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: | | 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*.