FIREFLY

AUGMENTATIVE AND ALTERNATIVE COMMUNICATION CLINIC SCREENER

Client First Name:		**Client Last Name:**	
Date of Birth:		**EMHware #:**	
Address:		**Date of Screener:**	2025-02-19
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**.