



AUGMENTATIVE AND ALTERNATIVE COMMUNICATION CLINIC SCREENER

Client First Name:

Client Last Name:

Date of Birth:

EMHware #:

Address:

Date of Screener:

Informant:

School:

Child and/or **guardian** is interested in discussing Augmentative and Alternative communications options

AND

Child is three (3) years or older and is non-speaking/non-verbal or has extremely limited verbal output

Child is four (4) years or older and is very difficult to understand (only a Speech-Language Pathologist can make a referral to the AAC Clinic based on this concern)

Child is four (4) years or older, has difficulty using a regular computer system for written communication due to physical difficulties, and would benefit from an alternative written output system

If this is a referral from a third-party provider and the child is not yet a client of FIREFLY, please complete a General Referral Form ([click here](#)) and fax all documentation to FIREFLY's Centralized Intake at 1-866-470-1783 or by email to intake@fireflynw.ca.