

CHILD AUGMENTATIVE AND ALTERNATIVE COMMUNICATION (AAC) EVALUATION APPLICATION

Please provide the following information in addition to the Kay Armstrong Center for Communication Disorders Child Speech and Language Evaluation Application.

Child's Name:
Date of Birth:

Medical Diagnosis:	Speech or language diagnosis if known:
	<input type="checkbox"/> dysarthria <input type="checkbox"/> apraxia/dyspraxia <input type="checkbox"/> aphonic (without voice)
	<input type="checkbox"/> expressive aphasia <input type="checkbox"/> phonological delay <input type="checkbox"/> receptive-expressive language delay

EDUCATION:

Grade: _____	Class type:
	<input type="checkbox"/> full inclusion <input type="checkbox"/> resource <input type="checkbox"/> mild-moderate special day class
	<input type="checkbox"/> moderate-severe special day class <input type="checkbox"/> orthopedically handicapped class <input type="checkbox"/> other: _____
If in a special day class: _____ % of day spent in mainstream class.	

COMMUNICATION:

How does your child communicate wants, needs, and ideas?	
<input type="checkbox"/> gestures <input type="checkbox"/> sign language <input type="checkbox"/> eye gaze	<input type="checkbox"/> facial expressions <input type="checkbox"/> vocalizations (non-words) <input type="checkbox"/> unintelligible or partially intelligible speech _____% understood by parents _____% understood by unfamiliar people
How does your child indicate "yes" and "no"?	
Additional information about how your child communicates needs, wants, and ideas:	
Where does your child regularly communicate?	With whom does your child regularly communicate?
<input type="checkbox"/> home <input type="checkbox"/> school <input type="checkbox"/> daycare/afterschool care <input type="checkbox"/> community (stores, restaurants, parks, etc.) <input type="checkbox"/> therapies <input type="checkbox"/> medical offices <input type="checkbox"/> extracurricular activities: _____ _____	<input type="checkbox"/> parents <input type="checkbox"/> siblings <input type="checkbox"/> grandparents <input type="checkbox"/> other family members <input type="checkbox"/> teachers & aides <input type="checkbox"/> peers/students <input type="checkbox"/> caretakers <input type="checkbox"/> health professionals <input type="checkbox"/> therapists <input type="checkbox"/> other: _____ _____

AUGMENTATIVE COMMUNICATION EXPERIENCE

Describe AAC systems which your child has tried in the past or is currently using including icons, communication books, voice output or communication devices:

1. Problems or limitations:

2. Problems or limitations:

3. Problems or limitations:

Describe your child’s experience with electronics (iPad, computer, electronic games) for communication or other purposes:

MOTOR ABILITIES:

Gross motor skills:

- Walks unassisted
- Walks with assistance
- Uses walker
- Requires wheelchair to be pushed
- Pushes manual wheelchair independently
- Operates electric wheelchair

Fine motor access:

- Can point with one finger to pictures/objects
- Points with multiple fingers or hand
- Cannot use hands to point
- Can activate a single switch

Most reliable body part to activate a device or switch:

Dominant side/hand:

- right
- left
- unknown

Can your child move their head up-down and right-left? Yes No

Additional information about motor skills:

SENSORY SYSTEM:

Please describe impairments and provide requirements or recommendations (e.g. large print, high contrast, reduced background noise, increased volume, sensory diets, etc.):

Visual impairment:

Hearing impairment:

Tactile deficits/aversions/seeking:

Sensory processing difficulties:

ATTENTION AND BEHAVIOR:

Describe any attention or distractibility difficulties:

Describe any behavioral challenges:

How long does it take for your child to respond to a familiar question? _____ seconds

How long does it take for your child to respond to a new direction? _____seconds

Suggestions to promote best attention and behavior:

Please provide some of your child's favorite activities or interests:

What do you hope Augmentative and Alternative Communication or a communication device will provide?

Please provide any of the following which apply to your child with the application:

- Most recent speech and language assessment
- Most recent occupational therapy (OT) assessment
- Most recent physical therapy (PT) assessment
- Most recent triennial IEP and/or annual IEP documents
- Vision assessments
- Hearing assessments
- Any other information which may aid in selecting appropriate augmentative communication