



Service aux laryngectomisés,
Programme d'aide à la communication
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Programme d'aide à la communication
CHUM
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ATYPICAL COMMUNICATION AID REQUEST

User's identification

Last name: _____ First name: _____

RAMQ: _____ Expiry date: _____

Description of the difficulty (or difficulties) encountered by the patient*:

Attempt(s) to resolve the problem(s)*:

Requested atypical communication aid **: _____

Speech-language pathologist: _____ Telephone: _____

Workplace: _____ Date: _____

* Attach a copy of the speech-language pathology assessment or follow-up notes if relevant.

** Attach manufacturer's name, product number and available documentation.