



Children's
Treatment Network
Réseau de traitement
des enfants



Augmentative Communication Consultation Services (ACCS) Consultation Request Form Ontario Autism Program (ABA) Providers

When to Refer

Child/youth does not meet full ACCS referral criteria and:

- ABA team has questions regarding augmentative and alternative communication (AAC) approach or
- ABA team has questions regarding assessing and setting AAC related goals or
- ABA team needs support regarding a family self-purchased app that is Assistive Device Program (ADP) funded (e.g., Compass, Proloquo2Go, LAMP Words For Life, TouchChat, Snap+Core First, Predictable, Proloquo4Text)

How to Refer

- Complete the ACCS Consult Request referral form. Upload the 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.

What to Expect

- ACCS SLP will contact the ABA referral source to schedule a consultation with ACCS SLP or ACCS CDA
- Consultations can be booked in conjunction with the referring ABA provider
- ACCS SLP and/or CDA will provide 1-3 consultation visits



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Date of Request	
Child's Name	
DOB	
Diagnosis	
ABA Location	
Days child/youth attends ABA setting	<input type="checkbox"/> Mon AM <input type="checkbox"/> Tue AM <input type="checkbox"/> Wed AM <input type="checkbox"/> Thur AM <input type="checkbox"/> Fri AM <input type="checkbox"/> Mon PM <input type="checkbox"/> Tue PM <input type="checkbox"/> Wed PM <input type="checkbox"/> Thur PM <input type="checkbox"/> Fri PM
School or other setting	
School SLP	Is the school SLP involved: <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", SLP's name: Email:
Private SLP	Is a private SLP involved: <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", SLP's name: Email:
ABA provider submitting request	Name: _____ Position: _____ Email: _____ Phone: _____



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ABA provider's supervisor, if applicable	Name: _____ Position: _____ Email: _____ Phone: _____
Reason for consultation	<input type="checkbox"/> ABA team has questions regarding augmentative and alternative communication (AAC) approach <input type="checkbox"/> ABA team has questions regarding assessing and setting AAC related goals <input type="checkbox"/> ABA team needs support regarding a family self-purchased app that is Assistive Device Program (ADP) funded (e.g., Compass, Proloquo2Go, LAMP Words For Life, TouchChat, Predictable, Proloquo2Go for text). Please circle name of app. Other (specify):
Additional Information	Child is using the following AAC tool (please indicate): <input type="checkbox"/> PECS binder <input type="checkbox"/> Flip and talk <input type="checkbox"/> iPad with Proloquo2Go <input type="checkbox"/> iPad with LAMP Words for Life <input type="checkbox"/> iPad with TouchChat <input type="checkbox"/> iPad with Snap+Core First <input type="checkbox"/> Other (specify):



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	Child is using their AAC tool to:	
	Mand with	<input type="checkbox"/> nouns <input type="checkbox"/> verbs <input type="checkbox"/> descriptive words
		<input type="checkbox"/> single words <input type="checkbox"/> 2-word phrases
	Examples:	
	Tact with	<input type="checkbox"/> nouns <input type="checkbox"/> verbs <input type="checkbox"/> descriptive words
	<input type="checkbox"/> single words <input type="checkbox"/> 2-word phrases	
Examples:		
Answer questions with	<input type="checkbox"/> nouns <input type="checkbox"/> verbs <input type="checkbox"/> descriptive words	
	<input type="checkbox"/> single words <input type="checkbox"/> 2-word phrases	
Examples:		
Other		
Child is using their AAC tool at:		
<input type="checkbox"/> home <input type="checkbox"/> ABA setting <input type="checkbox"/> school <input type="checkbox"/> other: _____		



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I have had the reasons for an ACCS consultation and for information sharing between my ABA provider and CTN ACCS explained to me. I agree to the ACCS consultation and sharing of information (documentation in client's CTN electronic record if applicable).

Yes **No**

I agree to the sharing of information between the ACCS team and my child's school board speech-language pathologist:

Yes **No** **Not Applicable**

I agree to the sharing of information between the ACCS team and my child's private speech-language pathologist:

Yes **No** **Not Applicable**

Parent/Guardian Signature (or verbal): _____

Parent/Guardian Name: _____ Date: _____

Witness Signature: _____

Witness Name: _____ Date: _____