

# Speech-Language and AAC Evaluation

*Augmentative Communication Evaluation for Speech Generating Device*

SLP: \_\_\_\_\_ Date of Evaluation: \_\_\_\_\_

ASHA Number: \_\_\_\_\_ Time of Evaluation: \_\_\_\_\_

Patient Name: \_\_\_\_\_

DOB:	Sex: M F	Height:	Weight:
Address:	Primary Phone:		E-mail(s):
	Secondary Phone:		
Primary Speech MD:	MD Phone:		MD Fax:
Primary Insurance:	ID:	Group:	
Secondary Insurance:	ID:	Group:	

## Medical History

Speech Diagnosis:	Primary Diagnosis:
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 Expected & Treatment Options:	

## Daily Communication Needs

Describe the individual's daily communication needs:
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Patient Name: \_\_\_\_\_

**Daily Communication Needs (cont.)**

Can these needs be met using other <b>natural</b> modes of communication: If <b>Yes</b> , please <b>STOP</b> and use those modes.	Yes	No
If No, please explain why these modes cannot be used to meet the individual's needs:		

**Communication Impairment**

Type:	Severity:	
Language Skills:		
<b>Anticipated Course Of Impairment – Only Choose 1</b>		
<b>Stage</b>	<b>Choice</b>	<b>Comments</b>
Stage 1: No detectable speech disorder		
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			
Other:			

Patient Name: \_\_\_\_\_

**Speech Generating Device Trial(s) – if any**

Device(s) Tried:
Access Method(s) Tried:
Outcome(s):

**SGD: Synthesized Speech, Multiple Method Device Algorithm**

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

Patient Name: \_\_\_\_\_

**SGD Equipment Selection & Recommendation (check box to order)**

<input type="checkbox"/> (E2510)	Device Name (if known): _____
	Speech Generating Device, Synthesized Speech, Requiring Multiple Methods Of Message Formulation and Multiple Methods Of Device Access
<b>Accessories (if any) Needed:</b>	
<input type="checkbox"/> Keyguard: _____	
<input type="checkbox"/> Single Switch: _____	
<input type="checkbox"/> Multiple Switches: _____	
<input type="checkbox"/> Alternative Touch (i.e. head pointer, etc.): _____	
<input type="checkbox"/> Keyboard: _____	
<input type="checkbox"/> Other(s): _____	
_____	
_____	
<b>Mounts (if any) Needed:</b>	
<input type="checkbox"/> Table Mount: _____	
<input type="checkbox"/> 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 from 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 \_\_\_\_\_