Carolina Therapeutics, PLLC

ALTERNATIVE/AUGMENTATIVE COMMUNICATION
EVALUATION REFERRAL FORM

Client's Name: _____ Date of Birth: _____
Contact Name: _____ Phone No.: _____
Client's Email: _____
Home Address: _____

I. What is the recipient's health history and prognosis? (Include chronic illness.)

☐ *See attached documentation*

II. How does the client currently communicate?

☐ *See attached documentation*

☐ *Non-verbal*
☐ *Verbal approximations*
☐ *Gestures and/or signs*
☐ *Picture Exchange Communication*
☐ *Speech Generating Device:*
Year/Model: *Software:*

III. Why is this form of communication ineffective?

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IV. ***Please list any additional specialists who have seen the client.*** ☐ *See attached documentation*

V. ***Additional considerations related to communication:*** ☐ *See attached documentation*

☐ *Fine-motor difficulties*	☐ *Cognitive impairments*	☐ *Progressive disorder*
☐ *Visual motor deficits*	☐ *Destructive tendencies*	☐ *Seizures*
☐ *Vision impairments*	☐ *Hearing impairments*	☐ *Poor response to prior treatment*

Other:

Commonly Used ICD-10 Codes for Complex Communication Disorders (Check all that apply)

☐	F84.0 Autistic disorder	☐	G40.9 Epilepsy, unspecified
☐	I63 Cerebral infarctions	☐	G80.9 Cerebral Palsy, unspecified
☐	Q90.9 Down Syndrome, unspecified	☐	P91.60 Hypoxic Ischemic Encephalopathy (HIE)
☐	Q99.9 Chromosomal abnormality, unspecified	☐	S09.09 Unspecified intracranial injury

Other: (please list any specific ICD-10 Code and description)

_____

_____

AAC Evaluation Referral Form

Physician's Signature: _____ Date: _____

Physician's Printed Name: _____ NPI#: _____

When signed by a physician, this form acts as a prescription for therapy services.
Please fax this form along with any additional relevant medical information to 980-938-6088.