ACTS
AUGMENTATIVE COMMUNICATION REFERRAL FORM
INFANTS/TODDLERS

Date of Referral:

Form Completed by:

Telephone:

Infant's Name:

Birth Date:

Parents' Names:

Siblings:

Address:

Name/Ages:

City, State

Cell Phone:

Zip Code

Home Phone:

Early Intervention

Parent Infant Program _____Date Started: _____

Physical Therapy _____Date Started: _____

Occupational Therapy _____Date Started: _____

Speech Therapy _____ Date Started:_____

Other _____

Current Team Name: Telephone: Email:

Developmental Tx:

Speech/Lang. Path.

O.T.

P.T.

Case Manager :

Primary Care Physician:

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
- ☐ Seizures
- ☐ Other _____

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

Estimated receptive language age:

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

Estimated expressive language age:

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

Present Communication System(s):

Communicative Behavior:
(Check all that apply.)

- ☐ Uses formal/adapted signs
- ☐ 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: _____

Motor Abilities

	Yes	No
Is the infant able to walk or crawl _____?		
Does the infant approach people and/or objects in the environment to communicate his/her intent?	○	○
Describe the physical abilities the student has:		
1) Can he/she use hands to touch objects?	○	○
2) What part of the body is the infant best able to use voluntarily? e.g. hands, feet, head? _____		
3) Can the infant nod up and down?	○	○
4) Can the infant shake his/her head left to right?	○	○
5) Please describe any other aspect of motor behavior not listed above:		
6) Feeding: Is the infant able to eat orally?	○	○

Sensory Abilities

	Yes	No
1) Does the infant have a hearing impairment?	○	○
2) When was the last hearing test?		
3) Does the infant have any visual problems?	○	○
4) Has infant's vision been evaluated?	○	○
5) What is the visual diagnosis?		

_____

6) Does the infant have sensory-motor integration challenges?

Describe:

Behavioral

1) Is the infant whining/fussing frequently and difficult to soothe?	○	○

If yes, please describe:

2) Is the infant easily distracted and distressed by noise/activities in the environment? ◯ ◯

3) Is the infant responsive? Are there delays in the infant's ability to respond to you? ◯ ◯

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
- ☐ Direct Services
- ☐ Intervention Plan
- ☐ Consultation
- ☐ Parent Training
- ☐ Assistance in Educational Planning
- ☐ Other

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 #_____			
	Regional Center Case Manager			
	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 your most recent records, medical summaries, speech/language, occupational/physical therapy evaluations/progress reports, and any other pertinent records pertaining to the Augmentative Communication Evaluation.***