A.CT.S.

AUGMENTATIVE COMMUNICATION REFERRAL FORM
AAC FOR STUDENTS WITH AUTSIM

Date of Referral: _____ Form Completed by: _____

Student's Name: _____ Telephone: _____

School Name: _____ Birth Date: _____

School Address: _____ School Phone: _____

_____ School Fax: _____

Parents' Names: _____ Parents' Home Phone: _____

Parents' Address: _____ Work Number: _____

Parent's email _____ Parents Mobile Number _____

Educational Placement

Fulll Inclusion ❑ _____ (General Education Classroom)

Special Day Class ❑

SDC for students with Autism❑ SDC Mild/Mod ❑ SDC Mod❑
SDC Mod/Severe ❑

Grade Level

Preschool❑ Early Elementary (K-3) ❑ Intermediate Elementary (4-6) ❑
Middle School ❑ High School ❑ Transition❑ Adult ❑

Site Team Members

Teacher:		Telephone:	Email:
Speech/Lang. Path.		Telephone:	Email:
O.T.		Telephone:	Email:

P.T.		Telephone:	Email:
Program Specialist:		Telephone:	Email:
Behavior Specialist:		Telephone:	Email:
Other:		Telephone:	Email:

Pertinent History

Medical Diagnosis: **Autism**
(Check all that apply.)

- ☐ Nonverbal
- ☐ Limited Verbal Speech
- ☐ Verbal with atypical Language
- ☐ Mild Intellectual Disability
- ☐ Moderate Intellectual Disability
- ☐ Severe Intellectual Disability
- ☐ Self-Injurious Behaviors
- ☐ Physical agression
- ☐ _____(Other)
- ☐ _____(Other)

Speech/Language/Communication Status: (Describe present abilities including presence/absence of Apraxia, describe expressive language (speech) and communication abilities: _____

_____

_____

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 Augmentative Communication Systems such as *PECS*, Manual Communication Boards, *Picture Communication Symbols*, entry level speech generating device: _____

_____

Does the individual have an iDevice (iPad, iPodTouch, iPhone)
Yes ❑ No ❑

What communication apps does the individual currently have on the iDevice?

What are the problems the client using the current Communication Systems?

How effective is the iDevice on a scale of 1-5 with 5 being the most effective? (Include additional comments with your rating below).

Assistive Technology/Computer (PC/MAC)?

What software is the individual currently using?

Educational Functioning

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

Therapeutic Intervention

What current educational or therapeutic interventions are in place (Discrete Trial, TEAACH, ABA)?

Is the program named above implemented in the school, home, or both contexts?

How effective is the intervention on a scale of 1-5 with 5 being the most effective?
(Include additional comments with your rating below)

Sensory Abilities

1) Does the student have any vision problems? Yes _____ No _____

2) What is the visual diagnosis?

3) Does the student have a hearing loss? Yes _____ No_____
If so is the student wearing and benefiting from hearing aides? Yes _____No_____

4) Does the student have tactile-kinesthetic disorder? Yes _____ No_____
If so is the student on a sensory-diet? Yes _____No_____

Additional Information regarding sensory impairments:

Behavioral

1) Does the student have any behavioral problems? Yes _____ No _____
If yes, please describe:

2) Does the student have Behavioral Intervention Plan? Yes _____ No _____
(Send BIP with referral documents) _____ _____

3) Does the student have a one-to-one paraeducator/aide? _____

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	☐	Program Development
☐	Intervention Plan	☐	Other (Please describe.) Assist with AAC device funding
☐	Consultation		

Comments: _____

_____

_____

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

✓	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: ***If you are requesting an assessment, please send the most recent IEP and include a legible copy of the IEP service page specifying the AAC services. Send the referral form along with all pertinent records (psychological evaluation, speech/language, occupational/physical therapy evaluations/progress reports, Behavioral Intervention Plan) to the ACTS office. If this is a referral from a school district, you must get approval from your program specialist or special education administrator prior to referring to an outside provider such as ACTS. The parent must sign an Assessment Plan prior to or by the first scheduled date of service.***

Records Submitted with this Referral Packet (electronically or hard copy)

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 ❑ _____

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