AUGMENTATIVE COMMUNICATION EVALUATION REPORT

NAME:	
MEDICAID RECIPIENT ID#	
PATIENT INSURANCE ID #:	
DOB:	
DATE OF EVALUATION:	
PARENT(S):	
ADDRESS:	
COUNTY:	

MEDICAL DIAGNOSES:
Primary Medical Diagnosis:
Secondary Medical Diagnosis:

1. RELEVANT MEDICAL HISTORY

2. SENSORY STATUS

A. Vision (Include acuity & abilities in relation to utilizing an ACD):

B. Hearing (Include acuity & abilities in relation to utilizing an ACD):

C. Tactile/Sensory Involvement (in relation to utilizing an ACD):

3. POSTURAL, MOBILITY, & MOTOR STATUS

A. Motor Status (Including fine and gross motor abilities):

B. Optimal Positioning of ACD in Relation to Client:

C. Integration of Mobility with ACD:

D. Client's Access Methods (and Options) for ACD's:

4. DEVELOPMENTAL STATUS

A. Information on the Client's Intellectual/Cognitive/Developmental Status:

B. Determination of Learning Style (i.e., behavior, activity level):

5. FAMILY/CAREGIVER AND COMMUNITY SUPPORT SYSTEMS

A. A Detailed Description Identifying Caregivers And Support:

B. The Extent of Their Participation in Assisting the Recipient With Use of the ACD:

C. Their Understanding of the Use of the ACD:

D. Their Expectations if a Device is Recommended:

6. CURRENT SPEECH, LANGUAGE & EXPRESSIVE COMMUNICATION STATUS

A. Identification and Description of the Client's Expressive or Receptive Communication Impairment Diagnosis:

B. Speech Skills *AND* Prognosis of Developing Functional Expressive Communication:

C. Communication Behaviors and Interaction Skills (i.e., styles & patterns):

D. Description of Current Communication Strategies (including use of ACD, if applicable):

E. Previous Treatment of Communication Problems:

7. COMMUNICATION NEEDS INVENTORY

A. Description of Client's Current And Projected Speech/Language Needs:

B. Communication Partners *AND* Tasks: Including Partners' Communication Abilities and Limitations, if any:

C. Communication Environments and Constraints Which Affect ACD Selection and/or Features:

8. SUMMARY OF CLIENT LIMITATIONS

A. Description of the Communication Limitations:

9. ACD ASSESSMENT COMPONENTS

A. Justification For And Use to be Made of Each Component *And* Accessory Required (MUST MATCH QUOTE):

10. IDENTIFICATION OF THE ACD'S CONSIDERED FOR CLIENT (Must include at least 3)

A. Identification of the Significant Characteristics and Features of the ACD's Considered:

B. Identification of the *Cost* of the ACD's (including all required components, accessories, peripherals and supplies, as appropriate):

C. Identification of Manufacturer(s):

D. Justification Stating Why a Device is the Least Costly, Equally Effective Alternative Form of Treatment for Client (rule out the ones not recommended):

E. Medical Justification of Device Preference:

11. TREATMENT PLAN AND FOLLOW-UP

A. Description of Short *AND* Long Term Therapy Goals:

(i)Short Term Therapy Goals:

(ii)Long Term Therapy Goals:

B. Assessment Criteria to Measure the Client's Progress Toward Achieving Short and Long Term Communication Goals:

C. Expected Outcomes and Descriptions of How Device Will Contribute to These Outcomes:

D. Training Plan to Maximize Use of ACD:

12. DOCUMENTATION ON CLIENT'S TRIAL USE OF EQUIPMENT

A. Amount of Time of Evaluation:

B. Location of Evaluation:

C. Analysis of Ability to Use (use very specific details of functional use of ACD recommended):

13. RECOMMENDATIONS

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SLP Signature & Credentials Date