**AAC WEST Referral Form**

# (Augmentative and Alternative Communication

# West of England Specialised Team)

# Expectations

In order to achieve an effective assessment it is vital that the patient, local Speech and Language Therapist and the AAC WEST team work closely together, and that the expectations for the assessment process are understood and agreed prior to referral.

## What is expected from the patient using the service?

* To attend all agreed appointments and to contact the service if there are any infection control concerns that may prevent the appointment from going ahead (see appointment letter).
* To take care of any devices which are loaned and add the equipment to their home contents insurance policy and school insurance policy (where appropriate and possible)
* To work towards the goals that have been agreed for the loan period

## What is expected of the local Speech and Language Therapist?

* To complete a comprehensive referral form, including video evidence where possible
* To attend, and actively contribute to, all agreed appointments and understand that these can often be lengthy in duration
* To support the patient to participate and contribute during appointments
* To liaise with all appropriate local professionals involved in the patient’s care
* To attend any training sessions that are arranged
* To pass-on training and information to the teams around patients
* To provide regular support/therapy sessions to the patient throughout any equipment loan periods and monitor and evaluate the patient’s progress towards the agreed goals
* To provide information (e.g. vocabulary) and feedback to AAC WEST during the assessment and loan process
* To form a local support team: identify key people who can regularly give support to the patient during, and after, the assessment process
* To ensure that everyone in the patient’s communication environment is supportive of the referral and its intended goals/outcomes
* To ensure that any equipment loaned by AAC WEST to a patient is returned in a timely fashion if a return is requested, or the device is no longer needed

## What can you expect from AAC WEST?

* A comprehensive, patient-centred assessment of AAC needs by experienced practitioners taking into account all aspects of the patient’s needs, medical condition and wishes
* Appointments arranged at times to suit the patient, their carer’s and other professionals
* Loan of communication equipment for short term evaluation as appropriate
* Adequate training in use of devices given for loan
* Ideas on how to introduce AAC systems into activities of daily living
* Setting and reviewing outcomes with the patient and their team
* Comprehensive reports
* Provision of any equipment recommended at the end of the assessment for long term use

**Please complete all sections of this form as fully as possible. We are aware that this form is long, however, detail here saves time in triage and later appointments.**

|  |  |
| --- | --- |
| **Patient Details** | **Referring SLT Details** |
| Name:  Pronouns:  He/Him  She/Her  They/Them  Date of Birth:  Address (including postcode): | Name:  Address (including postcode): |
| Telephone:  *This number will be used for text message reminders about appointments.* | Telephone: |
| Email: | Email: |
| NHS number: | Details of SLT employment: (school, NHS trust etc.)  *Please note referrals can only be accepted from SLTs employed by a statutory body e.g. NHS, School, Local Authority.* |
| **Next of kin name**: | **School/Pre-school:** |
| Address(es): (if different from above) | Address: |
| Telephone: | Telephone: |
| Email: | Email: |
| **Appointment text message reminder contact details:** *(Telephone number you would like appointment text message reminders to be sent.)* | Contact:  Telephone Number: |

Days available for appointments (Please tick the relevant boxes)

| SLT | Monday | Tuesday | Wednesday | Thursday | Friday |
| --- | --- | --- | --- | --- | --- |
| Patient | Monday | Tuesday | Wednesday | Thursday | Friday |

Please be mindful that to avoid very long waiting times you may be offered an appointment on days you have not selected. We ask that you attend appointments offered where possible.

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| --- | --- |
| Is the patient able to travel to their local AAC centre (Bristol or Plymouth)? | Yes ☐ No☐ |
| Is the patient available for appointments during school holidays? | Yes ☐ No☐ |
| Is the referring SLT available for appointments during school holidays? | Yes ☐ No☐ |
| If relevant, is the residential/education setting available for appointments during school holidays? | Yes ☐ No☐ |
| Further information to support scheduling: |  |

| **Ethnicity code** *(please ask the patient to indicate which code best matches their heritage/identity. See list at the end of this form)* | Code (A-Z): |
| --- | --- |
| **Language:** Is the patient’s home language English? | Yes  No |
| If no, what languages are spoken at home? *(Please add relevant details)* |  |
| Does the patient or family require an interpreter? | Yes  No |
| If yes, what language? |  |

**Other professionals involved relevant to referral (please include GP, Paediatrician, OT, Physio, Advisory Teachers). Please ensure consent is gained for sharing information with these professionals (see consent section).**

**PLEASE NOTE: REFERRALS CANNOT BE ACCEPTED WITHOUT GP DETAILS**

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Professional | Address | Tel Number |
| - | - | - | - |
| - | - | - | - |
| - | - | - | - |

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| --- |
| **Medical Diagnosis/History**: |
| **SLT Diagnosis**: |
| **Hearing**: *describe any hearing difficulties and aids used, e.g. conductive/sensorineural loss* |
| **Vision**: *describe any visual difficulties. Please include any relevant reports e.g. following functional visual assessment* |
| **Date of Diagnosis/History**: |

## Does this patient meet the criteria for a specialist assessment?

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| --- | --- |
| Does the patient have: a severe/complex communication difficulty associated with a range of physical, cognitive, learning, or sensory deficits? | Yes  No |
| Is there a clear discrepancy between their level of understanding and ability to speak? | Yes  No |
| Are they able to understand the purpose of a communication aid? | Yes  No |
| Have they developed beyond cause and effect understanding? | Yes  No |
| Does the patient have experience of using a low tech system that is not meeting their needs? | Yes  No |

**If you did not answer yes to all of the above please contact AAC WEST to discuss the suitability of this referral before completing the rest of the form.**

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| Does this patient have a cognitive impairment that will prevent them from learning the skills necessary to use a communication aid? | Yes  No |

**If you answered yes to this question please contact AAC WEST to discuss before completing this form.**

**Additional information to support this referral**

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| --- | --- |
| Does the patient demonstrate a range of communicative functions? | Yes  No |
| Does the patient initiate communication in a variety of contexts? | Yes  No |
| If using direct touch, are they able to: |  |
| * navigate a multi-page vocabulary? | Yes  No |
| * combine ideas/words/symbols/concepts? | Yes  No |
| * use words/symbols/signs flexibly? (i.e. beyond rote-learned phrases / repetition) | Yes  No |

**Please include detailed examples of the skills above in the relevant sections below.**

**See our website for prompts to support you with the above decision making.**

1. **Reason for Referral**

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| **Who has requested this referral and why?** *Include how this referral fits in with any therapy goals and anticipated outcome. Does the patient have a rapidly degenerating condition?  If so, what has changed in last 3-6 months?* |

1. **Current communication skills**

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| **Comprehension:** *Including level at which able to follow conversation and tools required to support understanding of spoken language, key word level of understanding, include formal/informal assessment findings.* |
| **Expression:** *What’s the patient’s current means of communication, for example, key word level of expression, vocalisation, speech, eye pointing, signing, low tech system, high tech system, other.* |
| **What is stopping the patient from being able to communicate effectively?** *Include examples of communication breakdown here.* |

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| **Literacy - reading ability:** *Include level of reading e.g. words/phrases/sentences/paragraphs* |
| **Literacy - recording ability:** *Ability to spell e.g. first letter, some letters, whole words, use of alternative means of recording e.g. alphabet chart using hands or eyes to point.* |

## Existing or previous use of AAC

*Please note: This referral cannot be accepted without evidence of low-tech methods being in place which are not meeting the patient’s needs (see referral criteria).*

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| --- |
| **Low tech:** *Describe existing or previous use of low tech communication aid(s), including type of system, layout and frequency of use. Explain why this is not sufficient to meet communication needs:* |
| **High Tech:** *Describe existing or previous use of any high tech communication aids. The type of hardware, software systems and access methods are/were used. Explain why the system is no longer meeting communication needs:* |
| **Symbol system used** *e.g. Picture Communication Symbols/Widgit Literacy Symbols etc. or state whether pictures or photos are used for communication:* |

1. **Cognition**

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| **Cognitive Skills:** *including long and short term memory, concentration, attention, following instructions and their ability to learn new skills.* |

1. **Physical Skills and Mounting**

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| **Physical Skills:**  Please describe the patient’s functional ability for each part of the body. Does movement result in rapid fatigue/change over the course of the day? |

|  |  |
| --- | --- |
| **Head** | - |
| **Trunk** | - |
| **Arms** | - |
| **Hands** | - |
| **Legs** | - |
| **Feet** | - |

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| **What do you consider the patient’s most reliable movement for AAC access?** |

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| --- | --- |
| **How does the patient mobilise?** | **Mounting system required? Please detail** |

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| --- | --- | --- |
| **Ambulant?** | *Describe any support/ equipment needed* | Yes  No |
| **Powered chair?** | *Detail make and model. How is it controlled? Send a picture of the seating system with this form.* | Yes  No |
| **Manual chair?** | *Detail make and model. Self-propelled/attendant? Send a picture of the seating system with this form.* | Yes  No |

|  |  |
| --- | --- |
| **Are any other mounting solutions required?** *i.e. in bed, armchair, class chair. If yes, please give details:*  Chair make [REQUIRED]:  Model [REQUIRED]:  *Please include picture of the seating systems.* | Yes  No |

1. **Environment, Interests and Support**

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| **Living Situation:** *e.g. living in the family home, residential setting.* |
| **What support is available on a long term basis for this patient to help them with communicating?***SLT input, external agencies, family and friends; please describe availability and level of technical knowledge of support network(s).* |
| **Activities/Interests:** *please describe any activities/interests that would motivate the patient during assessment.* |
| **Employment/Education:** *please give details of present/previous.* |

1. **Additional information**

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| **Manual Handling:** *are there any issues that need to be considered at the appointment, e.g. special arrangements for toileting etc.* |

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| **Behaviours that challenge:** *Has the patient previously exhibited physical behaviours that challenge e.g. punching, kicking, biting etc. If yes, what type, frequency and to whom?* |

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| --- | --- |
| **Is the patient at risk of falling?**  *If yes, a Falls Risk Assessment will need to be completed by AAC WEST* | Yes  No |
| **Eating and Drinking:** *is**the patient able to eat and drink orally?*  *Please detail the difficulties/risks* | Yes  No |
| **Seizures:** *does the patient experience seizures? If yes, what type and frequency?* | Yes  No |

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| **Medication:** *if known**please detail any medication the patient takes.* |

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| --- | --- |
| **Any safeguarding issues that need to be considered?**  **Please note these here and expect phone contact with the referrer prior to the first appointment to discuss.** | Yes  No |
| **Any other health and safety issues?** | Yes  No |

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| Please provide any further information you feel is relevant, including any measures that need to be put in place prior to an appointment being offered. |

1. **Consent**

**PLEASE NOTE: REFERRALS WILL NOT BE ACCEPTED UNLESS THE CONSENT SECTION BELOW IS COMPLETED IN FULL**

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| --- | --- |
| **Consent to the referral:**  Can the patient consent to the referral?  *N.B. if unclear whether a patient is able to consent to this referral, a capacity assessment should be undertaken written/visual supports appropriate to the patient’s needs.* | Yes  No |
| If **YES** has the patient consented to this referral?  *Please detail how the patient gave their consent (verbally, using AAC, gesture etc.)* | Yes  No  How consented: |
| If **NO and patient 16 or over** - has the referral be discussed with relevant parties and agreed to be in the patient’s best interest?  Discussed with/name:  Relationship to patient:  Reason consent not gained from patient: | Yes  No  N/A |
| If **NO and patient under 16** - has someone consented on behalf of the patient?  Name:  Relationship to patient:  Reason consent not gained from patient: | Yes  No  N/A |
| **Consent to emailing:** Does the patient/their NOK if patient is under 16, consent to be contacted by email?  *Please be aware that confidentiality cannot be guaranteed, and the NHS is not liable for the confidentiality or security of any message once it’s been sent*. | Yes  No |
| **Consent to information sharing:**  Can the patient consent to information sharing?  *Examples of symbols to support this conversation can be downloaded at* [*https://www.nbt.nhs.uk/bristol-centre-enablement/referral-centre/aac-west-referral*](https://www.nbt.nhs.uk/bristol-centre-enablement/referral-centre/aac-west-referral) | Yes  No  (see below) |
| If **YES**, discuss information sharing consent with patient and indicate decisions below.  If **NO and patient 16 or over** - discuss information sharing consent with relevant parties/individuals and indicate best interest decisions below.  **Discussed with**:  If **NO and patient under 16** - discuss information sharing consent with parent/guardian and indicate decisions below.  **Discussed with**: |  |
| *Please indicate who AAC WEST can share information with (as per patient’s consent, parental consent or best interests decision) and provide contact details on page 3 in “Other professionals involved relevant to referral” section.*  Other members of AAC WEST team (SLT, OT, Teacher, Assistant, Clinical Technologist, technical team, admin team)  GP  Local SLT  School staff (if relevant)  Carers / Support Workers  Day centre staff  Occupational Therapist  Physiotherapist  Advisory Teachers, e.g. Qualified Teacher of VI or HI.  Wheelchair service (needed for mounting)  Environmental Controls  Other:  Other AAC Specialised Service (if patient moves out of the South West)  Family/friends (specify who and provide contact details):  DON’T SHARE INFO WITH: |  |
| **Expectations**  As the referring therapist, are you able to meet the expectations outlined on page one? | Yes  No |

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| --- |
| Have you discussed and agreed the expectations of an assessment at AAC WEST with: |

|  |  |  |
| --- | --- | --- |
| The patient?  Yes  No | The patient’s family?  Yes  No | The team around the patient?  Yes  No |

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| --- |
| Please detail any potential difficulties/barriers arising from these conversations. |

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| --- | --- |
| **Does this person require a report in an accessible format?** *i.e. with symbol support and/or simplified text, please give specific details if required.* | Yes  No |

**Please include your most recent communication report and a short video of the patient you are referring.**

See guidelines below regarding video content and if you require the video to be returned to you once we have reviewed it.

**Please complete all sections of this referral form and email to:** [**aacwestadmin@nbt.nhs.uk**](mailto:aacwestadmin@nbt.nhs.uk)

If you have any queries please contact AAC WEST on 0117 4145850

Signed:

Name:

Date of Completion:

**Ethnicity code:**

|  |  |  |  |
| --- | --- | --- | --- |
| A | White – British | K | Asian or Asian British – Bangladeshi |
| B | White – Irish | L | Asian or Asian British - any other Asian background |
| C | White – Any other white background | M | Black or Black British – Caribbean |
| D | Mixed – White and Black Caribbean | N | Black or Black British – African |
| E | Mixed – White and Black African | P | Black or Black British – Any other Black background |
| F | Mixed – White and Asian | R | Chinese |
| G | Mixed – Any other mixed background | S | Any other ethnic group |
| H | Asian or Asian British – Indian | Z | Does not wish to disclose |
| J | Asian or Asian British – Paskistani |  |  |

## GUIDELINES FOR MAKING A VIDEO

**Consent**

Before taking any video of your client, you need their permission or that of a parent or legal guardian in line with the current GPDR Act.

A video should provide us with information about a patient’s abilities in the following areas:

**Physical**

Details of the patient’s gross and fine motor skills.

**Seating**

Close up of the patient’s usual seating/wheelchair, and their position in the seating.

**If they propel a wheelchair themselves, show how this is done. If they are ambulant, a short film showing them moving around with emphasis on any difficulties.**

**Access**

Demonstrating any switches used, or other methods of accessing computers/communication aids.

**Interaction**

Clip showing how the patient’s normally interacts with family members and others, and how these attempts are interpreted by the communication partner.

**AAC**

Close up of any AAC (alternative and augmentative communication) system already in use (signing, symbol board or book, spelling chart, e-tran frame or any electronic speech output device).

**Language/Cognitive skills**

The patient’s engaged in any activity or discussion that gives an indication of their level of understanding and cognitive functioning.

The video should be no more than 3 minutes long and should illustrate each of the areas outlined above. Please add in anything else that you feel will help us to plan an effective assessment session for your patient.

Your video may be sent on an encrypted memory stick or emailed securely to: [aacwestadmin@nbt.nhs.uk](mailto:aacwestadmin@nbt.nhs.uk)

Please ensure the recording is properly finalised and actually works before sending. The video needs to be saved in Windows Media video format (files that end in .wmv). It is essential the item is clearly labelled with the patient’s NHS number for recognition by clinical staff.

**Returning hardware such as a memory stick or CD**

If the video is sent in the post and needs to be returned to you once we have viewed it please complete the return form below and enclose it with the memory stick/CD.

Please note: resources cannot be returned unless this has been completed.

|  |  |
| --- | --- |
| Name of Client: | NHS NO: |
| Signature of person sending the data: | Date: |
| Print name: |  |

## Return details:

|  |  |
| --- | --- |
| Name: | Profession or relationship to the client: |
| Address: | Post code: |