Augmentative Communication Device Evaluation Report Form

Name:			
DOB:		**Date of Evaluation:**	
Parent(s):			
Address:			
County:			

Medical Diagnosis:
(Primary)
(Secondary)
(Tertiary)

1. Relevant Medical History (To be completed by SLP)

2. Sensory Status (To be completed by SLP and OT, if applicable)
A. Vision SLP

OT

B. Hearing SLP

OT

C. Tactile / Sensory SLP

OT

3. Postural, Mobility & Motor Status (To be completed by SLP, OT and PT, if applicable)
A. Motor Status: SLP

OT

PT

B. Optimal Positioning: SLP

OT

C. Integration of Mobility with ACD: SLP

OT

PT

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

OT

PT

4. Developmental Status (To be completed by SLP)
A. Information on the Client's Intellectual / Cognitive / Developmental Status:

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

5. Family/Caregiver and Community Support Systems: (To be completed by SLP)
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 and Expressive Communication Status (To be completed by SLP)
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 and Patterns):

D. Description of Current Communication Strategies (Including Use of ACD, if applicable):

E. Previous Treatment of Communication Problems:

7. Communication Needs Inventory (To be completed by SLP)
A. Description of Client's Current and Projected (e.g. within 5 years) 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 (To be completed by SLP)
A. Description of the Communication Limitations:

9. ACD Assessment Components (To be completed by SLP)
A. Justification For and Use To Be Made of <u>EACH</u> Component <u>AND</u> Accessory Requested:

10. Identification of the ACD Considered for Client (<u>MUST INCLUDE AT LEAST 3)</u> (To be completed by SLP)
A. Identification of the Significant Characteristics and Features of the ACDs Considered:

B. Identification of the Costs of the ACDs (Including All Required Components, Accessories, Peripherals, and Supplies, As Appropriate):

C. Identification of Manufacturer:

D. Justification Why Recommended Device is <u>the Least Costly, Equally Effective Alternative Form of Treatment for Client</u>:

E. Medical Justification of Device Preference:

11. Treatment Plan & Follow-Up (To be completed by SLP)
A. Description of 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 Of Client's Trial Use of Equipment Including: (To be completed by SLP)
A. Amount of Time

B. Location

C. Analysis of Ability to Use

13. Recommendations: (To be completed by SLP**)**

_____ CCC-SLP _____

Signature ***Date***