

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	
4. REASON FOR REFERRAL	
This service is for Oxfordshire Adults only 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
Please describe how the client currently communicates:	
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"/>
	If the client has MND, support can be requested from an MND Association Volunteer by completing the application form on the website: https://www.mndassociation.org/getting-support/communication-aids-service/voice-banking-volunteer-support-application-form/ If the MND Association form is completed, they will share the information with SDS and this SDS form does not need to be completed
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 use of low tech AAC, including level of support required and examples of functional use							
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>31/8/2018 TP</i>	<i>Version</i>	<i>1a</i>

Please return completed form to Specialist Disability Service, The Oxford Centre for Enablement, Nuffield Orthopaedic Centre Windmill Road, Headington, Oxford OX3 7HE, specialist.disabilityservice@nhs.net (preferred route).