West Tennessee Hearing & Speech Center

Non-profit service since 1953

Augmentative Communication Evaluation
Preliminary Questionnaire

Thank you for choosing West Tennessee Hearing and Speech Center's program for Augmentative & Alternative Communication (AAC) services.

Please read through the attached forms, gather any information you will need to answer the questions, and complete the forms to the best of your ability. Your answers will help our speech language pathologist have necessary information to assist the patient and best understand and address concerns prior to receiving services.

Services will not be scheduled until the form is completed in its entirety and returned. Best estimates are helpful even if you do not have specific information. A doctor's order from the patient's primary physician for "AAC evaluation and treat" is also required.

Please submit your completed forms by fax to 731-668-7033 or by mail to WTHSC, Attn: AAC, 65 Ridgecrest Road, Jackson, TN 38305. Once all pieces are submitted, the patient's doctor's office will notify you of the scheduled AAC evaluation, and WTHSC staff will provide a reminder call prior to the date of evaluation. Please call our office with any questions you may have at 731-668-6076.

Thank you,

West Tennessee Hearing and Speech Staff

• 65 Ridgecrest Road • Jackson, Tennessee 38305 • Telephone: (731) 668-6076 • Fax: (731) 668-7033 • www.wthsc.com •

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Preliminary Questionnaire

To help us serve you better, please complete this form and return it according to the directions listed on pg 1. Your AAC Evaluation will be scheduled when the completed questionnaire is returned and we have received a doctor's order. If you have any questions, contact us at 731-668-6076. ***Thank you!***

Today's Date: _____
Patient Name: _____
Date of Birth: _____
Address: _____
_____
_____
Primary Physician: _____

Your Name: _____
Relationship to Patient: _____
Patient Age: _____
Phone Numbers – Please circle best number to use
Home Phone: _____
Cell Phone: _____
Work Phone: _____

Email Address: _____
Who referred you to our clinic? _____
Does the patient currently have an AAC device? If yes, please indicate the name of the device and when it was purchased. _____

MEDICAL HISTORY

Diagnosis: _____

Pertinent History – Please check all that apply and list date of onset

Seizures		Scoliosis	
Spasticity		Chronic ear infections	
Respiratory difficulties		Weakness/paralysis	
Visual impairment		Hearing impairment	
Other: please list			

Medications – Please list any medications the patient takes

Medication	**Reason**

Surgical History

Surgery	**Date**

Is the patient scheduled to have any surgeries in the next year? _____
If yes, please list type of surgery, date of surgery, and where the surgery will occur: _____
_____

What are your goals for this evaluation?
Immediate goal: _____

_____

Long term goal: _____

_____

Has the patient been seen prior to this evaluation to address any of the above goals? If so, please state by whom and when. Please include reports if available. _____

_____

ACADEMIC HISTORY

Name of School: _____
Current Grade: _____
Name of teacher: _____ Name of school SLP: _____

Type of Educational Program – Please Circle all that apply and provide any additional information in the space provided:

Regular *Special Education* *Autism* *Multiple Disability* *LD* *Other (describe below)*

_____

_____

Does the patient receive the following services:

Service:	**Yes/No**	**Location**
Speech/Language Therapy		
Occupational Therapy		
Physical Therapy		
Applied Behavior Analysis		
Psychology		
Counseling		
Other (please describe below)		

_____

_____

_____

FINE MOTOR

If the patient is able to write, please indicate the primary means below (circle one):

Computer *Pen/Pencil* *Dictation* *N/A*

How easy is it to read the patient's handwriting (circle one)?

Legible *Most words legible* *Most words not legible* *Not legible* *N/A*

If using a pen/pencil, how long can he/she write before becoming tired? _____

Does the patient use any switches to control music, toys, say messages? *Yes* or *No* – Please describe: _____

_____

_____

_____

COMMUNICATION

Are the patient's communication methods understood by:

Family	**Familiar communication partners?**	**Unfamiliar Communication Partners**
___ all the time	___ all the time	___ all the time
___ most of the time	___ most of the time	___ most of the time
___ some of the time	___ some of the time	___ some of the time
___ rarely	___ rarely	___ rarely
___ never	___ never	___ never

Is the patient frustrated with his/her present method of communication? Please describe: _____

_____

_____

Have the patient's social contacts been limited because communication is difficult? Please describe: _____

_____

_____

Does the patient follow simple directions? _____
Does he/she answer yes/no questions? _____
Can he/she identify pictures? _____
Can he/she read words? _____
Can he/she read sentences? _____
Does he/she spell words? _____
Does he/she put more than one word, symbol, or sign together to express an idea? Please list examples: _____

_____

Please describe the communication problem fully. You may continue your description at the end of the packet.

_____

_____

_____

_____

Please circle the settings in which the patient needs to have a more effective means of communication:

Home *School* *Playground* *Car* *Bus* *With Friends* *Stores* *Restaurants*
Other: _____

COMPUTER/TECHNOLOGY EXPERIENCE

Does the patient have any computer/tablet experience (iPad, Kindle Fire, smart phone etc…)? If no, please go to the next section. _____

_____

_____

_____

Where does the patient use this technology? _____

_____

If the patient cannot use a keyboard or mouse, please describe the assistive technology she/he uses to access a computer. _____

_____

What types of computers/tablet devices does the patient have access to at home or school/work? _____

_____

_____

Please list any software or apps being used: _____

_____

_____

List anyone in the home/family with background experience using computers/tablet devices: _____

_____

FUNCTIONAL MOBILITY

Please answer the following questions and provide any additional comments that you feel are important for us to know.

Can the patient hold up his/her head independently?	
Does the patient sit upright without support?	
Can the patient reach forward / right / left?	
Can the patient grab an object?	
Can the patient point with his/her finger?	
Does the patient use a hand or arm splint? If yes, please bring to the evaluation.	
Can the patient tap his/her foot?	
Is the patient independent in his/her mobility?	
Does the patient use a walker or similar device (please specify)?	

If the patient does **not** use a wheelchair, please proceed to the next section. If he/she **does** use a wheelchair, please answer the following questions:

Does he/she use a manual or power wheelchair?	
If a power wheelchair is used how does he/she operate the wheelchair (joystick, switches etc…)	
How many hours per day does he/she spend in the wheelchair?	
How much assistance does the patient require to navigate the wheelchair?	
Does the wheelchair have a lap tray?	

HEARING AND VISION

Does the patient hear speech well?	
Indicate the patient's last hearing evaluation or screening? Did the patient pass or fail? Where tested?	
Does the patient wear a hearing aid? If yes, which ears? Please bring them to the evaluation.	
Does the patient have any vision problems? Please describe.	
Does the patient wear glasses? If yes, when was the last exam? Where tested? Please bring the glasses to the evaluation.	
Can the patient follow an object with his/her eyes?	

PLAY/LEISURE

What time does he/she usually nap, if needed? _____
What kind of toys/hobbies does he/she enjoy? _____

How does he/she operate these toys? _____

What types of books does he/she enjoy? Please list some titles. _____

What type of music does the patient enjoy? _____

List any favorite movies, TV shows, DVDs: _____

How does he/she control TV, lights, music player? _____

Please list subjects/topics he/she likes to discuss (such as pets, friends, favorite toys/TV shows/video games):

What types of things does the patient especially **like** (i.e. games, activities, foods, etc…)? _____

What types of things does the patient especially **dislike** (i.e. games, activities, foods, etc…)? _____

FUNDING/INSURANCE INFORMATION

If AAC equipment/devices are recommended, what funding sources are available that may assist with purchasing this equipment? Check all that apply:

Medicaid ____
Medicare ____ Type: _____
Private Insurance (please list insurance company): _____

Please provide a clear copy of the patient's insurance card (front and back).

Thank you so much for taking the time to share this information with us. We look forward to speaking with you in the near future to discuss the patient's evaluation at our clinic. Please use the space below if there is any other information you feel would be helpful for us to know about the patient.

Reminder:
If the patient has completed any previous evaluations (psychology, speech therapy, physical therapy, occupational therapy, etc.), please attach the most recent evaluation report for each discipline. If you do not have a copy, please request one from the original provider. This will be very helpful with understanding the patient's full profile.