

## SPECIALIST DISABILITY SERVICE OXFORDSHIRE AAC REFERRAL FORM

Oxford Centre for Enablement, Windmill Road, Headington, Oxford, OX3 7HE  
T: 01865 737445 | specialist.disabilityservice@nhs.net

1. CLIENT'S DETAILS			
Full name:		Title:	
Address:	Telephone no:	Mobile no:	
NHS no:	Date of birth:	Email:	
Diagnoses:			
Person to contact to arrange appointments:	Telephone no:	Email:	
Consent gained from the client for this referral:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Best interest <input type="checkbox"/>
GP (name and initial)*:			
GP Address:			
<i>* Essential information to identify CCG before referral is processed</i>			
2. OTHER RELEVANT PROFESSIONALS INVOLVED (as applicable)			
Name and profession	Contact detail	Involvement	
Indicate means of transport to appointment:	Own/home vehicle <input type="checkbox"/>	Ambulance <input type="checkbox"/>	
If a home visit is required, please provide:	A brief rationale		
	Access details		
3. GENERAL INFORMATION			
Details of home/care arrangements:			
Level of mobility (including equipment used):			
Details of hand function and any changes:			
Details of any visual difficulties:			

Details of any hearing difficulties:	
Please provide rationale if this referral should be prioritised	
Please describe how the client currently communicates and difficulties experienced:	
Describe use of low tech AAC, including level of support required and examples of functional use	

#### 4. REASON FOR REFERRAL

This service is for Oxfordshire Adults. Referrals may be accepted for clients from other areas – please phone to discuss this prior to making a referral.

Referrals will only be accepted from a Speech & Language Therapist unless discussed and agreed in advance  
Please select the area(s) of the service for which a referral is being made:

Voice Amplifier	<input type="checkbox"/>	
Voice Banking/Message Banking Information and advice appointment	<input type="checkbox"/>	Complete section 5
Voice Output Communication Aid	<input type="checkbox"/>	Complete section 6

Detailed reason for referral, including aims of intervention:	
---	--

Other relevant information:	
-----------------------------	--

#### 5. VOICE BANKING/MESSAGE BANKING REFERRAL INFORMATION

Is the client likely to need support to complete the process?	No	<input type="checkbox"/>
	Yes. Who is available to provide this support?	<input type="checkbox"/>
Does the client have an internet connection at home?	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>

**6. VOICE OUTPUT COMMUNICATION AID REFERRAL INFORMATION**

How does the client communicate <i>yes</i> and <i>no</i> ?							
Does the client have good language and literacy skills?	Yes – please go to section 7	<input type="checkbox"/>					
	No – please complete the rest of section 6	<input type="checkbox"/>					
Brief summary of auditory comprehension: e.g. follows 1 word commands, 3 word commands,							
Brief summary of written comprehension:							
Brief summary of spelling skills: e.g. can spell part of word, single words							
Describe any strategies the client uses or initiates to support communication							
Who will provide daily support during a trial period with a VOCA?							
Who will provide long term support to update vocabulary following discharge from SLT?							

**7. REFERRER DETAILS**

Referred by:				Job title:			
Address:				Email:			
				Mobile:			
				Office:			

Signed:					Date of referral:		
<i>Document name</i>	<i>SDS AAC referral form</i>	<i>Issue Date/ Author</i>	<i>06/04/18 TP</i>	<i>Reviewed</i>	<i>30/10/2019 TP</i>	<i>Version</i>	<i>2</i>