

Augmentative Communication Service

Level 10, Main Nurses’ Home

Great Ormond Street Hospital

Great Ormond Street

London

WC1N 3JH

**For enquiries, please contact:**

Tel: 0207 405 9200 x1144

Email: [acsadmin@gosh.nhs.uk](mailto:acsadmin@gosh.nhs.uk)

Please do not send any patient-identifiable information to the above email address