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| **NHS Specialised Augmentative and Alternative Communication Service – Referral Form**  |

Prior to submission of this form you are required to ensure that your client meets the NHS Specialised AAC Service Criteria - [click here to view referral criteria](https://acecentre.org.uk/wp-content/uploads/2019/04/NHS-England-Specialised-AAC-ax-eligibility-decision-chart.pdf).



Ace Centre also provide guidance for completion of this form. We strongly recommend you refer to this document – [click here to view](https://acecentre.org.uk/wp-content/uploads/2019/04/Ace-Centre-Guidance-Notes-V1-2019.pdf). Further support can be provided via our helpline on 0800 080 3115.

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| **SECTION 1: CLIENT DETAILS** |
| 1.1 | Full name: | Click here to enter text. |
| 1.2 | Known as: | Click here to enter text. |
| 1.3 | Title: | Choose an item. | If other, please specify: | Click here to enter text. |
| 1.4 | Date of birth: | Click here to enter text. |
| 1.5 | NHS Number: | Click here to enter text. |
| 1.6 | Gender: | Choose an item. | 1.7 | Pronoun: | Choose an item. |
| 1.8 | First language: | Click here to enter text. |
| 1.9 | Other language(s): | Click here to enter text. |
| 1.10 | Primary diagnosis: | Choose an item. |
| 1.11 | Secondary diagnosis: | Choose an item. |
| 1.12 | Where you have answered ‘Other’ to question 1.10 and/or 1.11 above, please give details: |
|  | Click here to enter text. |
| 1.13 | Ethnicity:  | Choose an item. |
| 1.14 | Address: |
|  | Click here to enter text. |
| 1.15 | Postcode: | Click here to enter text. |
| 1.16 | Address type: | Choose an item. |
| 1.17 | Telephone no: | Click here to enter text. |
| 1.18 | Mobile no: | Click here to enter text. |
| 1.19 | Email address: | Click here to enter text. |
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| **SECTION 2: CONTACT DETAILS FOR PARENT, CARER OR SIGNIFICANT OTHER**  |
| Only complete where permission has been given for contact details to be shared with Ace Centre for the purpose of this referral.  |
| 2.1 | Name: | Click here to enter text. | 2.2 | Pronoun: | Choose an item. |
| 2.3 | Relationship to client: | Click here to enter text. |
| 2.4 | Telephone no: | Click here to enter text.  |
| 2.5 | Email address: | Click here to enter text. |
| 2.6 | Address if not already given above: | Click here to enter text. |
| 2.7 | Postcode: | Click here to enter text. |
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| **SECTION 3: GP DETAILS**The client must be registered with a GP Practice in England in order to be eligible for NHS England’s Specialised AAC Service. |
| 3.1 | GP name and address: |
|  | Click here to enter text. |
| 3.2 | GP postcode: | Click here to enter text. |
| 3.3 | GP telephone no: | Click here to enter text. |
| 3.4 | GP email address: | Click here to enter text. |
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| **SECTION 4: REFERRER DETAILS**Referrals are accepted from publicly funded health, education and social care professionals |
| 4.1 | Name: | Click here to enter text. | 4.2 | Pronoun: | Choose an item. |
| 4.3 | Professional role: | Click here to enter text. |
| 4.4 | Days worked: | Click here to enter text. |
| 4.5 | Referrer contact address: |
|  | Click here to enter text. |
| 4.6 | Postcode: | Click here to enter text. |
| 4.7 | Telephone no: | Click here to enter text. |
| 4.8 | Mobile no: | Click here to enter text. |
| 4.9 | Email address: | Click here to enter text. |
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| **SECTION 5: TEAM AROUND THE CLIENT** |
| 5.1 | Provide details for each of the key professionals currently supporting the client: |
|  | Name | Role | Tel. No. | Email address |
|  | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
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| **SECTION 6: OTHER SERVICES WORKING WITH THE CLIENT** |
| 6.1 | Where there is a local AAC service/lead in your area, provide details: |
|  | Name of service/lead: | Click here to enter text. | Tel no: | Click here to enter text. |
| 6.2 | Where the client is known to an Environmental Control Service, provide details: |
|  | Name of service/lead: | Click here to enter text. | Tel no: | Click here to enter text. |
| 6.3 | Where the client is known to the Wheelchair Service, provide details: |
|  | Name of service/lead: | Click here to enter text. | Tel no: | Click here to enter text. |
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| **SECTION 7: KEY CONTACTS FOR ARRANGING APPOINTMENT** |
| 7.1 | State preferred location for assessment: | Choose an item. |
| 7.2 | Name of preferred venue: | Click here to enter text. |
| 7.3 | Address of preferred venue: | Click here to enter text. |
| 7.4 | Postcode of preferred venue: | Click here to enter text. |
| 7.5 | Telephone no. of preferred venue: | Click here to enter text. |
| 7.6 | In addition to the client and referrer, who will be attending the appointment? Ensure the client consents to these people attending:  |
|  | Name: | Click here to enter text. | Role: | Click here to enter text. |
| 7.7 | Will you consider attending Ace Centre based appointments? | Choose an item. |
|  | **Please note that we expect all relevant people to attend appointments** |
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| **SECTION 8: REASON FOR REFERRAL / ELIGIBILITY FOR SERVICE***We strongly recommend you refer to the guidance notes to assist you in filling out this section* |
| 8.1 | Tick to confirm that the client meets the following criteria: [ ]  The client understands the purpose and need of a communication aid[ ]  The client has developed beyond cause and effect understanding |
| 8.2 | Indicate which, if any, of the prioritisation criteria your client meets – tick all that apply: |
|  | [ ]  | Client has a rapidly degenerating condition, e.g. MNDWhere this criterion applies, describe the level of change over the past 3-6 months (or longer, where appropriate):Click here to enter text. |
|  | [ ]  | Client currently has communication aid equipment that has ceased to be functional or is significantly unreliable to meet their communication needsWhere this criterion applies, state what equipment the client has, and how it is failing:Click here to enter text. |
|  |[ ]  Client is facing a transition to a new sector/school/college/workplace environment or is currently in rehabilitation provisionWhere this criterion applies, provide details of the establishment(s)/service(s) and the timescales involved:Click here to enter text. |
|  |[ ]  Client is at risk of developing psychological/challenging behaviour as a consequence of their inability to communicate without a communication aidWhere this criterion applies, please provide further details below:Click here to enter text. |
| 8.3 | Describe how your client is able to indicate yes/no. Do you consider this to be consistent and reliable?Click here to enter text. |
| 8.4 | Describe the client’s level of understanding, then describe the level at which the client is currently able to express themselves using (a) speech (b) other means [i.e. total communication] (c) technology:Click here to enter text. |
| 8.5 | Describe how your client is able to make purposeful choices including their level of independence in being able to do so:Click here to enter text. |
| 8.6 | Evidence where the client has linked ideas and used a range of language functions beyond basic requests (e.g. to refuse/initiate/comment/ask questions etc.):Click here to enter text. |
| 8.7 | Provide a brief summary of the severity/complexity of the client’s communication difficulty and their associated physical, cognitive, learning or sensory needs:Click here to enter text. |
| 8.8 | List the tools your client currently uses to communicate. Where possible, include a photograph / screenshot of the client’s current communication book / chart layout.Click here to enter text. |
| 8.9 | Describe how, where and with whom the client communicates at present. You should include details of all paper-based strategies and/or techniques you are using and the reasons why these methods are not meeting the client’s communication needs. Click here to enter text. |
| 8.10 | Where the client is pre-literate/developing their literacy/has an acquired reading or writing impairment, please describe their literacy skills in more detail:Click here to enter text. |
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| **SECTION 9: DETAILS OF THE CLIENT’S CURRENT COMMUNICATION ABILITIES** |
| 9.1 | Understanding | Reading comprehension |
|  | Able to follow group conversation |  | Able to read short stories |  |
|  | Able to follow long complex commands |  | Able to read newspaper articles |  |
|  | Able to follow short complex commands |  | Able to read paragraphs for meaning |  |
|  | Able to follow 3+ word commands |  | Able to read sentences for meaning |  |
|  | Able to follow 2 word commands |  | Able to read short phrases for meaning |  |
|  | Follows only 1 word commands |  | Able to read single words for meaning |  |
|  | Unable to follow single word commands |  | Unable to read single words for meaning |  |
|  | Expression(by any means) | Spelling/Writing(e.g. with pen, keyboard, alphabet chart or other means) | Word finding |
|  | Able to produce long grammatical sentences |  | Able to use sentences/ paragraphs |  | No word finding difficulties |  |
|  | Able to produce simple sentences |  | Able to convey short phrases |  | Able to retrieve words over 75% of the time |  |
|  | Able to produce 2-3 word phrases |  | Able to spell single words |  | Able to retrieve words correctly 50% of the time |  |
|  | Able to produce key word / single word utterances |  | Emerging / able to spell part of words |  | Able to retrieve words when supported by a cue |  |
|  | Able to indicate yes/no |  | Not able to spell |  | Able to retrieve words < 25% of the time |  |
| **SECTION 10: DETAILS OF CLIENT’S PHYSICAL ABILITIES** |
| **10.1** | Does movement result in rapid fatigue? | Choose an item. |
| **10.2** | Describe the client’s physical ability: |  |
|  | Ambulant |[ ]  Describe any support needed:Click here to enter text. |
|  | Power wheelchair |[ ]  Detail make & model, and state whether mounting is required for this chair. Send a picture of the seating system with this form.Click here to enter text.  |
|  | Manual wheelchair |[ ]  Detail make & model, and state whether mounting is required for this chair. Send a picture of the seating system with this form.Click here to enter text.  |
|  | Are there any other mounting needs (e.g. walker, table, bed, other)?Click here to enter text. |
|  | Where applicable, describe the client’s environmental control system?Click here to enter text. |
| **10.3** | Give an example of what the client is functionally able to do for each of the parts of the body specified below: |
|  | Head: | Click here to enter text. |
|  | Eyes: | Click here to enter text. |
|  | Left arm: | Click here to enter text. |
|  | Left hand: | Click here to enter text. |
|  | Left leg: | Click here to enter text. |
|  | Left foot: | Click here to enter text. |
|  | Right arm: | Click here to enter text. |
|  | Right hand: | Click here to enter text. |
|  | Right leg: | Click here to enter text. |
|  | Right foot: | Click here to enter text. |
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| **SECTION 11: DETAILS OF CLIENT’S OTHER NEEDS** |
| **11.1** | Does the client have any hearing loss? | Choose an item. |
|  | Where applicable, give details of any known concerns around the client’s hearing, including details of any hearing test results, hearing supports (e.g. hearing aids, cochlear implants etc.):Click here to enter text. |
| **11.2** | Does the client have any visual problems? | Choose an item. |
|  | Where applicable, give details of any known concerns around the client’s vision, including details of ophthalmological assessments, any measures of visual acuity, and details of any glasses/contact lenses:Click here to enter text. |
| **11.3** | Does the client have any memory difficulties? | Choose an item. |
|  | Where applicable, give details:Click here to enter text. |
| **11.4** | Does the client have reduced concentration/ attention span? | Choose an item. |
|  | Where applicable, please give details:Click here to enter text. |
| **11.5** | Provide details of existing technology the client currently uses (e.g. iPads / computers / educational equipment / switch adapted toys etc.) and where applicable, details of the organisation or service that provided it.Click here to enter text. |
| **11.6** | State what activities and/or topics the client finds motivating:Click here to enter text. |
| **11.7** | State what activities and/or topics should be avoided:Click here to enter text. |
| **11.8** | State what the client hopes to achieve from this referral. What outcome is expected?Click here to enter text. |
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| **SECTION 12: AAC KEY WORKER / COORDINATOR** |
|  | I understand that, as the referrer:* It is my responsibility to ensure that the appropriate consent for this referral has been obtained, and I hereby confirm that this consent has been obtained - and that
* I will be the main contact for this referral. It will be my responsibility to disseminate information from Ace Centre to the client, parent/carer/significant other and relevant professionals, and to co-ordinate their attendance and/or contribution to the assessment process.
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|  | Print name: | Click here to enter text. | Date: | Click here to enter text. |  |
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| **DATA PROTECTION STATEMENT** |
|  | Ace Centre are aware of their obligations as Data Controllers under the Data Protection Act 2018 and will comply with the Act at all times.Ace Centre will ensure that all data is processed fairly and lawfully.Data collected on this form will be used solely for the purposes of delivering the NHS Specialised AAC Service, including provision of assessment, review, service audit, evaluation and development. |  |
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| **NEXT STEPS** |
|  | Return the completed Referral Form to Ace Centre: |
|  | Email: | acecentre.admin@nhs.net |  |
|  | Fax: | 0161 358 0152 |  |
|  | Post for North West region: | Ace Centre, Hollinwood Business Park, Albert Street, Oldham OL8 3QL |  |
|  | Post for Thames Valley & Wessex region: | Ace Centre, 5 Hitching Court, Blacklands Way, Abingdon Business Park, Oxfordshire OX14 1RG |  |
|  | Ace Centre will acknowledge all referrals in writing within 10 days of receipt. The acknowledgement will be sent to the referrer and will advise on the client’s eligibility for the requested service or notify the referrer that further information is required. |  |
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