



REHABILITATION  
CENTRE FOR  
CHILDREN

# Specialized Communication Resources for Children REFERRAL FORM

Name of Person *Referring*: \_\_\_\_\_

Role or Relationship to the student: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Daytime Phone #: \_\_\_\_\_

Date: \_\_\_\_\_

Please mail or drop off:

**Rehabilitation Centre for Children**

**1155 Notre Dame Avenue**

**Winnipeg MB**

**R3E 3G1**

**Attention Stephannie Motuz, SLP or Lianne Belton, OT**

**OR FAX: 204 477-5547**

## Personal Information

Name of **client/child**: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ ☐ male ☐ female

Street Address: \_\_\_\_\_, \_\_\_\_\_

Mailing Address: \_\_\_\_\_, \_\_\_\_\_

Postal Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Parents'/Guardians' name(s) \_\_\_\_\_

Daytime Phone #: \_\_\_\_\_

Email Address: \_\_\_\_\_

Siblings: ☐ Yes ☐ No

Names: \_\_\_\_\_ Age: \_\_\_\_\_

\_\_\_\_\_ Age: \_\_\_\_\_

\_\_\_\_\_ Age: \_\_\_\_\_

Language spoken in home: ☐ English ☐ French ☐ Other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Reason for Referral:

- ☐ We would like to be put on the waiting list for the Relate Program.
- ☐ We are interested in workshops for ourselves or our team.
- ☐ We are interested in the Alternative and Augmentative Communication (AAC) Program.
- ☐ We want help evaluating the child's language abilities.
- ☐ We want help with prioritizing and planning AAC intervention for this child.
- ☐ We want to borrow or evaluate a communication device/mounting system.
- ☐ We want help in planning a picture based communication system for this child.
- ☐ We want help determining the child's speech potential.
- ☐ Other: \_\_\_\_\_

# Educational Setting

☐ Day Care    ☐ Preschool

☐ Early Years School    ☐ Middle Years School    ☐ Senior Years /Collegiate

School Name: \_\_\_\_\_ School Division: \_\_\_\_\_

Grade Level: \_\_\_\_\_

Other agencies providing service (Check all that apply):

☐ Society for Manitobans with Disabilities (SMD)    ☐ Children's disABILITY Services

☐ Provincial Outreach Therapy for Children (POTC)    ☐ Children's Hospital

☐ Child and Family Services    ☐ Child Development Clinic

☐ Rehabilitation Centre for Children    ☐ St. Amant Centre

☐ Other agency \_\_\_\_\_

**Check (✓) the one that best describe the child's academic involvement.**

☐ *Regular:* Academic expectations are the same as for peers, workload may be lightened, progress is evaluated the same as peers.

☐ *Adapted:* Academic expectations are similar as for peers, adaptations have been made for pace, content or volume of workload.

☐ *Significantly Adapted:* Student is included in classroom activities where possible. Academic expectations are significantly adapted or individualized.

☐ *Individualized:* The student's program consists of highly individualized objectives.

**Check (✓) the one that best describe the child's educational setting.**

☐ The child spends most if not all of his/her day in a typical classroom.

☐ The child spends a portion of his/her day in a typical classroom.

☐ The child participates in a specialized classroom or program e.g. Skills for Living Program

☐ The child is home schooled.

# Health and Physical Status

Medical diagnosis and related conditions: \_\_\_\_\_

\_\_\_\_\_

Physician: \_\_\_\_\_ of \_\_\_\_\_ clinic/agency.

Child's PHIN#: \_\_\_\_\_ Treaty Number: \_\_\_\_\_

Medications: \_\_\_\_\_

\_\_\_\_\_

Special health requirements: \_\_\_\_\_

\_\_\_\_\_

## 1. Describe the child's current hearing status. Check (✓) all that apply.

- ☐ Typical, no concerns      ☐ Concerns, may need assessment or reassessment
- ☐ Partial loss    ☐ Functionally deaf      ☐ Prescribed with hearing aids in one or both ears
- ☐ Currently wears hearing aid (s)      ☐ Does not currently wear hearing aid (s)

Additional comments \_\_\_\_\_

☐ A copy of the latest audiology report is included with this submission

Date of most recent evaluation: \_\_\_\_\_ Assessed by: \_\_\_\_\_

of \_\_\_\_\_ clinic/agency.

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## 2. Describe the child's current visual status. Check (✓) all that apply.

- ☐ Typical, no concerns      ☐ Concerns, may need assessment or reassessment
- ☐ Requires glasses/lenses to improve visual acuity
- ☐ Currently wears eyewear      ☐ Does not currently wear eyewear

Additional comments \_\_\_\_\_

☐ A copy of the latest vision/ophthalmology report is included with this submission

Date of most recent evaluation: \_\_\_\_\_ Assessed by: \_\_\_\_\_

of \_\_\_\_\_ clinic/agency.

# Communication Status

(Please check/complete all those that apply)

1. The child:

☐ Attends to and shows interest when their partners talk

☐ Shows understanding and responds to their partner's verbal communication acts.

☐ Shows understanding and responds to their partner's non-verbal communication acts (such as pointing, smiling, vocal emphasis).

☐ Initiates interactions with others

How: \_\_\_\_\_

Why: \_\_\_\_\_

\_\_\_\_\_

☐ Uses gestures to communicate naturally (unprompted)

☐ Uses some sign language such as : \_\_\_\_\_

☐ Regularly attempts speech but is hard to understand.

☐ Is heard to say a few words now and again such as: \_\_\_\_\_

\_\_\_\_\_

☐ Has used picture symbols as part of their programming.

☐ Has regular access to a picture-to-speech communication system such as an iPad. Describe:

\_\_\_\_\_

\_\_\_\_\_

☐ Has understandable phrase length speech saying things such as:

\_\_\_\_\_

☐ Usually speaks in full sentences

☐ Has been heard to echo other's speech

☐ Has been heard to repeat scripts such as movie scenes or lists of things to no one in particular.

# Review of Communication Teaching Strategies

| At home | At school, daycare, etc |  |
|---------|-------------------------|--|
|         |                         | Practicing the comprehension and use of non—verbal communication such as gestures and body movements and facial expressions.   |
|         |                         | Labeling of items in the environment (immersion)   |
|         |                         | Simple (2 or 3) symbol games or offering choices.  |
|         |                         | Picture symbol adapted books   |
|         |                         | Picture symbol adapted songs or nursery rhymes   |
|         |                         | Memory support strategies such as schedule systems and success journals (remnant books for instance).  |
|         |                         | <i>Modeling</i> of the targeted communication method(s) ie: pointing to single symbols or concentrated message displays, or otherwise using the child's system <i>when adults talk</i> to the child. |
|         |                         | Creating communication needs or opportunities (pretending you don't understand, using lots of small pieces, in a craft for example, that the child needs to repeatedly ask for).                     |
|         |                         | Role Playing (practice the scenario before it happens) Social Stories  |
|         |                         | Coaching (offering subtle verbal prompts and visual cues during an interaction)  |
|         |                         | Daily journaling   |
|         |                         | Syntax and Grammar development with picture sentence completion tasks, story retelling, form poetry etc.   |
|         |                         | Inclusion of the student in selecting language, and/or programming of the device   |
|         |                         | Literacy Program   |
|         |                         | Other:   |

Comments:

# Review of Previous and Current Interventions

| <i>Intervention</i>   | <i>Currently Involved?</i> | <i>Previously Involved?</i> |
|---|----------------------------|-----------------------------|
| POTC OT/PT/SLP<br>( Please circle applicable)               |                            |                             |
| School based OT/PT/SLP/Psych<br>( Please circle applicable) |                            |                             |
| Private OT/PT/SLP/Psych<br>( Please circle applicable)      |                            |                             |
| Intensive Behavioural Program<br>i.e. ABA                   |                            |                             |
| Behavioural Consultation                                    |                            |                             |
| DIR— Floortime  |                            |                             |
| Manitoba Movement Centre                                    |                            |                             |
| Chiropractic Care   |                            |                             |
| Vision Therapy  |                            |                             |
| Dietary<br>Modifications/Interventions                      |                            |                             |
| Other   |                            |                             |
| Other   |                            |                             |

# Team Survey

(Please complete the table below)

Briefly outline your contribution to the support team. For example: - assess communication skills, -contribute to IEP, - train or supervise support staff, provide direct treatment etc...

| Title                       | Name | Phone Number | email | Contribution to child's team |
|-----------------------------|------|--------------|-------|------------------------------|
| Parents                     |      |              |       |                              |
| Speech-Language Pathologist |      |              |       |                              |
| _____ hours per month       |      |              |       |                              |
| Resource Teacher            |      |              |       |                              |
| Educational assistant       |      |              |       |                              |
| _____ hours per day         |      |              |       |                              |



| Title                  | Name | Phone Number | email | Contribution to child's team |
|------------------------|------|--------------|-------|------------------------------|
| Classroom Teacher      |      |              |       |                              |
| Occupational Therapist |      |              |       |                              |
| _____ hours per month  |      |              |       |                              |
| Physiotherapist        |      |              |       |                              |
| _____ hours per month  |      |              |       |                              |
| Case Worker            |      |              |       |                              |
| Other Team Members     |      |              |       |                              |

Team Meetings:

How often and/or for how long does the team meet?

Who is able to attend regularly?
☐ Parents
☐ SLP
☐ Resource
☐ Para
☐ Classroom Teacher
☐ O.T.
☐ P.T.

other:

# Specialized Communication Resources for Children

## Consent for Exchange of Information

1155 Notre Dame Ave.  
Winnipeg, MB R3E 3G1

Phone: 452-4311



|                      |                           |              |
|----------------------|---------------------------|--------------|
| <b>Child's Name:</b> | <b>Birthdate: (M/D/Y)</b> | <b>RCC#:</b> |
| <b>Date:</b>         |                           |              |

**EXCHANGE OF INFORMATION:** I understand that the information collected and distributed will be used for the purposes of assessment, planning, developing programs and/or strategies that will benefit my child. This information may be shared verbally or in writing.

I authorize the exchange of information about my child with the following persons or services:

**Name of Resource Service**

**Name, Address, Agency & Telephone # (all information required)**

|  |       |
|--|-------|
| <input type="checkbox"/> Foster Parent(s)                    | _____ |
| <input type="checkbox"/> Early Childhood Educator            | _____ |
| <input type="checkbox"/> Resource Teacher                    | _____ |
| <input type="checkbox"/> Physician/Medical Specialist        | _____ |
| <input type="checkbox"/> Service Coordinator (CSS, SMD, CFS) | _____ |
| <input type="checkbox"/> Occupational Therapist              | _____ |
| <input type="checkbox"/> Physiotherapist                     | _____ |
| <input type="checkbox"/> Speech & Language Pathologist       | _____ |
| <input type="checkbox"/> Other:                              | _____ |

**Special Instructions:**

\_\_\_\_\_

**In the process of obtaining/gathering information about your child, it may be necessary to provide a copy of this form to a provider listed above. By doing this, they will become aware of other service providers named on the list.**

Initials \_\_\_\_\_

**This consent for exchange of information is valid for the duration of program participation unless otherwise specified.**

**Signature of Parent or Legal Guardian:**

\_\_\_\_\_

**Name (please print):**

\_\_\_\_\_

**Signature of Witness:**

\_\_\_\_\_

**Name (please print):**

\_\_\_\_\_



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## Creating and Submitting a Communication Sample Video

### Please Submit:

- A few short videos of your child interacting with a familiar adult partner, in at least two natural settings. These recordings should be no more than 3 minutes in length each.
- Trying playing with the child or “fooling around” as this may increase the likelihood that the child will produce natural expressions and other non-verbal communication acts.
- You might want to practice before recording.

### Please Do Not:

- *Prompt the child to say things.*
- *Send video that shows the child doing school work.*
- *Send video of an upset child.*
- *Send these to our email address as this is prohibited.*

### For Children with an Existing AAC System or Device:

- Create at least another 3 minutes of video of structured/prompted communication acts using any AAC materials that are familiar to the child.
- Video record a bit from the child's perspective (over the child's shoulder).
- Video record a bit from the partner's perspective (over the partner's shoulder).
- Be sure that the partner is trained to interact with the child and their materials.
- Make a minute or so of “show and tell” regarding any other AAC materials not yet demonstrated.

### Video Sample Checklist:

- ☐ I have provided at least 6 minutes of video footage.
- ☐ The sample includes the child in at least two different communication situations.
- ☐ The sample represents the child's best speech and non verbal communication (gestures, eye contact, turn taking skills, smiles etc).
- ☐ The sample represents the child's best AAC or sign language communication skills.  
(if applicable)
- ☐ The video has been reviewed and the sound and picture quality are adequate.

*We accept DVD's CD's and USB drives. We will return any of these on request.*