

**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**

DEMOGRAPHIC INFORMATION

Name _____ Birthdate _____ Age _____ Sex _____

Address _____ Phone _____

Date of referral _____

Referred by _____

Person completing questionnaire _____

Relationship to client _____

Address/Phone of person completing
questionnaire _____

Referring Physician: _____

Physician address/phone: _____

Physician license number: _____ Physician Insurance (Medicaid) #: _____

Indicate funding source for the AAC evaluation:

Children's Special Health Care Services (Crippled Children's Services) _____

Medicaid _____ Vocational Rehabilitation _____

Medicare _____ Private Insurance (company) _____

SSI _____ Other (explain) _____

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	Emerging	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?

Are you interested in any of the following:

- finding out more about this client's literacy skills (reading and writing)? _____
- school curricular recommendations (including adaptations)? _____
- literacy technology recommendations? _____

COGNITIVE INFORMATION (Check here if this section is not applicable _____)

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	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 circle 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?