AAC Evaluation for a SGD

Date of Evaluation:
Date of Report:

Client Information

Name:	Medicaid ID #:
Address:	Medicare ID #:
Phone:	Insurance Policy #:
Place of Residence: Home	Licensed SLP:
Date of Birth:	Medical Diagnosis:
Age:	Medical Diagnosis Onset:
Gender:	Speech Diagnosis:
Physician Referral:	Speech Diagnosis Onset:

Background Information

Family/ Social background

Summary of patient's pertinent medical history, speech language skills, speech intelligibility and current communication system

Measure of speech intelligibility

Anticipated Course of Impairment – length of impairment, current course, anticipated future course, prognosis for speech production.

Include this statement at the end: Given the severity of the communication impairment as described above, XXXX 's speech does not meet his daily communication needs.

Language Skills and Abilities

Formal tests (if any) that have been used, and results.

Information on receptive language

Information on expressive language

Information on pragmatic language

Level of reading/ writing skills

Cognitive Abilities

Level of impairment in cognitive functioning, including attention, memory and problem solving skills.

Statement of how long AAC (in any form) has been trialed.

Include this statement: XXXX demonstrates the necessary cognitive abilities (attention, memory and problem solving skills) to learn to use an SGD to achieve functional communication goals.

Physical Abilities

Statement of fine motor abilities.

> *Indicate how the client will access the device – be as specific as you can.*
>
> *Indicate whether the client's positioning will affect use of the device.*

Mobility information

> *Indicate whether client is ambulatory, and if not, what type of mobility assistance is required.*
>
> *Indicate whether a wheelchair mount will be required (if so, indicate make/ model of wheelchair)*
>
> *Indicate how the client will transport the device.*

Include this statement: Given the above modifications/considerations, XXXX possesses the physical abilities to effectively use an SGD with the required accessories to communicate.

Hearing and Visual Status

Indicate any hearing/ vision concerns, and what (if any) modifications are required to the SGD based on these concerns.

Daily Communication Needs

Indicate WHO the client needs to communicate with, WHERE the client needs to communicate, and WHAT TYPES of messages the client needs to be able to convey (e.g., express physical needs/ wants, express feelings, protest, etc)

Explain why the client's communication needs cannot be met with natural speech or a low-tech approach. Justify why an SGD is required.

Rationale for Device Selection

Input/ Output Features

State access method required (input)

State output features that are required (e.g, synthesized/ digitized speech, auditory feedback, display size)

Language Characteristics

Describe how the client will generate language (single meaning pictures, sequencing icons, words, letters, combination, etc.)

Device Features

State other device features that will be necessary for success – e.g., ability to program easily, provide rate acceleration techniques, vocabulary builder, icon tutor, etc. Justify each feature.

Additional Features and Accessories

List all other items, other than the actual device, that are being requested. For example, keyguards, mount, access method, etc.

SGD Assessment or Trial and CPT Codes

Describe all devices that were trialed, and a statement of the trial outcome. Description should include what vocabulary set up was used, what access method was used, and client level of success. Indicate the CPT code of all devices (e.g., E2510)

Explain why the recommended SGD was selected.

Recommended Speech Generating Device and Accessories

State the final recommendation of every component of the recommendation. Include the SGD (CPT code = E2510), any accessories including (CPT code = E2599) and any wheelchair mount (CPT code = E2512)

Functional Communication Goals

List short and long term goals for the client, and estimated times for completion following receipt of the SGD.

Support, Treatment Plan and Signature

Client/Family Support of the Speech Generating Device

Include this statement: XXXX 's (family member) was present and/or are supportive of the necessity of the SGD for meeting his communication needs.

Physician Involvement Statement

Include this statement: This report was forwarded to the treating physician, (insert MD name address and phone here) The physician was asked to write a prescription for the recommended equipment.

Treatment Plan

State the treatment plan upon receipt of the SGD – how many sessions needed to address functional communication goals, and whether it will occur in an individual or group session.

SLP Assurance of Financial Independence and Signature

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

Evaluating SLP Name:
ASHA Certification:
State License Number:

Speech Language Pathologist (SLP) Signature *Date*