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| Oxford University Hospitals NHS Foundation Trust logo |
| SPECIALIST DISABILITY SERVICE**OXFORDSHIRE AAC REFERRAL FORM** |
| Oxford Centre for Enablement, Windmill Road, Headington, Oxford, OX3 7HET: 01865 737445 | specialist.disabilityservice@ouh.nhs.uk |
| 1. **CLIENT’S DETAILS**
 |
| Full name: |  | Title: |  |
| Address: |  | Telephone no: |  |
|  |  | Mobile no: |  |
| NHS no: |  | Date of birth: |  | Email: |  |
| Diagnoses: |  |
| Person to contact to arrange appointments: |  | Telephone no: |  |
|  |  | Email: |  |
| Consent gained from the client for this referral: | Yes [ ]  | No [ ]  | Best interest [ ]  |
| GP (name and initial)\*: |  |
| GP Address: |  |
| *\* Essential information to identify CCG before referral is processed* |
| 1. **OTHER RELEVANT PROFESSIONALS INVOLVED** (as applicable)
 |
| Name and profession | Contact detail | Involvement |
|  |  |  |
|  |  |  |
| Indicate means of transport to appointment: | Own/home vehicle |[ ]   Ambulance |[ ]
| If a home visit is required, please provide: | A brief rationale |  |
|  | Access details |  |
| 1. **GENERAL INFORMATION**
 |
| Details of home/care arrangements: |  |
| Level of mobility(including equipment used): |  |
| Details of hand function and any changes: |  |
| Details of any visual difficulties: |  |
| Details of any hearing difficulties: |  |
| Please provide rationale if this referral should be prioritised |  |
| Please describe how the client currently communicates and difficulties experienced: |  |
| Describe use of low tech AAC, including level of support required and examples of functional use |  |
| 1. **REASON FOR REFERRAL**
 |
| This service is for Oxfordshire Adults. Referrals may be accepted for clients from other areas – please phone to discuss this prior to making a referral.Referrals will only be accepted from a Speech & Language Therapist unless discussed and agreed in advancePlease select the area(s) of the service for which a referral is being made: |
| Voice Amplifier |[ ]   |
| Voice Banking/Message BankingInformation and advice appointment |[ ]  Complete section 5 |
| Voice Output Communication Aid |[ ]  Complete section 6 |
| Detailed reason for referral, including aims of intervention:  |  |
| Other relevant information: |  |
| 1. **VOICE BANKING/MESSAGE BANKING REFERRAL INFORMATION**
 |
| Is the client likely to need support to complete the process? | No |[ ]
|  | Yes. Who is available to provide this support? |[ ]
| Does the client have an internet connection at home? | Yes |[ ]
|  | No |[ ]
| 1. **VOICE OUTPUT COMMUNICATION AID REFERRAL INFORMATION**
 |
| How does the client communicate *yes* and *no*? |  |
| Does the client have good language and literacy skills? | Yes – please go to section 7 |[ ]
|  | No – please complete the rest of section 6 |[ ]
| Brief summary of auditory comprehension:e.g. follows 1 word commands, 3 word commands,  |  |
| Brief summary of written comprehension: |  |
| Brief summary of spelling skills:e.g. can spell part of word, single words |  |
| Describe any strategies the client uses or initiates to support communication |  |
| Who will provide daily support during a trial period with a VOCA? |  |
| Who will provide long term support to update vocabulary following discharge from SLT? |  |
| 1. **REFERRER DETAILS**
 |
| Referred by: |  | Job title: |  |
| Address: |  | Email: |  |
|  |  | Mobile: |  |
|  |  | Office: |  |
| Signed: |  | Date of referral: |  |
| *Document name* | *SDS AAC referral form* | *Issue Date/ Author* | *06/04/18 TP* | *Reviewed* | *30/10/2019 TP* | *Version* | *2* |