Speech-Language & AAC Evaluation
Augmentative Communication Evaluation for Speech Generating Device

SLP(s): _____ ASHA Number: _____

Date of the Evaluation: _____ Time of the Evaluation: _____

Patient Name: _____

DOB:	**Sex:** ☐ **M** ☐ **F**	**Height:**	**Weight:**
Address:		**Primary Phone:**	**Email(s):**
		Secondary Phone:	
Primary MD Name:		**MD Phone:**	**MD Fax:**
Primary Insurance:		**ID:**	**Group:**
Secondary Insurance:		**ID:**	**Group:**

Medical History

Communication ICD-10 Diagnosis:	**Primary ICD-10 Diagnosis:**
Other ICD-10 Diagnoses:	
Hearing Difficulties: ☐ **Yes** ☐ **No** If **YES**, please explain:	**Vision Difficulties:** ☐ **Yes** ☐ **No** If **YES**, please explain:
Motor Difficulties: ☐ **Yes** ☐ **No** If **YES**, please explain:	**Ambulation Difficulties:** ☐ **Yes** ☐ **No** If **YES**, please explain:

Functional Communication Goals & Treatment Plan

List patient long & short terms goals expected to be achieved, frequency/duration of treatment, estimated times for completion following receipt of SGD, & treatment plan upon receipt of the SGD.

Patient Name: _____

Daily Communication Needs

Describe the patient's daily communication needs:
Can these communication needs be met using other natural modes of communication? ☐ **Yes** ☐ **No** If **YES**, please STOP and use those modes of communication. If **NO**, please explain why these natural modes cannot be used to meet the patient's communication needs.

Communication Impairment

Type:	**Severity:**
Language Skills (receptive, expressive, pragmatic):	

Anticipated Course of Impairment – Only choose 1 Stage

Stage		**Comments**
Stage 1: No detectable speech disorder	☐	
Stage 2: Obvious speech disorder, intelligible	☐	
Stage 3: Reduction in speech intelligibility	☐	
Stage 4: Natural speech supplemented with a SGD	☐	
Stage 5: No useful speech, Speech Generating Device only	☐	

Patient Name: _____

Cognitive/Academic Ability (specific to skill of using and navigating SGD)

Task	Yes	No	If NO, please explain.
Attends to SGD display	☐	☐	
Maintains attention to preferred task	☐	☐	
Ability to learn new tasks, including basic device operation	☐	☐	
Retains information about symbol location	☐	☐	
Recognizes functional device symbols (home, speak, back, clear)	☐	☐	
Navigates between pages	☐	☐	
Understands the SGD can be used to communicate wants and needs	☐	☐	
Reads	☐	☐	
Can patient write single words and/or sentences	☐	☐	
Recognizes numbers	☐	☐	
Learns well with repetition	☐	☐	
Good problem-solving abilities	☐	☐	
Able to answer yes/no questions	☐	☐	

Speech Generating Device Trials

Devices trialed:	
Access Method(s) trialed:	☐ **Direct Selection** ☐ **Switch** ☐ **Head Mouse** ☐ **Eye Gaze** ☐ **Other:**

Trial outcome(s):

Patient Name: 2342342342

SGD: Synthesized Speech, Multiple Method Device Algorithm

Algorithm	Yes	No
Does the patient possess a treatment plan that includes an expected training schedule for the device? If **YES**, continue. If **NO**, STOP and create an expected schedule then proceed.	☐	☐
Does the patient have the cognitive, language and physical ability to effectively use the recommended device and any accessories to communicate? If **YES**, continue. If **NO**, STOP and discuss alternatives.	☐	☐
Can the patient's speaking needs be met using natural communication methods? If **NO**, continue. If **YES**, STOP and order natural communication methods.	☐	☐
Have other forms of treatment been tried, and/or considered, and ruled out? If **YES**, continue. If **NO**, STOP and order those treatments.	☐	☐
Will the patient's speech impairment benefit from the recommended device? If **YES**, check to see if accessories and/or mounts are needed and order below. If **NO**, STOP and order the most appropriate equipment that will benefit the patient.	☐	☐
Will the patient need accessories to operate the device? If **YES**, please mark the appropriate accessories below. If **NO**, just order the device only and any mount if needed.	☐	☐
Will the patient require mount(s) to attach the device to a table and/or wheelchair? If **YES**, please provide wheelchair information below. If **NO**, do not mark any mounts.	☐	☐

SGD Equipment Selection & Recommendation (check box to order)

E2510	Device Name:
☐	Speech Generating Device, Synthesized Speech, Requiring Multiple Methods of Message Formulation and Multiple Methods of Device Access

Accessories Needed (if applicable):

Keyguard: _____

Single Switch: _____

Multiple Switches: _____

Alternative Access (i.e. head mouse, eye gaze etc.): _____

Keyboard: _____

Other(s): _____

Mounts Needed (if applicable):

Table Mount: _____

Floor Mount: _____

Wheelchair/Power Wheelchair Mount*: _____

*If selected, please list make, model, and serial numbers of wheelchair:

Make: _____

Model: _____

Serial Number: _____

Patient Name:_____

Signature Page

SLP Signature

As the evaluation therapist, I hereby attest that I have personally completed this evaluation and that I am not an employee of, or working under contract to, the manufacturer(s) of the equipment recommended in my evaluation. I further attest that I have not and will not receive remuneration of any kind from the manufacturer(s) or the provider(s) for the equipment that I have recommended in this evaluation.

CCC-SLP Signature: _____

Date: _____

CCC-SLP Name (printed): _____

CCC-SLP NPI Number: _____

CCC-SLP License Number: _____

CF-SLP Signature (if applicable): _____

Date: _____

CF-SLP Name (printed): _____

Physician Signature

I have reviewed and agree with the findings in this evaluation as to the recommended equipment and so order the equipment.

Physician Signature: _____

Date: _____

Physician Name (Printed): _____

Physician NPI Number: _____