

Dynamic Therapy Associates, Inc.
Speech Language Pathology and Assistive Technology
 3105 Creekside Village Dr., Ste. 604, Kennesaw, GA 30144
 Ph: 770-974-2424 Fax: 1-866-384-6451
mydynamictherapy@bellsouth.net www.mydynamictherapy.com

Step I: Initial Client Information Form
To be completed as much as possible by family/team prior to evaluation

Client Info: Personal

Client Name:	DOB:
Social Security Number:	Gender:
Date of Onset:	
Student: <input type="checkbox"/> yes <input type="checkbox"/> no Name of School:	Grade:
Employed: <input type="checkbox"/> yes <input type="checkbox"/> no	Name of Employer:
Medicare #	Medicaid #
Managed Care Medicaid <input type="checkbox"/> yes <input type="checkbox"/> no	Managed Care Medicaid ID#
Does client currently own a communication device: <input type="checkbox"/> yes <input type="checkbox"/> no Make and Model:	Date of Purchase:

Client Info: Residence

Place of Residence: <input type="checkbox"/> Home <input type="checkbox"/> Facility If Facility, Name: Facility Main Phone:	Address:
Home Phone:	County:
Alternate Phone:	
Email:	

Client Info: Medical Diagnosis

Medical Diagnosis:	ICD-9 Code:
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Speech Diagnosis:	ICD-9 Code:
Date of Onset, Accident, or Diagnosis:	Type of Accident: <input type="checkbox"/> Employment <input type="checkbox"/> Auto <input type="checkbox"/> Other
Date of Evaluation:	

Client Info: Family Contact/Legal Guardian

Use Client Address Info

Contact Name:	Relationship to Client:
Contact Home Phone:	Address:
Contact Alternate Phone:	
Contact Email:	
Contact Fax:	

Client Info: Treating Physician

Physician Name:	Physician Address:
Physician Phone:	
Physician Fax:	
Physician Email:	
Medicaid Provider #	Physician UPIN
Physician NPI #	Physician License #
Medicaid Primary Care Physician Name	Medicaid Primary Care Physician Phone

Client Info: Private Insurance

Use Client Address Info

Name of Insurance Company:	Address:
Employer Name:	
Policy #	Group #
Policy Holder Name:	Case Manager:
Policy Holder SS#	Policy Holder Relationship to Client <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> parent <input type="checkbox"/> legal guardian
Policy Holder Date of Birth:	

Client Info: Other Insurance

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Use Client Address Info

Name of Insurance Company:	Address:
Employer Name:	
Policy #	Group #
Policy Holder Name:	Case Manager:
Policy Holder SS#	Policy Holder Relationship to Client <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> parent <input type="checkbox"/> legal guardian
Policy Holder Date of Birth:	

Client Info: Alternate Funding-
Please list and describe in detail any alternate funding sources

Necessary Documents to Bring to Evaluation:

- Prescription from Primary Physician stating:** “Augmentative Communication Evaluation, Treatment and Modification as needed”
- Copies of ALL insurance and Medicaid/Medicare cards, front/back**

Statement of Problem:

Please explain the concerns which brought you to this office

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Desired Outcome of Treatment:

What would you like to happen as a result of today's visit and our subsequent involvement with your family?

Step II: Augmentative Communication Evaluation

1. Background Information

Team Members Planning to Attend Evaluation	<i>Present at Evaluation?</i>
	<input type="checkbox"/>
	<input type="checkbox"/>
	<input type="checkbox"/>
	<input type="checkbox"/>

Educational History

In Grade Level:

Early Childhood/Preschool

Elementary- Grade: _____

College

Other

Completed Grade:

Elementary School High School College Post-Graduate Other

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Type of Program:
 Special Education General Education Combination of Special and General Education Other:
 No School

Current Therapy Services:

Therapy	Frequency	Site	Therapist/Phone #
Speech Therapy			
Occupational Therapy			
Physical Therapy			
Other:			
None			

Medical History (add pertinent medical procedures, history, medications, if any)

Vocational History:

Unemployed
 Attends workshop/day program: _____
 Employed at _____

Additional Comments (vocation)

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Additional Comments (Background Information):

2. Speech and Language Status

Speech and Language Status Determined by:

- report (e.g. client, family, other therapists, teachers)
- informal assessment
- formal testing

Formal Tests Administered and Results:

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Receptive Language:

- No deficits in Comprehension

Comprehends:
<input type="checkbox"/> single words
<input type="checkbox"/> phrases
<input type="checkbox"/> sentences
<input type="checkbox"/> conversation
<input type="checkbox"/> one-step directions
<input type="checkbox"/> two-step directions
<input type="checkbox"/> multiple-step directions
<input type="checkbox"/> yes/no questions
<input type="checkbox"/> choice questions
<input type="checkbox"/> wh-questions
Additional information:

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Expressive Language

Communicates Using:
<input type="checkbox"/> facial expression
<input type="checkbox"/> pointing
<input type="checkbox"/> gestures
<input type="checkbox"/> eye gaze
<input type="checkbox"/> formal signs
<input type="checkbox"/> vocalizations
<input type="checkbox"/> speech at the <input type="checkbox"/> word level <input type="checkbox"/> sentence level
<input type="checkbox"/> objects/pictures/symbols/printed words
<input type="checkbox"/> voice output communication device
Speech Intelligibility:
____ % intelligible with familiar listeners
____ % intelligible with unfamiliar listeners
Additional Information:

Written Language

Produces by handwriting:	Produces by typing:	Given single words (with or without symbols), produces:
<input type="checkbox"/> Nothing	<input type="checkbox"/> Nothing	<input type="checkbox"/> Nothing
<input type="checkbox"/> Letter	<input type="checkbox"/> Letter	<input type="checkbox"/> 2-3 word phrases
<input type="checkbox"/> Words (copying)	<input type="checkbox"/> Words (copying)	<input type="checkbox"/> Simple sentences
<input type="checkbox"/> Words (independently)	<input type="checkbox"/> Words (independently)	<input type="checkbox"/> Complex sentences
<input type="checkbox"/> Sentences	<input type="checkbox"/> Sentences	
<input type="checkbox"/> Paragraphs	<input type="checkbox"/> Paragraphs	

Adaptations For Typing

<input type="checkbox"/> Standard keyboard	<input type="checkbox"/> ABC keyboard
<input type="checkbox"/> Writing tool adapted	<input type="checkbox"/> Spelling on device
<input type="checkbox"/> QWERTY keyboard	<input type="checkbox"/> Word prediction support

Reading

Functional Reading Comprehension	Reading Comprehension Level
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<input type="checkbox"/> Nothing	<input type="checkbox"/> Age-appropriate (at grade level)
<input type="checkbox"/> Sight words only	<input type="checkbox"/> Below age-level (grade level)
<input type="checkbox"/> Sentences	Approximate Grade Level:
<input type="checkbox"/> Paragraphs	
Additional Information:	

Cognition

Memory for tasks presented:

within functional limits
 partially limited
 severely limited

Attention to tasks presented:

within functional limits
 partially limited
 severely limited

Learning:

demonstrated new learning during this evaluation (e.g., new techniques, devices).

Summary:

possesses the cognitive abilities to effectively use an augmentative communication device to achieve functional communication goals.

Additional Information (Cognition):

Summary of Speech and Language Status

- **Emergent/Functional**
 - Difficult to fully assess receptive language
 - Beginning to communicate using a variety of methods (gestures, body language, facial expressions, simple symbols)
 - Requires assistance from the communication partner
 - Communicates a limited number of messages in a small set of specific contexts or routines

- **Context Dependent/Situational**

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- Understands simple and clear symbols; beginning to understand more abstract symbols.
- Understands most communication about things that are present. May misunderstand references to people, situations and items that are not present
- Communicates effectively in a limited number of situations OR communicates in a limited way across a variety of situations
- Overall ability to communicate effectively depends on the environment, topic or communication partner
- Has very limited ability to creatively combine symbols to create new messages
- Limited literacy skills

- **Independent/Creative**
 - Age appropriate receptive language
 - Follows the linguistic rules appropriate for his/her age
 - Writes and spells at or near age level
 - Able to combine single words, spelling, and phrases together to create novel and flexible messages about variety of subjects.

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3. Current Communication Needs

Environments: *please check all environments the client participates in*

- | | |
|---|--|
| <input type="checkbox"/> Home/Residence | <input type="checkbox"/> Community |
| <input type="checkbox"/> School | <input type="checkbox"/> Support Group |
| <input type="checkbox"/> Work | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Medical Facility | |
| <input type="checkbox"/> Face-to-Face | |
| <input type="checkbox"/> Telephone | |

Partners: *please check all partners with whom the client interacts*

- | | |
|--|--|
| <input type="checkbox"/> Immediate Family | <input type="checkbox"/> Medical professionals |
| <input type="checkbox"/> Extended Family | <input type="checkbox"/> Home health assistants/caregivers |
| <input type="checkbox"/> Friends | <input type="checkbox"/> Individuals in the community |
| <input type="checkbox"/> Peers | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Co-Workers | |
| <input type="checkbox"/> Teachers | |
| <input type="checkbox"/> Residential staff | |

Topics: *please check all topics about which the client needs to communicate*

- Activities of Daily Living (ADLs)
- Medical needs
- Medical/Personal/Legal decision-making
- Emergency needs/information
- Personal needs
- Personal information
- Other: _____

Functions:

- Ask questions
- Respond to questions
- Social interaction (family and community)
- Social etiquette
- Resolve/prevent communication breakdowns
- Other: _____

Summary and Prognosis:

Choose one of the following:

- Daily functional communication needs cannot be met using natural speech or low-tech/no-tech augmentative communication techniques.

OR

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Improvements in the quantity and intelligibility of clietn's speech are unlikely, possible, expected at this time. At this time, verbal skills do not allow him/her to meet all of his/her daily communication needs nor do they allow him/her to continue to develop/ regain age-appropriate language skills.

OR

Client has a degenerative condition for which traditional speech/language therapy is not effective. His/her natural speech does not allow him/her to meet the majority of his/her daily communication needs.

Additional information:

Prognosis for functional use of an augmentative communication system:

excellent good fair poor

4. Sensory and Motor

The focus of this section is to provide information regarding vision, hearing and motor skills as they relate to the use of an augmentative communication device. Information for parts of this section may be provided by an occupational therapist, if one is involved in the evaluation process.

<p>Vision</p> <input type="checkbox"/> unaided and functional for AAC use <input type="checkbox"/> corrected (glasses/contacts) and functional for AAC use <input type="checkbox"/> functional use of AAC system required vision accommodations (<i>check necessary accommodations</i>)	<p>Vision Accommodations: <input type="checkbox"/> increased font size <input type="checkbox"/> increased symbol size <input type="checkbox"/> color contrast <input type="checkbox"/> auditory feedback <input type="checkbox"/> other:</p>
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<p>Hearing</p> <input type="checkbox"/> unaided and functional for AAC use <input type="checkbox"/> Hearing Aids <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> bilateral and functional for AAC use <input type="checkbox"/> Modifications needed (with/without hearing aids)	<p>Hearing Accommodations: <input type="checkbox"/> increased volume <input type="checkbox"/> visual cues (display of message, highlight on activation) <input type="checkbox"/> headphones <input type="checkbox"/> dual display for communication <input type="checkbox"/> other:</p>
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Additional information related to visual and hearing abilities of client or family members/caregivers:

Motor:

Mobility:

- no assistive devices
- a cane
- a quad cane
- a walker
- a manual wheelchair (self-propelled or partner-dependent)
- a power wheelchair (joystick, head array, or sip and puff switch)
- a scooter

Head:

- Control: complete partial, no
 Functional Movement: complete partial, no

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Additional information:

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