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 II, Speech and language history: Client has been receiving services since….)

CLIENT ID

Washington State Department of Social & Health Services
HRSA Health & Recovery Services Administration

DURABLE MEDICAL EQUIPMENT PROGRAM MANAGEMENT UNIT (DME-PMU)
PO BOX 45535
OLYMPIA, WA 98504-5535

Speech Language Pathologist (SLP) Evaluation For Speech Generating Devices

Fax number: 1-866-668-1214

NOTE: Do not alter this form in any way. This form may only be completed by a qualified provider, acting with the scope of their practice as required by WAC 388-543-1100(1) (d), and all spaces must be completed. The form must be signed and dated within 60 days of HRSA receiving the request. **This form is required in addition to a prescription.**

CLIENT NAME	LENGTH OF NEED IN MONTHS/YEARS
CURRENT PLACE OF RESIDENCE ☐ Home ☐ Assisted Living ☐ Skilled Nursing Facility ☐ Group Home ☐ Other (specify):	
NAME OF FACILITY	
ADDRESS CITY STATE ZIP CODE	
PRESCRIBING PHYSICIAN	FAX NUMBER
SPEECH LANGUAGE PATHOLOGIST NAME	FAX NUMBER
PHYSICAL/OCCUPATIONAL THERAPIST NAME (if applicable)	FAX NUMBER

SECTION I: BACKGROUND INFORMATION

Provide pertinent history relative to diagnosis and current communication capabilities:

Current Hearing Status: Within normal limits with best correction? ☐ Yes ☐ No

Does hearing status influence the client's communication and/or the choice or use of a device? ☐ Yes ☐ No

Explain:

Current Vision Status: Within normal limits with best correction? ☐ Yes ☐ No

Does vision status influence the client's communication and/or the choice or use of a device? ☐ Yes ☐ No

Explain:

General Education Status:	**Grade Level**	**Employed:** ☐ Yes ☐ No **Comments:**

SECTION II: SPEECH AND LANGUAGE STATUS - Evaluated by Speech and Language Pathologist.

Cognition Assessment: Describe client's abilities and/or deficits in each of the following areas, as they relate to the ability to use an SGD and accessories.

Attention To:
1) Task:

2) Memory:

CLIENT ID

3) Problem Solving:

4) Age Level:

Current Receptive Language Abilities

Communicates Using: ☐ Letters ☐ Words ☐ Objects ☐ Pictures ☐ Symbols ☐ Numbers

Describe ability to follow commands (i.e. 1-step, 2-step):

Describe comprehension of yes/no questions:

Additional comments:

Current Expressive Language Abilities

Communicates Using: ☐ Vocalizations ☐ Sign Language ☐ Gestures ☐ Writing ☐ Alphabet Board
☐ Pictures ☐ Symbols ☐ Numbers ☐ Other (explain):

Initiates communication consistently? ☐ Yes ☐ No

Explain:

Explain briefly why current communication methods are not meeting client's communication needs:

Describe briefly client's spelling/literacy skills:

Additional comments:

Speech and Language Diagnosis

Briefly describe the client's speech and language therapy history:

Prognosis for functional oral speech: ☐ Good ☐ Fair ☐ Poor

Intelligibility % of oral speech: _____ familiar communication partners _____ unfamiliar communication partners

SECTION III: MOTOR/POSTURAL/MOBILITY STATUS

Functional Ambulation/Mobility/Motor Function (please check)

☐ Independent ambulation

☐ Modified independent ambulation (devices, limited distance/ control

Specify:

☐ Dependent manual wheelchair user

☐ Manual wheelchair user, functionally independent

Check if applicable:

☐ Client owned primary wheelchair currently being used will have mount attached for speech generating device.

☐ power wheelchair ☐ manual wheelchair

State wheelchair serial number:

Additional comments:

CLIENT ID

☐ Power wheelchair user. Drives with: ☐ standard joystick ☐ head control ☐ chin control ☐ sip and puff ☐ other (specify):	☐ Client has reliable and consistent motor responses sufficient to operate a SGD. Describe any gross or fine motor skill limitations that would affect ability to use a SGD, and what device modifications and/or accessories would be needed to overcome those limitations.

SECTION IV: RATIONALE FOR PRESCRIBED DEVICE

Identify all SGDs considered for the client. Choice of SGDs to consider should reflect a range from low to high tech, as appropriate. Recommended device should be the least costly alternative that meets the client's need for functional communication. Add additional pages if documenting more than 5 device trials. Circle the name of each device trialed, and state the name of any others trialed that are not listed.

1) Device description: Digitized speech using prerecorded messages, less than or equal to 8 minutes recording time. **Check all listed devices trialed:** ☐ Tech-Speak ☐ Message Mate 40/300 ☐ Message Mate 20/60 ☐ Message Mate 20/120 ☐ Step by Step Other non-listed devices trialed:	**OUTCOMES:** ☐ Ruled out without trying due to: ☐ Ruled out following trial due to: ☐ Tried and considered appropriate
Describe setup and any modifications or accommodations: Additional comments:	Type of communication demonstrated: ☐ Spontaneous ☐ Response
2) Device description: Digitized speech using prerecorded messages with greater than 8 minutes but less than or equal to 20 minutes recording time. **Check all listed devices trialed:** ☐ Macaw 3 ☐ Message Mate 40/600 ☐ DynaMo ☐ Easy Talk Other non-listed devices trialed:	**OUTCOMES:** ☐ Ruled out without trying due to: ☐ Ruled out following trial due to: ☐ Tried and considered appropriate
Describe setup and any modifications or accommodations: Additional comments:	Type of communication demonstrated: ☐ Spontaneous ☐ Response

CLIENT ID

3) Device description: Digitized speech using prerecorded messages, with greater than 40 minutes recording time.

Check all listed devices trialed:

☐ Springboard ☐ MightyMo ☐ Mini-Mo

Other non-listed devices trialed:

Describe setup and any modifications or accommodations:

Additional comments:

OUTCOMES:

☐ Ruled out without trying due to:

☐ Ruled out following trial due to:

☐ Tried and considered appropriate

Type of communication demonstrated:

☐ Spontaneous ☐ Response

4) Device description: Synthesized speech, message formulation by spelling and access by physical contact with device.

Check all listed devices trialed:

☐ DynaWrite ☐ Link ☐ Lightwriter

☐ Chat PC II

Other non-listed devices trialed:

Describe setup and any modifications or accommodations:

Additional comments:

OUTCOMES:

☐ Ruled out without trying due to:

☐ Ruled out following trial due to:

☐ Tried and considered appropriate

Type of communication demonstrated:

☐ Spontaneous ☐ Response

5) Device description: Multiple methods of message formulation and device access, synthesized and digitized speech.

Check all listed devices trialed:

☐ DynaVox MT4 ☐ Dynavox DV4

☐ Mercury ☐ Geminii ☐ Enkidu E-Talk

☐ Mini Merc

Other non-listed devices trialed:

Describe setup and any modifications or accommodations:

Additional comments:

OUTCOMES:

☐ Ruled out without trying due to:

☐ Ruled out following trial due to:

☐ Tried and considered appropriate

Type of communication demonstrated:

☐ Spontaneous ☐ Response

Type of current communication behaviors

CLIENT ID

☐ Responds to questions only ☐ Initiates occasionally ☐ Spontaneously initiates in a variety of settings

Comments:

Type of communication behaviors demonstrated with recommended device

☐ Responds to questions only ☐ Initiates occasionally ☐ Spontaneously initiates in a variety of settings

Comments:

Name and model of requested device:

Wheelchair mount: ☐ Yes ☐ No Wheelchair serial number:

Accessories Required (keyguards, switches, etc.)	Medical Justification For Accessories

SECTION V: TREATMENT PLAN AND FOLLOW UP TRAINING IN USE OF THE DEVICE.

COMMUNICATION GOALS:

1) Describe how client will be able to independently and effectively communicate medical needs to healthcare providers utilizing the requested SGD.

2) Describe environments in which the requested SGD will be used.

3) Describe how client will attain specific speech therapy goals and objectives according to the speech treatment or training plan.

4) State the plan of care indicating who will initially train the client with the device, assess efficacy of the SGD to meet the client's stated needs, program the device, and monitor and re-evaluate the client on a periodic basis.

Note: It is expected that the treating SLP will be involved with the development of this treatment plan. It is the evaluating SLP's responsibility to develop, in coordination with the client, caregivers, and treating SLP (e.g., school, day program, LTC) a basis vocabulary to be provided to the vendor for initial setup of the device.

SECTION VI: HISTORY OF PREVIOUS SPEECH GENERATING DEVICES.

DOES CLIENT CURRENTLY OWN A SGD? ☐ Yes ☐ No	IF YES, NAME OF DEVICE	PURCHASED BY ☐ Private ☐ DSHS ☐ Donated
DATE PURCHASED **OR**	APPROXIMATE AGE	SERIAL NUMBER

Does client's current SGD meet his/her medical needs? ☐ Yes ☐ No

If no, why not?

SPEECH LANGUAGE PATHOLOGIST'S SIGNATURE	PRINTED NAME	DATE
PRESCRIBING PHYSICIAN'S SIGNATURE	PRINTED NAME	DATE
PHYSICAL/OCCUPATIONAL THERAPIST'S SIGNATURE (if applicable)	PRINTED NAME	DATE