Office Use Only: AAC Eval. scheduled on____________________ Location: Carls, Home, Other Agency

AUGMENTATIVE AND ALTERNATIVE COMMUNICATION SERVICES
DEPARTMENT OF COMMUNICATION DISORDERS
HEALTH PROFESSIONS BUILDING 2169
CENTRAL MICHIGAN UNIVERSITY
MT. PLEASANT, MI 48859

AUGMENTATIVE COMMUNICATION PRE-ASSESSMENT FORM

Complete this form and return via snail mail to:
Theresa Jones, Director of Clinical Instruction
Department of Communication Disorders, HPB 2187
Central Michigan University, Mount Pleasant MI 48859
Phone = (989) 774-3960, fax = (989) 774-1891
https://www.cmich.edu/colleges/CHP/hp_academics/communications_disorders/clinical_programs/Pages/AACCenter.aspx

Today's date:____________

DEMOGRAPHIC INFORMATION

Name_______________________Birthdate____________Age__________Sex________

Address _____________________Phone_____________ Email Address______________

City _______________________________State_______ Zip Code__________________

***Person completing questionnaire ____**

***Relationship to client____**

***Address/Phone/email of person completing questionnaire____**

INSURANCE INFORMATION -- We may need a referral from your physician in order to bill your insurance for this evaluation. Please provide the following information so we can evaluate whether this is the case with your insurance.

Primary Insurance:

Insurance Name____

Cardholder's Name_____________ Cardholder's Date of Birth_______________

Cardholder is: (circle) Child Parent Self Spouse Other

ID# from Insurance Card _________________Group # ___________________

Secondary Insurance:

Insurance Name____

Cardholder's Name_____________ Cardholder's Date of Birth_______________

Cardholder is: (circle) Child Parent Self Spouse Other

ID# from Insurance Card ____________________Group # ________________________

Referring Physician:____

Physician address:____

Physician Phone number ____________________Physician Fax number______________

CURRENT COMMUNICATION IMPAIRMENT

STATEMENT OF THE PROBLEM

Please describe the communication problem for which you are seeking AAC services:

MEDICAL INFORMATION

What is the medical diagnosis of the client? (For example cerebral palsy, seizure disorder, ALS etc.)

Describe any recent medical or dental procedures the client has had or has planned in the near future.

What medications is the client presently taking and for what reasons?

COMMUNICATION

Date of most recent speech/language evaluation:

Receptive information:

Does the client seem to have difficulty understanding speech?
Yes ? _____ No? _______

Please describe:

Please indicate the client's current level of understanding by checking the following:

Does not understand spoken words ______________________

Understands single words ______________________________

Understands simple sentences__________________________

Understands 2 and 3 part commands ____________________

Understands conversations _____________________________

Expressive information:

Does client attempt to communicate?
____

Does the client initiate communication? Yes_____ No______

If yes, with whom does the client attempt to communicate?

Please indicate all means of communication currently used: (If possible, rank order from most to least frequently used; 1 being most frequent.)
Speech __________________________ Eye pointing ___________________
Vocalization _________________ _____Spoken yes/no _________________
Manual signing* __________________ Gestural yes/no ________________
Facial expressions ________________ Bodily gestures ________________
Communication equip. _____________ Writing ________________________

*What type of signs (e.g. ASL etc.) does the client use and about how many does he/she use spontaneously?

What is the approximate rate of client's current communication? E.g. words per minute)

SPOKEN COMMUNICATION

If the client speaks, please indicate if speech is:
Understood by strangers
____

Understood by family/close associates only
____

Difficult for family/close associates to understand
____

Is never understood by others
____

Indicate average number of words in client's message

____

What percentage of the client's speech are you able to understand? (Please circle.) 100% 75% 50%

If client is not understood, is he/she:
Quickly discouraged__________ Persistent __________
Frustrated __________________ Apathetic __________
Has the client ever spoken better than he/she does now?

AIDED COMMUNICATION (Use of communication boards, electronic devices etc.)

Please describe the type of aided communication system/device currently used:

How long has the client been using the device described?___________________

Please list all communication systems used in the past and check whether the system proved to be unsuccessful or unsuccessful.

System	Successful	Unsuccessful (State possible reason for lack of success.)
____________	__________	_______________
____________	__________	_______________
____________	__________	_______________

How are (or would) vocabulary items represented on the client's communication board/device? Also what size and how many items?
Photographs ____________ Size ______________Number ________________
Color pictures ___________ Size ______________Number ________________
Line drawings ____________Size _____________ Number _________________
Letters/words ____________Size _____________ Number _________________
Other __________________ Size _____________ Number ________________

If possible, list the vocabulary items displayed on the client's communication aid.

The client primarily uses the communication aids/devices:
Imitatively ________________________
In response to questions ________________________

In response to commands _____________ (Example: "Show me what you want.")
Spontaneously _________________ (i.e. on his/her own initiative without cueing)

Are modifications necessary to accommodate visual impairments? (i.e. color contrast, placement of pictures on overlays, etc.)

Does the client combine symbols to form a message? How many?

Identify switch, activation site, and reliability of site (if applicable):

List any other adaptive equipment necessary for use with the communication system:

EDUCATION/LITERACY (Check here if this section not applicable________)

Does the client currently attend a school program?____________________

If yes, what is current classroom placement? Include Special Education Certification if applicable (e.g. SXI, EMI etc.)

____

Literacy Skills	**N/A**	**Emergent**	**Present**
Recognizes rhyme			
Identifies number of letters in a word			
Identifies letters of the alphabet			
Understands letter sound correspondence			
Decodes unknown words			
Spells words			
Reads independently			
Uses strategies to support comprehension			
Answers comprehension questions			
Composes text with assistance			
Writes independently			

Estimated literacy level for both reading and writing (emergent, pre-primer, primer, grade 1, etc.)?____

What literacy activities does this client engage in on a regular basis (emergent literacy activities, decoding, guided reading, independent reading, writing)? How often?

COGNITIVE INFORMATION

Does client demonstrate functional object use; that is, play with or use objects in the way that they are typically used (e.g. puts phone to ear, spoon to mouth etc.)?

If not, please describe the client's interaction with objects by checking those actions he/she typically engages in: Puts objects in his/her mouth __________
Hits/bangs objects on a surface ________
Shakes objects _______
Drops or throws objects on the floor _______
Other (please specify)
____

Has the client has a psychological/psycho-educational evaluation prior to this time?
Yes_______ No _____
Date and results of most recent testing:_________________________________

VISION

Does the client have any visual problems? Yes?_____ No? _____
Does client wear glasses? Yes?_____ No? _____
In what situations?
Date of most recent vision testing______________________________________
Test results:

HEARING

Does the client seem to have any difficulty hearing? Yes?_____ No? _____
If so, please describe:

Date of most recent hearing test ____
Test results:

MOTOR ABILITIES (Check here if this section not applicable_____________)

If applicable, please check all that apply:

	Normal	Able but slow/labored	Too weak or uncoordinated without assistance	Unable without assistance
Holds head steady				

Sits without help				
Walks				
Uses hands				

Does client fall or lose balance easily?

In what position does client spend the majority of the time at home? (Please check one):

	Sitting erect		semi-reclined		on back		on stomach		on side (Right) __ (Left) __

Apparatus/aids: Please check boxes in this table that apply

	Uses presently	**Used in the past**	**Never used**
Wheelchair			
Lower extremity braces			
Back brace/trunk support			
Crutches/cane/walker			
Splint(s) where?			
Overhead sling			
Headstick			
Computer			
Dressing aids			
Transfer aids			
Feeding aids			
Other			

If wheelchair is used, please describe the following:
Make ____
Motorized_____________________ Manual ______________________________
Insert components ___________________Lap belt _________________________
Harness____________________________ Lap tray measurements ____________
Independent mobility____
Activities tray is used for
____

Does client prefer the right or left hand? ___________________________________

Most reliable movement patterns:
Pointing________________________ Eye pointing _______________________
Raising arm_____________________ Other e.g. foot or knee etc._____________

Does client have difficulty chewing or swallowing?   Does he/she drool?

SOCIAL INFORMATION/ COMMUNICATION NEEDS

Describe the client's interactions with others:

Please list the items the client most frequently desires/attempts to indicate:
Food:

Activities/toys:

Daily needs:

Other:

Is the client currently employed? Yes? _______ No? _______
If so, please describe duties and communication needs in the work place.

THERAPEUTIC HISTORY

List all therapeutic/services the client is currently receiving in the table below:

Type of Service (ST, OT, PT etc.)	Frequency (# month)	Duration (# minutes per 'session')	Site (School, outpatient etc.)	Objectives

If an AAC system is recommended, who will be the people to implement the AAC system for/with the client?

SUPPORT SERVICES

Indicate agencies for possible financial assistance:

Children's Special Health Care Services ____
Medicaid ______________Vocational Rehabilitation __________________________ Medicare ______________Private Insurance (company) ______________________
SSI ___________________Church group _________________________________
Service Group __________Fund raisers ___________________________________
Other (explain) ___________________

ADDITIONAL INFORMATION

What do you feel are the client's major assets?

What do you feel are the client's major problems or concerns for the future?

What do you expect from this evaluation?