SLP Evaluation for Speech Generating Devices - Additional Response Sheet

This state evaluation form has limited space in the response boxes. Any extra text outside of the assigned boxes does not appear on the final copy. Please use this sheet to document answers which go outside of the allotted response boxes and include the section number and question. On the state form, include "*See separate sheet*".

(ex. Section 7B, Communication Partners and Tasks: Client is communicating with peers….)

(Place on letterhead)

AUGMENTATIVE COMMUNICATION EVALUATION REPORT

NAME:	
MEDICAID RECIPIENT ID#	
PATIENT INSURANCE ID #:	
DOB:	
DATE OF EVALUATION:	
PARENT(S):	
ADDRESS:	
COUNTY:	

MEDICAL DIAGNOSES:

Primary Medical Diagnosis:
Secondary Medical Diagnosis:

1. RELEVANT MEDICAL HISTORY

2. SENSORY STATUS

A. Vision (Include acuity & abilities in relation to utilizing an ACD):

B. Hearing (Include acuity & abilities in relation to utilizing an ACD):

C. Tactile/Sensory Involvement (in relation to utilizing an ACD):

3. POSTURAL, MOBILITY, & MOTOR STATUS

A. Motor Status (Including fine and gross motor abilities):

B. Optimal Positioning of ACD in Relation to Client:

C. Integration of Mobility with ACD:

D. Client's Access Methods (and Options) for ACD's:

4. DEVELOPMENTAL STATUS

A. Information on the Client's Intellectual/Cognitive/Developmental Status:

B. Determination of Learning Style (i.e., behavior, activity level):

5. FAMILY/CAREGIVER AND COMMUNITY SUPPORT SYSTEMS

A. A Detailed Description Identifying Caregivers And Support:

B. The Extent of Their Participation in Assisting the Recipient With Use of the ACD:

C. Their Understanding of the Use of the ACD:

D. Their Expectations if a Device is Recommended:

6. CURRENT SPEECH, LANGUAGE & EXPRESSIVE COMMUNICATION STATUS

A. Identification and Description of the Client's Expressive or Receptive Communication Impairment Diagnosis:

B. Speech Skills *AND* Prognosis of Developing Functional Expressive Communication:

C. Communication Behaviors and Interaction Skills (i.e., styles & patterns):

D. Description of Current Communication Strategies (including use of ACD, if applicable):

E. Previous Treatment of Communication Problems:

7. COMMUNICATION NEEDS INVENTORY

A. Description of Client's Current And Projected Speech/Language Needs:

B. Communication Partners *AND* Tasks: Including Partners' Communication Abilities and Limitations, if any:

C. Communication Environments and Constraints Which Affect ACD Selection and/or Features:

8. SUMMARY OF CLIENT LIMITATIONS

A. Description of the Communication Limitations:

9. ACD ASSESSMENT COMPONENTS

A. Justification For And Use to be Made of Each Component *And* Accessory Required (MUST MATCH QUOTE):

10. IDENTIFICATION OF THE ACD'S CONSIDERED FOR CLIENT (Must include at least 3)

A. Identification of the Significant Characteristics and Features of the ACD's Considered:

B. Identification of the *Cost* of the ACD's (including all required components, accessories, peripherals and supplies, as appropriate):

C. Identification of Manufacturer(s):

D. Justification Stating Why a Device is the Least Costly, Equally Effective Alternative Form of Treatment for Client (rule out the ones not recommended):

E. Medical Justification of Device Preference:

11. TREATMENT PLAN AND FOLLOW-UP

A. Description of Short *AND* Long Term Therapy Goals:
- **(i)Short Term Therapy Goals:**
- **(ii)Long Term Therapy Goals:**

B. Assessment Criteria to Measure the Client's Progress Toward Achieving Short and Long Term Communication Goals:

C. Expected Outcomes and Descriptions of How Device Will Contribute to These Outcomes:

D. Training Plan to Maximize Use of ACD:

12. DOCUMENTATION ON CLIENT'S TRIAL USE OF EQUIPMENT

A. Amount of Time of Evaluation:

B. Location of Evaluation:

C. Analysis of Ability to Use (use very specific details of functional use of ACD recommended):

13. RECOMMENDATIONS

1.
2.
3.
4.

This report was forwarded to the treating physician (insert MD name/address/phone) on (DATE). The physician was asked to write a prescription for the recommended equipment.

The professionals who performed this evaluation are not employees of and do not have any financial relationship with the supplier of any SGD.

SLP Signature **Date**

COMMUNICATION PROSTHESIS PAYMENT REVIEW SUMMARY

1. PATIENT INFORMATION

Name:

Street:

City: **State:** **Zip:**

Birthdate:

Health Ins #:

Medical Diagnosis:

Speech Diagnosis:

2. FACILITY INFORMATION

Facility:

Address:

City:

State: **Zip:**

Telephone:

Physician:

Specialty:

Speech-Language Pathologist:

3. DEVICE INFORMATION

Item Description:

Manufacturer:

Distributer:

4. PHYSICAL STATUS PER DOCUMENTATION

	Adequate	Inadequate	N/A
General Medical Status:			
Respiratory:	☐	☐	☐
Hearing:	☐	☐	☐
Vision:	☐	☐	☐
Head Control:	☐	☐	☐
Trunk Stability:	☐	☐	☐
Arm Movement:	☐	☐	☐
Ambulation:	☐	☐	☐
Seating/Positioning (for ACD use):	☐	☐	☐
Ability to access ACD (switches, etc.):	☐	☐	☐

Summary:

5. COGNITIVE PREREQUISITES

	Yes	No
a. Attempts to communicate with consistent response mode	☐	☐
b. Functional Yes/No	☐	☐
c. Understands communication will cause an action to occur:	☐	☐
d. Understands symbols (pics, signs, etc.) stand for verbal communication:	○	○
e. Prognosis to develop intelligible speech:	☐	☐
f. Demonstrates memory of verbal instruction:	☐	☐
g. Standardized test scores (if applicable):	☐	☐

6. SELECTION OF DEVICE

a. Patient's current means of communication:

b. Other ACDs considered and rationale for elimination:

c. Rationale for selection of specific ACD:

d. Indicators for success with recommended ACD:

7. PROGNOSIS

a. Communication ability:

b. Independence within environments:

c. Placement in least restrictive environment:

d. Academic ability:

e. Vocational Training/retraining:

Physician Signature **Date** **Speech-Language Pathologist Signature** **Date**

Augmentative Communication Evaluation Team Qualifications

Speech-Language Pathologist

Name: _____ ABESPA License#:_____

Degree: _____University Name & Location: _____

ASHA CCC in Speech-Language Pathology Award Date: _____

****SLP must attach a list of current continuing education in AAC**

(If other team members contribute their opinions for the ACD evaluation report then their qualifications are required on this form.)

Physical Therapist

Name:_____

Degree: _____ AL License #:_____

University Name & Location: _____

Occupational Therapist

Name:_____

Degree: _____ AL License #:_____

University Name & Location: _____

Social Worker

Name:_____

Degree: _____ AL License #:_____

University Name & Location: _____

Rehab Tech Specialist

Name:_____

Degree: _____ AL License #:_____

University Name & Location: _____

Statement of Non-Affiliation

We hereby certify that we do not have a financial relationship or other affiliation with nor will we receive any other gain from a manufacturer, vendor, or sales representative of augmentative communication devices (ACDs) and their accessories.

_____

Speech-Language Pathologist

_____

Occupational Therapist

_____

Physical Therapist

_____

Social Worker

_____

Rehab Technology Specialist

Date: _____