Augmentative Communication and Access to Technology Consultative Services
REFERRAL FORM

Client Information

Name: _____ Phone #: _____

Address: _____ Health Card #: _____

Diagnosis: _____

Reason for Referral: _____

_____

_____

Service Requested (check all that apply):

❑ Augmentative and Alternative Communication (AAC): Speech does not meet client's communication needs

- ❑ Face to Face
- ❑ Other (please specify): _____

❑ Alternate access: use of a keyboard / touchscreen / computer technology is challenging

❑ Environmental control / smart home technology

❑ Device mounting

❑ Other (please specify): _____

Client's preferred device, if known:

❑ Mac ❑ PC ❑ Tablet ❑ Smart Phone ❑ Other: _____

Referral completed by:

❑ Self ❑ Physician ❑ Occupational Therapist ❑ Speech−Language Pathologist

❑ Other (please specify): _____

Name: _____ Phone number: _____

Email: _____ Date completed: _____ (YYYY/MON/DD)

Fax to 902−473−1321 or drop off to Occupational Therapy department secretary
1st floor OT dept. Nova Scotia Rehabilitation and Arthritis Centre, 1341 Summer Street, Halifax, NS