Oxford University Hospitals
NHS Foundation Trust

# SPECIALIST DISABILITY SERVICE
# OXFORDSHIRE AAC REFERRAL FORM

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

| **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 ☐ | No ☐ | Best interest ☐ | | |
| GP (name and initial)*: | | | | | |
| GP Address: | | | | | |

** Essential information to identify CCG before referral is processed*

| **2. OTHER RELEVANT PROFESSIONALS INVOLVED** (as applicable) | | |
|---|---|---|
| Name and profession | Contact detail | Involvement |
| | | |
| | | |

| | | | | |
|---|---|---|---|---|
| Indicate means of transport to appointment: | Own/home vehicle | ☐ | Ambulance | ☐ |
| 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 | ☐ | |
| Voice Banking/Message Banking<br>Information and advice appointment | ☐ | Complete section 5 |
| Voice Output Communication Aid | ☐ | 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 | ☐ |
| | Yes.<br>Who is available to provide this support? | ☐ |
| Does the client have an internet connection at home? | Yes | ☐ |
| | No | ☐ |

| 6. VOICE OUTPUT COMMUNICATION AID REFERRAL INFORMATION | | |
|---|---|---|
| How does the client communicate *yes* and *no*? | | |
| Does the client have good language and literacy skills? | Yes – please go to section 7 | ☐ |
| | No – please complete the rest of section 6 | ☐ |
| 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: | |