Augmentative Communication Systems Client Assessment Report

Date: _____

Patient Name: _____

Recipient Identification Number: | | | | | | | | | |

Assessment Team Members:

Speech/Language Pathologist: _____

Primary Care Physician: _____

Parent(s) or primary care giver: _____

Other medical professionals: _____

Client Demographic/Biographic Summary:

Diagnosis and reason for referral:

Age: _____ Approximate physical size (height and weight): _____

Living arrangement (e.g., with family and size and composition, in a nursing or group facility):

Primary occupation(s) (e.g., school and grade level, employment and type, workshop or day treatment, stays at home, etc.):

List of other supportive resource individuals, if any (e.g., family members, friends, aide at school or work, in-home worker, facility staff):

Inventory of skill levels, sensory functions, and use of assistive devices, if any, in the following areas:

Vision:

Hearing:

Ambulation mode(s), including appropriateness of seating/positioning, if applicable:

Functional gross and fine motor skills in head/neck, trunk, and all four extremities:

Cognition and learning potential! to include:

- Object permanence (ability to remember objects and realize they exist when they are not seen):
- Cause and effect (ability to associate certain behaviors or event with actions that will follow):
- Means end (ability to anticipate events independent of those currently in progress):
- Cognitive level (to include any available, recent standard or observational measurements of mental and developmental ages, and demonstrated consistent ability to attend, match, categorize, and sequence):

Inventory of the present and anticipated future communication skill levels for each of the following:

Type of expressive communication method/mode(s) used:

Functional level of oral, written and gestural expressive language capabilities, including oral motor speech status, and the communication functions of requesting, protesting, labeling and sharing information:

Identification of a reliable and consistent motor response, which can be used independently to communicate:

Assessment of present and future communication needs, including the types of communication needed, with whom, and in what environments (e.g., to enhance conversation, and/or to write and signal emergency, basic care and related medical needs):

Features needed in client communication system, as applicable:

Type and number of messages, vocabulary size, coding system, symbol sets, message retrieval:

Size, layout, system memory, optical indicators, auditory prompts, rate enhancement, programmability, computer compatibility:

Type of input method (e.g., switches, mouth stick, head pointer, alternative keyboard, and direct selection, scanning, encoding):

Type of output (e.g., speech print, LCD, Braille):

Mounting and portability:

Extent of training required to use the system and availability of training and technical assistance for its use:

Availability of customer service by manufacturer or supplier:

Availability of trial rental period and statement regarding whether rental fees can be applied towards purchase price:

Other considerations:

Summary of intervention options, to include:

- Description of the systems tried by client during or prior to the assessment and success in terms of actual ability, motivation, independence, and improvement in communication effectiveness:

- The advantages, disadvantages, cost, and availability of training/customer service, for the two or three most appropriate communication system for the client as determined through the assessment, specifying available features and client needs for each:

Documentation of client trial and success, including ability, motivation, independence, and improvement in communication effectiveness; in using one or more recommended communication systems, which may be accomplished prior to or during the assessment, or the rental cost for which may be requested through the prior approval process following the assessment:

Final recommendation of which system is most appropriate to meet the client's medical needs and why, to include documentation of a vendor's price quote, a copy of the warranty, the availability of maintenance, the shipping location, and a recommendation of at least one other system which would meet the client's medical needs. Department approval will be based on the most cost effective system that meets the individual's medical needs.

Attach additional pages if necessary.

Required Attachments:

1. Prescription and Certification of Medical Necessity (including medical history information)
2. Individual Treatment and Implementation Plan
3. Literature on Recommended Equipment

Signature of Preparer: _____

Address: _____

Phone Number: _____