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AUGMENTATIVE COMMUNICATION & TECHNOLOGY SERVICES (ACTS)
ADULT REFERRAL FORM

Date of Referral: _____ Form Completed by: _____

Referring Agency: _____ Telephone: _____

Adult's Name: _____ Birth Date: _____

Spouse: _____ Telephone: (Home) _____

Address: (Work) _____

Street: _____

City: _____ State: Zip: _____

Day Setting: (home, work, adult program, Rehab. Ctr.)

Contact: Email:

Place: Address:

Telephone:

Evening Setting: (home, facility)

Place: Address:

Telephone:

Transdisciplinary Team	Name:	Telephone:	Email:
Care Provider:			
Physician:			
Speech/Lang. Path.			
O.T.			
P.T.			
Respiratory Therapist:			
Social Worker:			
Other:			

Pertinent History

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Medical Diagnosis: (Type; Degree; Severity)_____
(Check all that apply.)

- ☐ ALS
- ☐ Multiple Sclerosis
- ☐ Post CVA
- ☐ Head Injury/Trauma
- ☐ Degenerative Disease (non-specified)
- ☐ Autism
- ☐ Severe cognitive impairment (MR)
- ☐ Seizure Disorder
- ☐ Cerebral Palsy
- ☐ _____

Speech/Language/Communication Status: (Describe present abilities)

Speech/Language Diagnosis: (Check all that apply.)

- ☐ Dysarthria
- ☐ Dyspraxia
- ☐ Tracheostomy
- ☐ Aphonic (without phonation)
- ☐ Aphasia
- ☐ Severe language delay/disorder

Present Communication System(s):

_____

Communicative Behavior:
(Check all that apply.)

- ☐ Uses formal/adapted signs or fingerspelling
- ☐ Uses natural gestures
- ☐ Appropriate facial expressions
- ☐ Good use of eye gaze
- ☐ Vocalizations
- ☐ Limited verbal speech
- ☐ Verbal with poor intelligibility

Former Communication System(s): Describe those tried in the past and whether or not they were successful.

Assistive Technology/Computer Experience:

<u>Educational Level</u>

Premorbid Education: (e.g. college, high school grad.)

_____

Current Literacy Level: (e.g. able to read standard print in newspaper)

_____

Current Writing Ability: (e.g. able to handwrite, uses keyboard)

_____

<u>Motor Abilities</u>

Is the adult ambulatory? Yes ☐ No ☐
Does the adult operate an electric wheelchair? Yes ☐ No ☐

Describe the physical abilities the adult has:

1) Can he/she use hands to touch objects or pictures? Yes ☐ No ☐
2) Can he/she operate a single switch? Yes ☐ No ☐
   Describe: _____
3) What body site yields the most reliable response?

_____

4) Can the adult nod up and down? Yes ☐ No ☐
5) Can the adult nod left to right? Yes ☐ No ☐
6) Please describe any other aspect of motor behavior not listed above:

_____

7) Feeding: Is the adult able to eat orally? Yes ☐ No ☐

GT/Tube: Yes ☐ No ☐

8) Does the patient have a tracheotomy? Yes ☐ No ☐

9) Does the patient have a voice prosthesis? Yes ☐ No ☐

_____

Sensory Abilities

1) Does the adult have a hearing impairment? Yes ☐ No ☐
2) When was the last hearing test? _____
3) Does the adult have any visual acuity problems? Yes ☐ No ☐
4) Has the adult had a visual assessment? Yes ☐ No ☐
5) What is the visual diagnosis?

Psychosocial

1) Does the adult have any emotional problems? Yes ☐ No ☐
   If yes, please describe:

_____

2) Does the adult have a short attention span and distractibility? Yes ☐ No ☐
3) What is the adult's estimated response time?
   How long does it take the adult to respond?)

_____

Special Health Requirements (Services, Diet, Feeding, Medications): _____

Services Needed

What is the primary reason you are seeking augmentative communication services?

Please indicate the services needed below:

- ☐ Evaluation for Speech Generating Device
- ☐ Prescription of Speech Generating Device
- ☐ Direct Services
- ☐ Consultation
- ☐ Programming of Speech Generating Device
- ☐ Training Care Providers
- ☐ Other (Please describe)

Comments:

Funding for Equipment: **Check all that apply**

4	**Funding for Services and DME Equipment**	**Contact**	**Address**	**Phone**
	Medi-Cal Active MR #			
	Medicare Active MR#			
	Private Health Ins. Carrier:			
	Private Pay			

Private Health Insurance Information

Name of Insurance Carrier		Type of Plan (e.g. PPO, HMO)	
Primary Insured Name		Primary Insured ID Number	
Group Name:		Group ID Number	
Other Insurance:		Other Insurance ID Number	
Referring Physician:		Referring Physician's License #	
Physician Phone Number:		Physician Fax Number:	

Please submit relevant reports (Speech/Language, Occupational/Physical Therapy, Medical Summary, and Vision/Hearing testing results with this referral form.