Hotel Dieu Shaver
HEALTH AND REHABILITATION CENTRE

Augmentative and Alternative Communication Clinic

INTAKE FORM

Thank you for your interest in the Augmentative and Alternative Communication (AAC) Clinic at Hotel Dieu Shaver Health and Rehabilitation Centre. Our inter-professional team's purpose is to provide client-centred care to adults in Niagara whose written and face to face communication does not meet their daily communication needs through the provision of augmentative and alternative communication systems.

Please fill out the information as completely as possible.

This information assists us in preparing for the assessment process. Other people working with you may help you complete the form. If there is additional documentation (i.e., reports that deal with communication and/or a recent vision assessment) that you are able to attach, please do so.

Which parts of the Intake Form do I fill out?

Please complete **pages 2, 3 and 6** as this information is necessary for your assessment.

If you were referred for only **written communication**, please complete **page 4**.

If you were referred for **face-to-face communication**, please complete **page 5**.

If you were referred for **both** face-to-face and written communication needs, please complete **all** the pages.

Who do I contact if I have questions?

If you have any questions, please contact us at **(905) 685-1381 ext. 85210.**

Where do I send my Intake Form once it's completed?

There a few ways to submit your completed Intake Form:

In person or by mail:

Augmentative and Alternative Communication Clinic
Hotel Dieu Shaver Health and Rehabilitation Centre
541 Glenridge Avenue
St. Catharines, ON L2T 4C2

Or by fax to: **905-688-9905**

We suggest you keep a copy of the completed referral form for your records.

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INTAKE FORM

CLIENT INFORMATION

Client Name: _____ **Date:** _____
(Last) (First)

Date of Birth: _____ **Gender:** ☐ Male ☐ Female
(Day) (Month) (Year)

Address: _____ _____
(Street) (City)

_____ **Telephone #:** _____ _____
(Postal Code) (Home) (Work/Cell)

Health Card #: _____ **Version Code:** _____

OHIP Card Colour: ☐ Red/White ☐ Green with a Picture **Expiry Date:** _____

Is a change of residence anticipated in the near future? ☐ No ☐ Yes, specify: _____

Do you receive Social Assistance benefits? ☐ No ☐ Yes, specify: _____

Do you have any of the following medical concerns:

Allergies?: ☐ No ☐ Yes, specify: _____

Antibiotic Resistant Infection? (i.e. MRSA, VRE or ARO): ☐ No ☐ Yes, specify: _____

Communicable Diseases? (i.e. TB, Hepatitis, etc.): ☐ No ☐ Yes, specify: _____

REASON FOR REFERRAL

☐ **Written Communication** ☐ **Face to Face Communication** ☐ **Both**

Have you been seen for AAC Services prior to this referral? ☐ No ☐ Yes, When: _____

Where: _____

What are your expectations of this referral?

_____

_____

What is the best time of day for appointments?: ☐ Morning (9 am to 12 pm) ☐ Afternoon (1 pm to 4 pm)

When are you available for appointments?: ☐ Monday ☐ Tuesday ☐Wednesday ☐ Thursday ☐ Friday

PERSONAL CONTACT INFORMATION

	Name	Relationship to client	Phone
Who is your Power of Attorney?			
Who completed this intake form? ☐ Client ☐ Other, specify			
Who should we call to book appointments? ☐ Client ☐ Other, specify			

Is English easily understood? ☐ Yes ☐ No, Specify Primary Language: _____

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RELEVANT HEALTH INFORMATION

Vision:

Wears glasses: ☐ No ☐ Yes, Describe: _____

Visual deficits: ☐ No ☐ Yes, Describe: _____

Other visual difficulties: ☐ No ☐ Yes, Describe: _____

Circle the smallest number that you can see at 40 cm or 16 in (with glasses if required):

24 20 18 16 14 12 10 8

Hearing:

Hearing difficulties: ☐ No ☐ Yes, Describe: _____

Wears hearing aids: ☐ No ☐ Yes, Describe: _____

Cognition:

Do you currently have any difficulties with:

☐ Memory ☐ Problem Solving ☐ Learning new information
☐ Attention ☐ Initiation ☐ Behaviour
Describe: _____

Mobility:

Do you use a wheel chair? ☐ No ☐ Yes, Specify Make: _____

Do you use any special equipment to control TV, lights, radio, etc.? ☐ No ☐ Yes, Describe:

_____

Physical:

Can you consistently control the movement of:

Right hand	☐ No	☐ Yes	Hand Dominance:
Left Hand	☐ No	☐ Yes	
Head	☐ No	☐ Yes	☐ Right
Mouth	☐ No	☐ Yes	☐ Left
Eyelids	☐ No	☐ Yes	
Right Foot	☐ No	☐ Yes	What hand do you currently use?
Left Foot	☐ No	☐ Yes	
Shoulders	☐ No	☐ Yes	☐ Right
Knee	☐ No	☐ Yes	☐ Left

Which movement is the most reliable and comfortable? _____

Do you have problems with fatigue? ☐ No ☐ Yes, Describe: _____

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WRITTEN COMMUNICATION AIDS INFORMATION

What are your daily written communication needs?

_____

_____

_____

Do you have the physical ability to print/handwrite? ☐ Yes ☐ No

Do you have issues with any of the following while printing/handwriting:

☐ Legibility ☐ Pain ☐ Fatigue ☐ Speed

☐ Other, describe: _____

Are you able to use a computer with a standard keyboard and mouse? ☐ Yes ☐ No, Describe difficulties:

_____

Do you have any concerns with literacy? ☐ No ☐ Yes, Specify:

☐ Reading: _____

☐ Spelling: _____

Do you have any previous computer experience? ☐ No ☐ Yes, Specify:

☐ Computer, specify type: _____

☐ Word processing software, specify type: _____

☐ Email, specify address: _____

☐ Internet, specify provider: _____

☐ Software used, specify type: _____

☐ Any computer adaptations, specify type: _____

☐ Other pertinent information: _____

Do you own a computer system (include type and age):

☐ Desktop: _____

☐ Laptop: _____

☐ iPad: _____

☐ Other: _____

Has the applicant been assessed or treated by an occupational therapist? ☐ No ☐ Yes, Specify Why?:

_____

OT Name: _____ Phone Number: _____

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FACE TO FACE INFORMATION

Please check all the ways that you currently communicate:

- ☐ Speech
  - ☐ Vocalizations (i.e., laughing, crying)
  - ☐ Meaningful vocalizations (i.e., identifiable sounds for specific activities)
  - ☐ Single word utterances (Vocabulary size: ☐1-10, ☐11-20, ☐over 20 words)
  - ☐ Phrases/Sentences (Number of words: ☐2-3 ☐more than 4)
- ☐ Eye gaze
- ☐ Facial expressions
- ☐ Gestures
- ☐ Manual signs, How many? _____
- ☐ Augmentative communication system, describe below:

_____

_____

How is **Yes/No** indicated? (i.e., head nodding, speech, gesture, etc.): _____

Is speech understood by familiar listeners? ☐ Yes ☐ No ☐ Sometimes

Is speech understood by unfamiliar listeners? ☐ Yes ☐ No ☐ Sometimes

What are some things you want to communicate but cannot:

_____

_____

_____

Do you understand spoken language? ☐ No ☐ Yes, Specify:

- ☐ Words with symbols
- ☐ Simple sentences
- ☐ Printed material
- ☐ Single words
- ☐ Conversation
- ☐ Multi-step instructions

Who is available, on a consistent basis, to follow through on recommendations?

_____

Have you been assessed or treated by Speech-Language Pathologist? ☐ No ☐ Yes, Specify Why?:

_____

SLP Name: _____ Phone Number: _____

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FACILITATOR INFORMATION

- A facilitator is an individual(s) who will take the responsibility to support the use of your augmentative communication system. This could be a spouse, family member, caregiver or healthcare professional. It should be someone who interacts with you regularly on a long-term basis.
- Individuals who are non-speaking will need a facilitator.
- A facilitator will:
    1) Attend the assessment and the training sessions.
    2) Support the maintenance of the system or device.
    3) Serve as a contact person between the AAC Clinic at Hotel Dieu Shaver Health and Rehabilitation Centre and you.
    4) Assist with the equipment transportation between you and the clinic.

Facilitator # 1

Name(s): _____

_____

Relationship to AAC Client: _____

Agency, if applicable: _____

Address: _____

Telephone: Home: _____

Cell: _____

Work: _____

Email: _____

Number of hours spent with client in an average week: _____

Facilitator # 2 - Optional

Name(s): _____

_____

Relationship to AAC Client: _____

Agency, if applicable: _____

Address: _____

Telephone: Home: _____

Cell: _____

Work: _____

Email: _____

Number of hours spent with client in an average week: _____