



Children's Treatment Network

AAC Consult Request - Simcoe

Date of Request: _____

Non-Client Consult (general questions)

by phone clinician meeting

Purpose of Consult:

Client Specific Consult

by phone clinician meeting joint visit with client/team

Client Name	
CTN#	
Date of Birth	
School	
Grade/Placement	
SLP	

AAC Update and Purpose of Consult:

Parent/Guardian Consent if Client has a CTN Electronic Record:

I have had the reasons for the AAC Consult and information sharing between _____ and the Children's Treatment Network of Simcoe York explained to me, and I understand those reasons. I agree to the AAC Consult and sharing of information (documentation in client's CTN electronic record if applicable).

Yes No

Parent/Guardian Signature: _____

Signature of Person Sending Request

Print Name & Professional Designation

Date

Agency

Email Address

Telephone

Upload form to the client's electronic record and email the ACCS clinic (accsclinic@ctnsy.ca) to inform a consult has been submitted OR fax form to ACCS Clinic at 705-719-2405.