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: Secondary Phone:	E-mail(s):
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:

Patient Name: _____

Daily Communication Needs (cont.)

Can these needs be met using other **natural** modes of communication: If **Yes**, please **STOP** 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:	

Anticipated Course Of Impairment – Only Choose 1

Stage	**Choice**	**Comments**
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	☐	☐	

Patient Name: _____

Cognitive/Academic Ability (Continued)

Task	Yes	No	Comments
Can write full sentences	☐	☐	
Can write in coherent paragraphs	☐	☐	
Learns well with repetition	☐	☐	
Good problem-solving abilities	☐	☐	
Recognizes numbers	☐	☐	
Other:	☐	☐	

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 **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.		

Patient Name: _____

SGD Equipment Selection & Recommendation (check box to order)

☐ (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 mouse, etc.): _____
- ☐ Eye Gaze: _____
- ☐ 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 _____