Speech Evaluation Form

I. Demographic Information

Patient Name: Client Advocate:

Address: Phone #:

DOB: Medicare/Medicaid ID#:

Primary Diagnosis: ICD-9: Onset:

Secondary Diagnosis: ICD-9: Onset:

Speech Language Pathologist Name: Phone #:

Address: Email Address

Date of Evaluation:

Physician Name and Address:

Phone #: Fax #

NPI# License #

II. Current Communication Impairment

A. General Statement of Patient's condition-diagnosis: List medications, if applicable

____

____

____

1. **Type of Communication impairment**: Check all that applies

Dysarthria	
Aphasia	
Apraxia	
Aphonia	

2. **Severity of impairment**: List impairment checked above with the corresponding severity.

Mild	
Mild-Moderate	
Moderate	
Moderate-Severe	
Severe	

3. **Anticipated Course of Impairment**: Check which applies

No detectible Speech Disorder	
Obvious Speech Disorder, intelligble	
Reduction in speech intelligibly	
Natural Speech supplemeted with SGD's	
No useful Speech (SGD only)	
Loss of Speech	

B. **Comprehensive Assessment**

1. **Hearing Status**

Does the patient possess the hearing ability to effectively use a SGD to communicate functionally? Yes ________ No________

Does the client use a hearing aid? Yes_______ No________

2. **Vision Status**

Does the patient possess the visual ability to effectively use SGD to communicate effectively? Yes_______ No_______

Does the client wear prescribed eyeglasses? Yes_______ No________

3. **Physical Status**

Does the patient possess the physical ability to effectively use a SGD and required accessories to communicate? Yes _______ No _______

	Comments
Motor Skills	
Ambulatory Status	
Direct Selection	
Scanning	

4. **Language Skills**

Linguistic Impairment Severity: Check which applies

Mild
Mild-Moderate
Moderate
Moderate-Severe
Severe

Assessment tools/tests used in evaluation:

Assessment test	
Evaluation	

Current communication ability: Check which applies

Sign Language	
Gestures	
Pictures	
Words	
Writing/Spelling	
Verbal Speech	

Additional Comments: ____

____

____

5. **Cognitive Ability**

Impairment Level: Check which applies

No Impairment	
Mild Impairment	
Moderate Impairment	
Significant Impairment	

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Abilities with an SGD: Check which applies

	Poor	Fair	Good	Excellent
Memory				
Attention				
Problem Solving Skills				

Comments:____
____

III. Daily Communication Needs

1. Specific Communication Needs:

a. Client interacts daily with: Check all that applies

Family ___________
Caretaker ___________
Health Care Professionals ___________
Community ___________

b. Clients needs: Check which applies

Request Emergency Aid ____________
Obtain Medical Care ____________
Advocate for him/herself ___________
Express pain/reaction to medication ___________
Express hunger/thirst ___________
Express likes/dislikes ___________

Additional Needs: ____
____
____

2. **Ability to meet communication needs with Non-SGD treatment**:

a. Speech Therapy
Date Began ______________ Date Ended:____________

Current Prognosis without a SGD: Check which applies

Poor ______
Fair ______
Good ______
Excellent ______

Future Prognosis without a SGD: Check which applies

Poor ______
Fair ______
Good ______
Excellent ______

b. Low Tech Strategies used during therapy sessions:
____
____
____

Results of Low Tech Strategies: Check which applies

Poor ______
Fair ______
Good ______
Excellent ______

Can the patients daily communication needs be met by low tech AAC or no-tech AAC technique? Yes _______ No________

IV. Functional Communication Goals: Level of communicative independence the patient is expected to achieve outside the therapeutic environment with an SGD.

Check all that apply:

_____ Client will independently communicate physical needs and emotional status to immediate family/caretaker on daily basis, as needed.

Expected length of time to achieve goal: Circle which applies
Immediate **Short Term** **Long Term**

_____ Client will describe her physical symptoms and ask any questions when interacting with his/her physician and other health care professionals.

Expected length of time to achieve goal: Circle which applies
Immediate **Short Term** **Long Term**

_____ Client will engage in social communication exchanges with immediate family and extended members in person and by use of the telephone.

Expected length of time to achieve goal: Circle which applies
Immediate **Short Term** **Long Term**

_____ Client will engage in social communication exchanges with friends at home and in other community settings.

Expected length of time to achieve goal: Circle which applies
Immediate **Short Term** **Long Term**

_____ Client will engage in decision making of his/her own personal affairs.

Expected length of time to achieve goal: Circle which applies
Immediate **Short Term** **Long Term**

V. Rationale for Device Selection

A. General Features of recommended SGD and accessories:

Input/output features

1. **Direct Selection**: Check all that apply to client

_______Keyboard access ability
_______ Touchscreen
_______Other, Please Specify
____
____

2. **Scanning**:

A. Switch Access Capability:

_____Single _____Double _____Other, please specify

Comments: ____
____
____

B. Method:

______ Linear ______ Row-Column ______Group

______ Other, Please specify

Comments: ____
____
____

C. Ques:

_______ Auditory _______Visual

Comments: ____
____
____

3. **Symbols**

_______Pictures ______Words/Phrases

_____Other, Please Specify

Comments: ____
____
____

4. **Other Features**

a**.** Portability Access: Check which applies

Carrying Case ________
Wheelchair Mounting:__________
(Please provide name and manufacturer of wheelchair)

b. Battery time required-*If Medicare is a payer, please use ABN form*

Long life ______
Additional Battery_____

c. Misc. *Please list all that are necessary-If Medicare is a payer please use ABN form*
Example: Environmental Control, Additional RAM, additional switch, additional mount or mount pieces, larger screen size, etc.

____
____
____

B. Recommended Device and Accessories

The client's ability to meet daily communication needs will benefit from an acquisition and use of the HCPCS category:

______ E2500= Speech Generating Device, digitized speech, suing pre-recorded messages, less than or equal to 8 minutes recording time. *Mini Message Mate*

______E2502= Speech generating Device, digitized speech, using pre-recorded messages, greater than 8 minutes but less than or equal to 20 minutes recording time. *Message Mate's*

______E2504= Speech generating device, digitized speech, using pre-recorded messages greater than 20 minutes but less than or equal to 40 minutes recording time.

______ E2506=Speech Generating device, digitized speech, using pre-recorded messages, greater than 40 minutes recording time.

______ E2508= Speech generating device, synthesized speech requiring message formulation by spelling and access by physical contact with the device. *Say-it! SAM Communicator V2*

_______E2510=Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access. *Freedom SGD, Say-it! Sam Tablet XP1 or SM1, Conversa, Freedom Lite Convertible, Freedom Lite*

_______Other please describe:________________________________
____

C. Trials with SGD's

Device #1
Name of Device:
Features:
Client Success: circle all that apply

Poor *Difficult* *Good* *Easy*

Explain: ____
____

Device #2
Name of Device:
Features:
Client Success: circle all that apply

Poor *Difficult* *Good* *Easy*

Explain: ____
____

Device #3
Name of Device:
Features:
Client Success: circle all that apply

Poor *Difficult* *Good* *Easy*

Explain: ____
____

D. Specific Recommended Device

A. (Reference quote provided by Sales Representative, if applicable)

Name of Device:

Accessories:

Vendor:

E. Patient and Family Support of SGD

Please identify if the client and family members/caretakers are motivated and agree with the device selected.

____
____
____
____

F. Physician Involvement

A copy of this report was forwarded to the clients treating physician and he/she will generate a prescription for the recommended device and accessories.

VI. Treatment Plan

- The client will receive 4 hours of training with the local sales representative.
- The client will receive _______ therapy sessions with the Speech Language Pathologist once they receive the device.

VII. Signatures/SLP Assurance

The Speech Language Pathologist performing this evaluation is not an employee of and does not have a financial relationship with the manufacturer/supplier of the device.

____
SLP Name

ASHA #
State License #