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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 7HE  T: 01865 737445 | [specialist.disabilityservice@ouh.nhs.uk](mailto: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 advance  Please select the area(s) of the service for which a referral is being made: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Voice Amplifier | | | | | | |  | |  | | | | | | | | | | | | | | | | | | | | | |
| Voice Banking/Message Banking  Information 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* |