**AAC WEST Specialist Service Bristol/Plymouth Expectations**

**Re-referral Form**

**Re-Referral** – Please complete this form if it is two years or less since the person’s last input from Bristol/Plymouth. **Please ensure** both the AAC user and the referring professional are able to meet the expectations detailed below.

**What is expected from the person using the service?**

* To attend all agreed appointments
* To take care of any devices which are loaned and add the device to their home contents insurance policy, & school insurance policy (where appropriate)
* To work towards the goals that have been agreed for the loan period
* To provide regular opportunities to practice using the communication aid.
* To cooperate with any conditions / requests made by AAC WEST regarding the use/safety of equipment on loan.

**What is expected of the local Therapist?**

* To complete a comprehensive referral form, using the AAC WEST screening tool if available
* To provide video evidence with the referral form wherever possible
* To attend all agreed appointments at the Communication Aid Service and understand that these can often be lengthy in duration
* To support the person during the initial assessment
* To actively contribute to the discussions taking place during the initial assessment
* To liaise with all appropriate local professionals involved in the person’s care
* To provide AAC WEST with vocabulary if required
* To attend any training sessions that are arranged
* To regularly support the person’s throughout any equipment loan periods that may take place and as part of the assessment process monitor and evaluate the person’s progress towards the agreed goals
* To provide feedback to AAC WEST during equipment loans
* To form a local support team: Identify key support people in the person’s home environment who can regularly give support during and after the assessment process
* For the local team (Speech and Language Therapist or assistants) to provide regular support sessions during the assessment period in order to ensure the best outcome for the person being referred
* Ensure that everyone in the person’s communication environment is supportive of the referral and its intended goals/outcome
* To ensure that any equipment loaned by AAC WEST to a person’s is returned in a timely fashion when the loan period is over or if it is no longer needed.

**What you can expect from AAC WEST**

* A comprehensive, person centred assessment of AAC needs by experienced practitioners taking into account all aspects of the person’s needs, medical condition and wishes
* Appointments arranged at times to suit the person and their carers and 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
* Goal setting with person and their team to provide evidence of outcome of assessment
* Telephone reviews during equipment loans as appropriate
* 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: |

Days available for appointments (Please tick the relevant boxes)

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

|  |  |
| --- | --- |
| Is the patient able to travel to their local AAC centre (Bristol or Plymouth)? | Yes [ ]  No[ ]  |

| **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 |
| --- | --- | --- | --- |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

| **Medical Diagnosis/History**: |
| --- |
| **SLT Diagnosis**: |

**Time since last AAC WEST input** (please tick)

| **< 6 months** [ ]  | **6mth > 12mths ☐** | **12mths +** (Complete a full referral form) |
| --- | --- | --- |

| **Date last seen by Bristol/Plymouth:**  |
| --- |

|  |
| --- |
| **Reason for re-referral:** *(please give brief summary & provide further details on the next page)* |

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| **High Tech AAC:** What AAC device is the client currently using? *Please note any issues or difficulties in each area.*Device:Access method:Software and/or vocabulary package: |
| **Low tech AAC:** What low tech AAC backup does the client have access to?  |

|  |  |
| --- | --- |
| **Client’s Condition:** Has the client’s condition or diagnosis changed or deteriorated? If yes, please give details: | Yes [ ]  No [ ]  |
| **Mounting:** Does the client have a mounting system provided by AAC WEST? If yes, is it meeting their needs? If no, please give details: | Yes [ ]  No [ ] Yes [ ]  No [ ]  |
| **Support:** Has the client’s level of available support changed, e.g. from carers, professionals and family members? If yes, please give details: | Yes [ ]  No [ ]  |
| **Communication environment and opportunities:** Has the client’s home, work, education or social situation changed? If yes, please give details: | Yes [ ]  No [ ]  |

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

|  |  |
| --- | --- |
| **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 [ ]  |

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

|  |  |
| --- | --- |
| **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 [ ]  |

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 – Pakistani |  |  |