

## Referral Criteria - Communication and Writing Aids (CWAS) Writing Aids (WA)

CWAS's Writing Aids (WA) service works with clients with **physical disabilities** who speak, but need tools to assist them to complete written work. This service is specific to clients who require **written communication support.** 

In order to be eligible for referral, the client must meet all of the following criteria:

- · Client is verbal
- Is under the age of 19 (at the time of referral)
- Has difficulty with handwriting because of a physical condition
- · Has regular writing needs at home
- Can compose ideas in writing
- Does not have a writing aid that is meeting his/her needs at home
- Has the ability/potential to use a writing aid to increase speed and/or legibility of writing

\*If the referral is being made on behalf of a client, the client/family must be aware of the referral.



Appointment Services: 150 Kilgour Rd. Toronto, ON, M4G 1R8

Tel: (416) 424-3804 Fax: (416) 422-7036

## **HEALTH PROFESSIONAL REFERRAL FORM – OUTPATIENT SERVICES**

Referral Source:	☐ Health C	are Professional	☐ Client and Family	☐ Other
Please complete <u>all</u> see	ctions of this forr	n as incomplete forms will	result in processing delays.	
NOTE: This informatio	n will be shared	with Holland Bloorview st	aff as required	
Family is aware of	this referral:	Yes ☐ (must be checke	ed) Referral Date:	(dd/mm/yy)
CLIENT INFORMATION	l:			
Client Name:				
Su	rname	First Na	ime Middle	e Initial
Date of Birth:			☐ Male ☐ Female	
		Month / Year	_	
Is an interpreter requi	red? □ Yes □ No	o Languages spoken:		
			 City:	
		Postal Code:		
			Version Code:	
		□ Yes □No I		
			dians □ Independent □ Group F	Home □ Other:
			· ·	
Primary Contact(s) – P	_			
			Tel. (cell):	
Secondary Contact(s)				
Address:				
				<del></del>
			Tel. (cell):	
PRIMARY CARE PHYSIC	CIAN:			
Name:				
Address:				
Tal ·			Fav:	

COMMUNITY	AGENCIES/PROFESSIONALS CURRENTLY	' INVOLVED:		
Agency(s) (e.g. Child Protection, Community)		Professional (e.g. OT, Psychologist)		
1				
3				
MEDICAL INFO	ORMATION:			
Primary Diagr	nosis:			
Other Diagno	ses:			
Does this clie	nt require any special infectious disease	precautions? Yes N	o	
If yes, what fo	or:			
Medical Histo	ory/Allergies:			
Taking Medic	ation: 🗆 Yes 🗆 No			
Risks (i.e. free	quent falls)			
Reason for Re	eferral/Concern/Goals:			
Spe	ecialized Services:		<del></del>	
	Aquatic Therapy		Post-Secondary Transition Service	
	Augmentative & Alternative Communic  Writing Aids	ation (AAC)	Prosthetics (including myoelectric & cosmetic Therapeutic Recreation Services	
	Clinical Seating Infant Development Services	_		
	Life Skills Services	De	ntal Services:	
	Music Therapy		Cleft Lip & Palate (general anesthesia	
	Nursery Schools (Holland Bloorview)	,	available for qualifying clients)	
	Orthotics (including protective headwe	ar)	Special Needs Dentistry (general anesthesia available for qualifying clients)	
REFERRING P	ROFESSIONAL/CLIENT OR FAMILY:		aramata ara quam, mg anama,	
Name:				
Organization:				
Email:				
Signature:				

Please fax your completed Referral Form to Appointment Services: (416) 422-7036

