(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: _____