****

**AAC Consult Request - Simcoe**

**(FAX to ACCS Clinic at 705-719-2405)**

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