AUGMENTATIVE COMMUNICATION SYSTEM SELECTION

Recipient Name | Medicaid Number | Date of Birth

Address | City | State | ZIP

Section A – To be completed by physician. Use additional sheets as needed.

Medical diagnosis and history:

Physician Signature _____ Name _____

Provider Number _____ Phone _____

Address _____

Section B - To be completed by speech or language pathologist. Use additional sheets as needed.
Please describe current functional abilities in terms of:

Communication Skills:

Motor Status:

Sensory Status:

Cognitive Status:

Social/Emotional Status:

Language Status:

Information is also needed on the following:

Educational ability and needs:

Vocational potential:

Anticipated duration of need:

Prognosis regarding oral communication skills:

Prognosis with a particular device: (Has there been a trial period with this or a similar device?)

Recommendation: (Why this particular device? What other kinds of equipment have been used?)

_____ Name _____

Physician Signature

_____ Phone _____

Address