

A.C.T.S.
AUGMENTATIVE COMMUNICATION REFERRAL
FORM AAC FOR STUDENTS WITH AUTISM

Date of

Form Completed by:

Referral:

Student's Name:

Telephone:

School Name:

Birth Date:

School Address:

School Phone:

School Fax:

Parents' Names:

Parents' Home Phone: _____

Parents'

Work Number:

Address:

Parents Mobile Number

City, State, Zip

Mother's Email:

Father's Email:

Educational Placement

Full 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

Name:

Telephone:

Email:

Teacher:

Speech/Lang. Path.

O.T.

P.T.

Program Specialist:

Behavior Specialist:

Other:

Pertinent HistoryMedical Diagnosis: Autism

(Check all that apply.)

- | | |
|--------------------------|----------------------------------|
| <input type="checkbox"/> | Nonverbal |
| <input type="checkbox"/> | Limited Verbal Speech |
| <input type="checkbox"/> | Verbal with atypical Language |
| <input type="checkbox"/> | Mild Intellectual Disability |
| <input type="checkbox"/> | Moderate Intellectual Disability |

- | | |
|--------------------------|--------------------------------|
| <input type="checkbox"/> | Severe Intellectual Disability |
| <input type="checkbox"/> | Self-Injurious Behaviors |
| <input type="checkbox"/> | Physical aggression |
| <input type="checkbox"/> | _____ (Other) |
| <input type="checkbox"/> | _____ (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:

- | | |
|--|--|
| <input type="checkbox"/> <12 months | <input type="checkbox"/> 18 to 24 months |
| <input type="checkbox"/> 12 to 18 months | <input type="checkbox"/> _____ |

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

- | | |
|--|--|
| <input type="checkbox"/> <12 months | <input type="checkbox"/> 18 to 24 months |
| <input type="checkbox"/> 12 to 18 months | <input type="checkbox"/> _____ |

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

Yes No

- 1) Does the student have any vision problems?
- 2) What is the visual diagnosis?

-
- 3) Does the student have a hearing loss?

If so is the student wearing and benefiting from hearing aides?

- 4) Does the student have tactile-kinesthetic disorder?

If so is the student on a sensory-diet?

Additional Information regarding sensory impairments:

Behavioral

- 1) Does the student have any behavioral problems?

If yes, please describe:

-
- 2) Does the student have Behavioral Intervention Plan?

(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:

<input type="checkbox"/>	Augmentative Communication Assessment	<input type="checkbox"/>	Staff Training
<input type="checkbox"/>	Direct Services	<input type="checkbox"/>	Program Development
<input type="checkbox"/>	Intervention Plan	<input type="checkbox"/>	Other (Please describe.) Assist with AAC device funding
<input type="checkbox"/>	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 copy of the IEP service page specifying the AAC or AT 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. Distirct: Please have the parent sign the Assessment Plan just prior to the first scheduled date of the evaluation service. This will insure that the assessment is completed within the required time frame.*

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 ☐ _____

A.C.T.S.

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