Children's Treatment Network
Réseau de traitement des enfants

MARKHAM STOUFFVILLE HOSPITAL
CHILD DEVELOPMENT PROGRAMS

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, Proloquo2Go for text)

How to Refer

- Complete the ACCS Consult Request referral form and submit by fax 905-773-7090 or drop off at CTN Oak Ridges location, 13175 Yonge Street, Oak Ridges to the attention of Sandy Sokol, CTN ACCS. Do not send via email.
- Please send an email notification to ssokol@msh.on.ca when a referral has been submitted.

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 on Wednesdays and Thursdays in the morning or afternoon and Friday in the morning
- Consultations will 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	☐ Mon AM ☐ Tue AM ☐ Wed AM ☐ Thur AM ☐ Fri AM ☐ Mon PM ☐ Tue PM ☐ Wed PM ☐ Thur PM ☐ Fri PM
School or other setting	
School SLP	Is the school SLP involved: ☐ Yes ☐ No If "yes", SLP's name: Email:
Private SLP	Is a private SLP involved: ☐ Yes ☐ 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	☐ ABA team has questions regarding augmentative and alternative communication (AAC) approach ☐ ABA team has questions regarding assessing and setting AAC related goals ☐ 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):** ☐ PECS binder ☐ Flip and talk ☐ iPad with Proloquo2Go ☐ iPad with LAMP Words for Life ☐ iPad with TouchChat ☐ iPad with Snap+Core First ☐ Other (specify):

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Child is using their AAC tool to:

Mand with	☐nouns ☐verbs ☐descriptive words	☐single words ☐2-word phrases
	Examples:	
Tact with	☐nouns ☐verbs ☐descriptive words	☐single words ☐2-word phrases
	Examples:	
Answer questions with	☐nouns ☐verbs ☐descriptive words	☐single words ☐2-word phrases
	Examples:	
Other		

Child is using their AAC tool at:

☐home
☐ABA setting
☐school
☐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: _____

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