ACTS
AUGMENTATIVE COMMUNICATION STUDENT REFERRAL FORM

Date of Referral:

Form Completed by:

Student's Name:

Telephone:

School Name:

Birth Date:

School Address:

School Phone:

Parents' Names:

School Fax:

Address:

Parents' Home Phone:

City, State:

Parents' Work Phone: _____

Zip Code:

Mother's email: _____

Father's email: _____

Type of Placement

Special Day Class

Preschool ☐ Primary (K-3) ☐ Intermediate 4th-6th ☐
Middle School ☐ High School ☐ Transition ☐
Learning Challenged ☐ Severely Challenged ☐
Orthopedically Challenged ☐ Other _____

Resource

Percent of Mainstreamed Classes _____
Number of Class Periods in Resource _____

Full Inclusion Grade _____ Room Number _____

Site Team Members	Name:	Telephone:	Email:
Teacher:			
Speech/Lang. Path.			
O.T.			
P.T.			
Program Specialist:			

Vision Specialist:

Other:

Pertinent History

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

- ☐ Spastic cerebral palsy
- ☐ Mixed cerebral palsy
- ☐ Athetoid cerebral palsy
- ☐ Other cerebral palsy
- ☐ Motor dyspraxia
- ☐ Acquired neurological impairment
- ☐ Autism
- ☐ Severe cognitive impairment (mental retardation)
- ☐ Seizures
- ☐ Other

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

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

- ☐ Dysarthria
- ☐ Dyspraxia
- ☐ Severe phonological delay
- ☐ Aphonic (without phonation)
- ☐ Expressive Aphasia
- ☐ Severe language delay (receptive & expressive)

Estimated receptive language age as determined by formal/informal measures:

- ☐ <12 months
- ☐ 12 to 18 months
- ☐ 18 to 24 months
- ☐ _____

Estimated expressive language age as determined by formal/informal measures:

- ☐ <12 months
- ☐ 12 to 18 months
- ☐ 18 to 24 months
- ☐ _____

Present Communication System(s):

Communicative Behavior:
(Check all that apply.)

- ☐ Uses formal/adapted signs
- ☐ Vocalizations

- ☐ Uses natural gestures
- ☐ Appropriate facial expressions
- ☐ Good use of eye gaze
- ☐ 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: _____

Educational Functioning

Reading Grade Level: _____
Writing Grade Level: _____
Math Grade Level: _____

Estimated developmental age:

- ☐ <6 months
- ☐ 6 to 12 months
- ☐ 12 to 18 months
- ☐ 18 to 24 months
- ☐ _____ months/years

Motor Abilities

Is the student ambulatory? Yes ◯ No ◯
Does the student approach people and/or objects in the environment to communicate his/her intent? Yes ◯ No ◯
Does the student operate an electric wheelchair? Yes ◯ No ◯

Describe the physical abilities the student 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 student nod up and down? Yes ◯ No ◯
5) Can the student shake left to right? Yes ◯ No ◯
6) Please describe any other aspect of motor behavior not listed above:

7) Feeding: What are the child's feeding skills? GT/Tube Yes ◯ No ◯

_____ :

Sensory Abilities

1) Does the student have a hearing impairment? Yes ◯ No ◯
2) When was the last hearing test? _____
3) Does the student have any visual acuity problems? Yes ◯ No ◯
4) Has the student had a visual assessment? Yes ◯ No ◯
5) What is the visual diagnosis? _____
6) Does the student have tactile-kinesthetic disorder? Yes ◯ No ◯

Describe:

_____

Behavioral

1) Does the student have any behavioral problems? Yes ◯ No ◯
   If yes, please describe: _____
2) Does the student have a short attention span and distractibility? Yes ◯ No ◯
3) What is the student's estimated response time? (How long does it take the student 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:

☐ Augmentative Communication Assessment ☐ Staff Training

☐ Direct Services
☐ Intervention Plan
☐ Consultation
☐ Workshop
☐ Other (Please describe.) Assist with AAC device funding

Comments:

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

4	**SOURCES OF FUNDING**	**Contact**	**Address**	**Phone**
	California Children's Service MTU Active?			
	Medi-Cal Active MR #_____			
	Low Incidence Eligibility/School District IDEA-R Assistive Technology Regs.			
	Primary Insurance Carrier:_____ Name of Primary Insured:_____ Primary Insured Birth date:_____ Relationship of primary insured to child:_____ Insurance Plan_____ Primary Insured Id Number_____ Primary Insured Group Number_____ Child's ID number:_____ Child's Physician:_____ Physician's phone/fax_____ Physician's License #:_____			

NOTE: ***Send the ACTS referral form along with all pertinent records (psychological evaluation, speech/language, occupational/physical therapy evaluations/progress reports) to the ACTS office electronically or via fax or snail mail. School district referrals must be prior authorized by a school district administrator and an contract for service (ISA) must be in place before services can begin.***

Records Submitted with this Referral Packet

I.E.P. Dated _____

- Were AAC Services Specified on the IEP Yes ◯ No ◯
- If Yes, how are they listed on the I.E.P. _____

Speech/Language Evaluation Dated _____

Speech/Language Progress Report Dated _____

Occupational Therapy Evaluation Dated _____

Occupational Therapy Progress Dated _____

Physical Therapy Evaluation Dated _____

Physical Therapy Progress Dated_____

Psychological Evaluation Dated _____

Other Pertinent Reports _____

A.C.T.S.
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