****

**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 [ ]  NoParent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Person Sending Request Print Name & Professional Designation Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Agency Email Address Telephone