Communication Technology Resources, LLC
1 Scenic Drive - Unit 1405
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Phone: (732) 737-4298
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PEDIATRIC AAC EVALUATION INTAKE FORM

*Please attach most recent copies of **speech-language, OT and educational reports** and current **IEP**
(Note: An appointment will not be scheduled until all support material is received.)

I. GENERAL INFORMATION

- Referring School or Agency: ______________________________
- Address: ______________________________
- Scheduling Contact Person: ______________________________Today's Date: _________
- Phone Number: ____________________ E-Mail: ____________________
- Indicate the questions you would like to have addressed during this meeting __________________

  ____

II. STUDENT INFORMATION

- Child's Name: ______________________________Date of Birth: _______________
- Medical Diagnosis: _________________ Educational Classification _________________Sex: ___
- Parent/Guardian's Name: (Last) ____________________ (First) _______________
- Address: ______________________________
- Home Phone: ________________ Cell Phone: ________________E-Mail: ________________
- Physician's Name/ Address: ______________________________

III. PRESENT EDUCATIONAL PLACEMENT

- School/Facility**:** ______________________________
- Address: ______________________________
- City: ____________________ State: ____________________ Zip: ________________
- Case Manager: ____________________Phone: ______________ E-Mail:_______________

IV. COMMUNICATION INFORMATION

- Please estimate the percentage of time the student/client demonstrates the following skills:

a. Responds to speakers ________%

b. Understands what is said to him/her ________% **Recep. Vocab. Age Score** ________

c. Follows simple directions ________%

	w/ Familiar Listeners	w/ Unfamiliar Listeners
d. Makes needs and wants known	________%	________%
e. Initiates communication	________%	________%
f. Speaks in words	________%	________%
g. Makes sounds	________%	________%
h. Uses own gestures to communicate	________%	________%
i. Uses facial expression or body language	________%	________%
j. Uses PECS	________%	________%
k. Uses a manual communication board	________%	________%
l. Uses a voice-output device	________%	________%

- If student/client uses a voice output device, specify device name and when device was acquired:

  ____

- Does the student/client have a functional yes/no for acceptance/ negation? _____**Yes**____ **No**
- Can the student/ client use yes/no to answer open-ended questions? (i.e. Did your mom drive you to school today? Do you put milk in your coffee?)

  ___________**Yes**___________**No**___________**Inconsistent**

- What is the student/client's primary mode of communication? ______________________________
- Is the student/client aware of his/her speech limitations? __________________________________
- How does the student/client indicate that he/she wants to communicate? ___________________
- What are the current therapy goals for the student/client? _________________________________
- What are the most important communication needs at home? _____________________________
- What are the most important communication needs in the school/vocational setting? ___________

  ____

- Can the student/client recognize: (Check all that apply)

  _____ Objects ______ Photos ______Pictures _____ Line Drawings

- Is the student/client able to read? ______ **Yes** ____**No** **Estimated Grade Level** ___________
- Is the student/client able to spell? ______**Yes** ____**No** **Estimated Grade Level** ___________

V. PHYSICAL/MEDICAL

- Speech Diagnosis: ____
- Onset of medical condition/ diagnosis: ________________________________
- Seizures (type/frequency): _______________________________________
- Current Medications: ____
- Adaptive equipment (e.g., splints, switches, lap tray): ___________________

  ____
- Does the he/ she use a wheelchair? ___Yes ___No Type: _________________
- Is motor function of upper extremities adequate to consistently and reliably:

  ______write ______sign/gesture ______point _______activate a switch ?
- Is vision normal? ______Yes _____No (Attach vision eval. reports) __________Not Known
- Is hearing normal? _____Yes _____No (Attach audiological reports) _________ Not Known
- Describe any other significant problems: ___________________________

VI. BEHAVIORAL CHARACTERISTICS

	Adequate	Inadequate
a. Attention	_______	_______
b. Frustration Tolerance	_______	_______
c. Impulse Control	_______	_______

- Describe other behaviors that may interfere with learning? __________________

  ____
- Estimate attending skills for structured tasks: _________________________

  ____

VII. ENVIRONMENTAL INFORMATION

- Who is requesting use of AAC techniques? _________ Family ________School ________Other

  (specify) ____

VIII. SUPPORT MATERIAL

- If the student/client is **non-ambulatory, please include a photograph** of the individual in his/her seating system to assist us in determining access needs.
- If referring agency or family feels that the **student/client's** performance during the session would not reflect actual abilities, you may include a brief video with this packet.

IX. FUNDING SOURCE

_________Self- Pay _______ School District

PERSON/AGENCY RESPONSIBLE FOR PROCESSING PAYMENT:

- Name: ____________________
- Title: ____________________
- Address: ____________________
- : ____________________
- City: ____________ State: ____________ Zip: ____________
- Phone: ____________ E-Mail:____________

X. APPOINTMENT INFORMATION

a. **Participants planning to attend this appointment: (parents, Therapist, CST, Teacher)**
Name(s) and relationship:

____

____

____

c. **For off-site evaluations:**

School Name ____________________
School Address ____________________
City ____________State ____________ Zip ____________
Office Phone ____________________

XI. Please send completed packet and support material to:

Joan Bruno, Ph.D., CCC-SLP
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