ATYPICAL COMMUNICATION AID REQUEST

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| --- |
| **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: | Cliquez ici pour entrer une 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*.