AAC EVALUATION

DEMOGRAPHICS

SLP Name: _____ **Date of Evaluation:** _____

ASHA Number: _____ **Time of Evaluation:** _____

Patient Name: _____

DOB:	**Sex:** ☐ M ☐ F	**Height:** Inches **Weight:** lbs
Address:	**Primary Phone:** **Secondary Phone:**	**Email:**
Primary Speech MD:	**MD Phone:**	**MD Fax:**
Primary Insurance:	**ID:**	**Group:**
Secondary Insurance:	**ID:**	**Group:**

MEDICAL HISTORY

Speech Diagnosis ICD-10:	**Medical Diagnosis ICD-10:**
Other Diagnoses:	
Hearing Difficulties: ☐ Yes ☐ No **If Yes, please explain:**	**Vision Difficulties:** ☐ Yes ☐ No **If Yes, please explain:**
Motor Difficulties: ☐ Yes ☐ No **If Yes, please explain:**	**Ambulation Difficulties:** ☐ Yes ☐ No **If Yes, please explain:**
Functional Communication goals with SGD: (include 2 short term goals, 1 long term goal, 1 caregiver education goal, as well as the length of the plan of care to achieve goals):	

Patient name:

AAC EVALUATION

DAILY COMMUNICATION NEEDS

Describe the individual's daily communication needs:

Has the patient previously owned a speech generating device? ☐ Yes ☐ No

If so, when :

Make **Model:**

Can these needs be met using other natural modes of communication: ☐ Yes ☐ No
If Yes, please STOP and use those modes.

If No, please explain why these modes cannot be used to meet the individual's needs:

Has natural speech been considered and ruled out for this patient (yes/no)? ☐ Yes ☐ No
If yes, why was it ruled out?

Has sign language been considered and ruled out for this patient (yes/no)? ☐ Yes ☐ No
If yes, why was it ruled out?

Have low technology AAC options (e.g., pictures, low tech switches, message boards) been considered and ruled out for this patient (yes/no)? ☐ Yes ☐ No
If yes, why was it ruled out?

COMMUNICATION IMPAIRMENT

Type:

Severity:

Receptive Language Skills:

Expressive Language/Articulation skills:

Patient Name:

AAC EVALUATION

Anticipated Course Of Impairment – Only Choose 1

Stage:	Choice:	
Stage 1: No detectable speech disorder	☐	Comments:
Stage 2: Obvious speech disorder, intelligible	☐	
Stage 3: Reduction in speech intelligibility	☐	
Stage 4: Natural speech supplemented with Speech Generating Device	☐	
Stage 5: No useful speech, SGD only	☐	

Cognitive/Academic Ability

Task:	Yes | No	Comments:
Reads	☐ ☐	
Visually attends to task	☐ ☐	
Has good memory for newly learned tasks	☐ ☐	
Retains information well	☐ ☐	
Recognizes pictures of objects	☐ ☐	
Recognizes functional symbols (i.e. stop sign, exit, bus stop, etc.)	☐ ☐	
Can spell	☐ ☐	
Can write single words	☐ ☐	
Can write full sentences	☐ ☐	
Can write in coherent paragraphs	☐ ☐	
Learns well with repetition	☐ ☐	
Good problem solving abilities	☐ ☐	
Recognizes numbers	☐ ☐	
Comprehends yes/no questions	☐ ☐	
Answers yes/no questions (i.e., head nods, facial expressions, body movements, vocalizations)	☐ ☐	

SPEECH GENERATING DEVICE TRIAL(S) - IF ANY

Devices Tried:

1:

2:

3:

Direct selection methods trialed: **-Touch, head mouse, eye gaze, other (please describe)**

Indirect selection methods trialed : **-Switch scanning, auditory scanning, joystick (please describe)**

Accessories trialed/considered: **-Adaptive stylus, keyguard, other (please describe)**

Outcome(s):

Patient trialed high-tech AAC for _____sessions, for _____ minutes per session, over the course of _____ days

SGD: SYNTHESIZED SPEECH, MULTIPLE METHOD DEVICE ALGORITHM

	Yes	No
Does the individual possess a treatment plan that includes an expected training schedule for the device? If YES, continue. If NO, STOP and create an expected schedule then proceed.		
Does the individual have the cognitive and physical abilities to effectively use the recommended device and any accessories to communicate? If YES, continue. If NO, STOP and discuss alternatives.		
Can the individual's speaking needs be met using natural communication methods? If NO, continue. If YES, STOP and order natural communication methods.		
Have other forms of treatment been tried, and/or considered, and ruled out? If YES, continue. If NO, STOP and order those treatments.		
Will the individual's speech impairment benefit from the recommended device? If YES, check to see if accessories and/or mounts are needed and order below. If NO, STOP and order the most appropriate equipment that will benefit the individual.		
Will the individual need accessories in order to operate the device? If YES, please mark the appropriate accessories (see Page 4). If NO, just order device only and any mount (if needed).		
Will the individual require mount(s) in order to attach the device to a table and/or their wheelchair or power wheelchair? If YES, please order mount(s) (see Page 4). If NO, do not mark any mounts.		
Caregiver has verbalized agreement to participate in AAC training and implementation		

SPEECH GENERATING DEVICE TRIAL(S) - IF ANY

☐ **(E2510)**	**Device Name (if known):** _____ **Speech Generating Device, Synthesized Speech, Requiring Multiple Methods Of Message Formulation and Multiple Methods Of Device Access**

Accessories (if any) Needed:

☐	Keyguard	
☐	Single Switch	
☐	Multiple Switches	
☐	Alternative Touch (i.e. head pointer, etc)	
☐	Keyboard	
☐	Other(s)	

Mounts (if any) Needed:

☐	Table Mount	
☐	Wheelchair/Power Wheelchair Mount *	

***If selected, please list make, model and serial number (if possible) of wheelchair:**
Make: _____ **Model:** _____
Serial Number: _____

SIGNATURES

As the evaluating therapist, I hereby attest that I have personally completed this evaluation and that I am not an employee of, or working under contract to, the manufacturer(s) or the provider(s) of the equipment recommended in my evaluation. I further attest that I have not and will not receive remuneration of any kind form the manufacturer(s) or the provider(s) for the equipment that I have recommended in this evaluation.

Therapist Signature: _____ **Date:** _____

I have reviewed and agree with the findings in this evaluation as to the recommended equipment and so order the equipment.

Physician's Signature: _____

Physician's Name (Printed): _____

Physician's Signature Date: _____