

Augmentative & Alternative Communication Device Evaluation

SECTION 1 – Patient Demographics

Date of Evaluation: _____

EVALUATION SITE & REFERRING PHYSICIAN

Evaluation Site / Facility Name: _____

Evaluating Speech-Language Pathologist: _____

Referring Physician: _____

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ Age: _____

Home Address: _____

Medical Diagnoses:

Diagnosis	ICD-10 Code	Date of Onset

Communication Diagnoses:

Diagnosis	ICD-10 Code	Date of Onset	Severity*

****Please note: for Medicare funding, the beneficiary's medical condition must be one resulting in severe expressive speech impairment.***

Caregivers' and patient's expectations of this evaluation include (choose one or more):

- Responding to a physician's recommendation for SGD evaluation
- Learning about available SGDs
- Trialing equipment
- Improving communication skills of patient
- Other (describe): _____

SECTION 2 - Current Communication Impairment

1. General Statements

Secondary to diagnosis of _____, patient presents with **severe expressive communication impairment** characterized by _____. For this reason, patient was referred for this evaluation by the physician listed above.

2. Current/Previous Speech-Generating Device

Does the patient currently own, or did the patient previously own, an Augmentative Communication Device?

No

Yes (provide information below)

Make and model of device: _____

Date of Purchase: _____

Funding Source: _____

Functional benefit of upgrade: _____

SECTION 3 – Comprehensive Assessment

1. Hearing

Hearing is within functional limits (WFL) with no modifications needed	
Patient presents with hearing loss but compensates in the following way: _____	
Patient is aided with _____	
Other: _____	

With modifications listed above, patient is able to use a speech-generating device functionally.

2. Vision

Visual Acuity is WFL with no modifications needed	
Patient uses prescription glasses or contacts. Please specify: <input type="checkbox"/> Single-focus lenses <input type="checkbox"/> Progressive lenses <input type="checkbox"/> Bifocals <input type="checkbox"/> Other _____	
Patient presents with decreased visual acuity but compensates in the following way _____	
Other: _____	

With modifications listed above, patient is able to use a speech-generating device functionally.

3. Physical

Mobility (select all that apply)	
Ambulates safely and independently	
Uses Manual Wheelchair Make/Model _____	

Uses Power Wheelchair Make/Model _____ Alternative power wheelchair controls include (if applicable): _____	
Other mobility aids: _____	
Neuromuscular	
Muscle Tone WFL	
High Muscle Tone	
Low Muscle Tone	
Degenerative Condition that indicates progressive change of tone over time	
Fine Motor	
Patient demonstrates ability to use direct access with SGD	
Patient requires access modifications (listed in Rationale for Device Selection section below)	

This patient possesses the necessary physical abilities to effectively use a speech-generating device and accessories to communicate and achieve functional goals (listed below).

4. Language and Cognition

Patient demonstrates the following language/cognitive skills (select all that apply):	
Consistent response to name	
Understands single words	
Attends when spoken to	
Comprehends yes/no, open-ended and choice questions	
Follows one-step directions	
Follows multi-step directions	
Understands simple conversation	
Understands complex adult conversation	
Performs functions necessary to effectively trial speech-generating devices	

This patient possesses the necessary cognitive/linguistic abilities to effectively use a speech-generating device and accessories to communicate and achieve functional goals (listed below).

5. Oral Motor & Speech Intelligibility

Patient demonstrates the following (select all that apply):	
Decreased speaking rate of _____ WPM (speaking rates < 95-110 WPM are often indicative of an imminent decline to nonverbal status)	
Decreased intelligibility, estimated at _____% to an unfamiliar listener	
Oral motor control is impacted in the following ways:	
Oral mechanism examination revealed the following:	

6. Social / Behavioral Observations:

Patient demonstrates the following (select all that apply):	
Motivation to use a speech generating device to communicate wants and needs	
Has a positive change in behavior with access to a communication device.	
Absence of a communication device results in the following negative behavior:	

7. Anticipated Course of Impairment (select one or more):

- Communication is unlikely to improve without use of the recommended speech-generating device
- High probability of continued decline in verbal speech
- Other: _____

SECTION 4 - Daily Communication Needs

1. Patient's specific daily communication needs include (select all that apply):

- Expressing needs in emergency situations
- Expressing physical wants and needs (e.g., hunger; thirst; pain; toileting)
- Expressing informed consent regarding medical decisions
- Gaining a listener's attention (e.g., "help!")
- Requesting object/action (e.g., "drink!")
- Refusal (e.g., saying "I don't want that")
- Sharing information (e.g., providing name and address in case of emergency)
- Commenting (e.g., "yum, that's good!")
- Labeling (e.g., "that's a cup.")
- Asking questions (e.g., "Did I take my medicine?")
- Asking for repetition (e.g., "I didn't understand. Can you say that again?")
- Answering yes/no questions
- Answering open ended questions (e.g., providing an appropriate answer to "What's up with you?")
- Other: _____

2. Ability to Meet Communication Needs with Non-SGD Treatment

- Patient is unable to consistently meet these functional daily communication needs using low-tech strategies, natural speech or non-SGD treatment approaches.
- Therapy to improve natural speech production is no longer indicated or appropriate.

Describe previous attempts to meet communication needs with non-SGD treatment:

SECTION 5 - Rationale for Device Selection

1. General Features of Recommended SGD and Accessories

Based on the comprehensive assessment documented above, it has been determined that patient requires a Speech-Generating Device to meet their functional communication goals. Other forms of treatment have been considered and ruled out. This SGD must allow the following:

Input Features	
Direct selection via touch screen	
Switch compatible to allow scanning	
Option to use eyegaze as access method	
Customizable access options such as delay in acceptance time	
Option for a keyguard	
Option for a wheelchair mount	
Other:	
Message Features	
Text to speech capabilities	
Predictive and rate-enhancement features, including word and phrase prediction	
Option to incorporate message and voice banking	
Symbol-based communication pages	
Phrase-based message selection	
Availability of core vocabulary to allow for spontaneous and novel utterance generation	
Ability to create custom language content and pages	
Other:	
Other Features	
High quality visual display with small screen for portability	
High quality visual display with larger screen due to access or vocabulary needs	
Easily programmed	
Durable	
Handle for independent transport	
Wearable speaker for more effective interaction with listeners	
Other:	

2. Trials with SGDs:

Device / Accessories	Selection Method	Procedures / Outcome
Device 1	<input type="checkbox"/> Direct Selection Modification(s) required: _____ <input type="checkbox"/> Eye Gaze Accessories used: _____ <input type="checkbox"/> Scanning Accessories used: _____ <input type="checkbox"/> Mouse Emulation Accessories used: _____ <input type="checkbox"/> Integration with Power Wheelchair Controls <input type="checkbox"/> Head Pointing Accessories used: _____ <input type="checkbox"/> Other: _____ _____	
Device 2	<input type="checkbox"/> Direct Selection Modification(s) required: _____ <input type="checkbox"/> Eye Gaze Accessories used: _____ <input type="checkbox"/> Scanning Accessories used: _____ <input type="checkbox"/> Mouse Emulation Accessories used: _____ <input type="checkbox"/> Integration with Power Wheelchair Controls <input type="checkbox"/> Head Pointing Accessories used: _____ <input type="checkbox"/> Other: _____ _____	

Device 3	<input type="checkbox"/> Direct Selection Modification(s) required: _____ <input type="checkbox"/> Eye Gaze Accessories used: _____ <input type="checkbox"/> Scanning Accessories used: _____ <input type="checkbox"/> Mouse Emulation Accessories used: _____ <input type="checkbox"/> Integration with Power Wheelchair Controls <input type="checkbox"/> Head Pointing Accessories used: _____ <input type="checkbox"/> Other: _____	
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3. Recommended Equipment & Medicare Codes

Based on comprehensive assessment and SGD trials, it was determined that the equipment below is feature-matched to meet the patient's stated communication needs.

Name of device or accessory	HCPC Code	Justification
	<input type="checkbox"/> E2510 (SGD) <input type="checkbox"/> E2512 (Mount or mount plate) <input type="checkbox"/> E2599 (Accessory)	<input type="checkbox"/> Medically necessary to meet functional communication goals <input type="checkbox"/> Medically necessary to allow access to SGD
	<input type="checkbox"/> E2510 (SGD) <input type="checkbox"/> E2512 (Mount or mount plate) <input type="checkbox"/> E2599 (Accessory)	<input type="checkbox"/> Medically necessary to meet functional communication goals <input type="checkbox"/> Medically necessary to allow access to SGD
	<input type="checkbox"/> E2510 (SGD) <input type="checkbox"/> E2512 (Mount or mount plate) <input type="checkbox"/> E2599 (Accessory)	<input type="checkbox"/> Medically necessary to meet functional communication goals <input type="checkbox"/> Medically necessary to allow access to SGD
	<input type="checkbox"/> E2510 (SGD) <input type="checkbox"/> E2512 (Mount or mount plate) <input type="checkbox"/> E2599 (Accessory)	<input type="checkbox"/> Medically necessary to meet functional communication goals <input type="checkbox"/> Medically necessary to allow access to SGD
	<input type="checkbox"/> E2510 (SGD) <input type="checkbox"/> E2512 (Mount or mount plate) <input type="checkbox"/> E2599 (Accessory)	<input type="checkbox"/> Medically necessary to meet functional communication goals <input type="checkbox"/> Medically necessary to allow access to SGD

The patient's ability to meet daily communication needs will benefit from the acquisition and use of the _____ device and _____ accessories, billing codes _____.

These items are available from:
 Forbes Rehab Services, Inc. (Forbes AAC)
 181 Illinois Ave. South
 Mansfield, OH 44905
 fax 419.589.5146

4. Anticipated Modifications

The device and accessories listed above are the most appropriate and least expensive feature-matched options for this patient. It is anticipated to meet the patient’s communication needs over the next 2-5 years. Anticipated changes and modifications during this time include:

- No Modifications anticipated at this time
- Addition or Change in Mount _____
- Access Method Change anticipated _____

5. Patient and Family Support of SGD

The patient’s immediate family and/or primary caregiver was present at this evaluation. All individuals present were supportive of patient using the stated SGD, and agreed to the necessity of the SGD for meeting the patient’s communicative needs.

SECTION 6 - Treatment Plan & Functional Communication Goals

1. Treatment/Implementations Options:

- Self-study (patient and caregiver(s))
- Onsite training at assessment facility
- Formal training from manufacturer representative
- Ongoing technical support from manufacturer
- Other: _____

2. Treatment Plan & Training Schedule:

Upon receipt of SGD, it is recommended that the patient receive _____ (duration) of _____ (type of treatment) every _____ (frequency). This intervention will address the functional communication goals listed below.

3. Functional Communication Goals:

Upon receipt of the recommended equipment, patient will achieve the following:

	Functional Communication Goal	Time Frame
<input type="checkbox"/>	Patient and/or caregiver will master basic maintenance and operations of SGD (on-off, charging, positioning, etc.).	<input type="checkbox"/> Within 2 weeks <input type="checkbox"/> Within 2-6 weeks <input type="checkbox"/> Within 6-12 weeks <input type="checkbox"/> Other: _____
<input type="checkbox"/>	Patient will request assistance or call for help from a caregiver in another room using SGD.	<input type="checkbox"/> Within 2 weeks <input type="checkbox"/> Within 2-6 weeks <input type="checkbox"/> Within 6-12 weeks <input type="checkbox"/> Other: _____

<input type="checkbox"/>	Patient will contact a family member, caregiver, friend or public agency on the telephone using SGD.	<input type="checkbox"/> Within 2 weeks <input type="checkbox"/> Within 2-6 weeks <input type="checkbox"/> Within 6-12 weeks <input type="checkbox"/> Other: _____
<input type="checkbox"/>	Patient will describe physical condition, report symptoms, and respond to health care professionals' questions during a medical appointment using SGD.	<input type="checkbox"/> Within 2 weeks <input type="checkbox"/> Within 2-6 weeks <input type="checkbox"/> Within 6-12 weeks <input type="checkbox"/> Other: _____
<input type="checkbox"/>	Patient will independently convey needs and make requests to caregivers, by spelling or retrieving pre-programmed messages on SGD.	<input type="checkbox"/> Within 2 weeks <input type="checkbox"/> Within 2-6 weeks <input type="checkbox"/> Within 6-12 weeks <input type="checkbox"/> Other: _____
<input type="checkbox"/>	Patient will participate in social exchanges outside of the home with unfamiliar communication partners using SGD.	<input type="checkbox"/> Within 2 weeks <input type="checkbox"/> Within 2-6 weeks <input type="checkbox"/> Within 6-12 weeks <input type="checkbox"/> Other: _____
<input type="checkbox"/>	Initiate social greetings, offer information, ask questions, express feelings and opinions through spelling and retrieving stored messages on SGD, during 1:1 and group situations with familiar and unfamiliar partners.	<input type="checkbox"/> Within 2 weeks <input type="checkbox"/> Within 2-6 weeks <input type="checkbox"/> Within 6-12 weeks <input type="checkbox"/> Other: _____
<input type="checkbox"/>	Other (1):	<input type="checkbox"/> Within 2 weeks <input type="checkbox"/> Within 2-6 weeks <input type="checkbox"/> Within 6-12 weeks <input type="checkbox"/> Other: _____
<input type="checkbox"/>	Other (2):	<input type="checkbox"/> Within 2 weeks <input type="checkbox"/> Within 2-6 weeks <input type="checkbox"/> Within 6-12 weeks <input type="checkbox"/> Other: _____
<input type="checkbox"/>	Other (3):	<input type="checkbox"/> Within 2 weeks <input type="checkbox"/> Within 2-6 weeks <input type="checkbox"/> Within 6-12 weeks <input type="checkbox"/> Other: _____

4. **Expected Goal Achievement:** It is anticipated that the functional communication goals listed above are reasonable and achievable within the time frame stated.

SECTION 7- Physician Involvement

A copy of this report, including equipment recommendations, has been forwarded to the patient's treating physician, Dr. _____, on _____ (date) for review and prescription.

SECTION 8 - Signatures / SLP Assurance of Financial Independence

The Speech-Language Pathologist performing this evaluation is not an employee of, and does not have a financial relationship with, the supplier of the recommended SGD.

Signed,

Name, M.S., CCC-SLP
Speech-Language Pathologist
ASHA #: _____
License #: _____ State of License: _____

Signatures of other team members are not required by Medicare, but should be included when available.