

I. General Consumer Background Information

A) Current therapy services (✓ all that apply):

Occupational Speech Hearing Physical Vision Music

Other: _____

B) Medical History & Background Information

Medical diagnosis:

Speech diagnosis:

Seizure history:

Medications:

Surgeries:

Date of last Hospitalization:

Age of onset:

Other pertinent medical information:

2. What areas need to be addressed during the assessment (✓ all that apply)

voice output written output mounting alternate access

manual communication board AAC-environmental control

AAC-computer access telephone use

other: _____

3. Do you have any assistive technology that will need to be used in conjunction with the communication device (i.e. wheelchair, computer)?

4. List any AAC trialed to date and briefly discuss the results. Include: gestures, sign language, manual communication boards and eye gaze methods, as well as switches, speech output devices, and computers.

Approximate Date

System Used

Results

E.) Recreational Information

1. Please list motivating items and activities that can be used during evaluation.

II. Positioning and Mobility

A) Mobility

If ambulatory:

- Walks independently
- Walks with difficulty (weak, poor balance, unable to carry 4lb object)
- Independently mobile with walking aides (walker, cane, crutches)
- Depends on others for mobility

Describe: _____

If wheelchair user:

- Uses a power wheelchair independently
- Learning to use a power wheelchair
- Considering power wheelchair use
- Has tried a power wheelchair
- Uses a manual wheelchair for long distances
- Uses a manual wheelchair for short distances
- Learning to propel a manual wheelchair
- Requires another person to push wheelchair

Describe: _____

B) Current Positioning

Describe the specific type of wheelchair used:

III. Motor Skills/ Access

A) Consumer usual means of pointing:

- Left hand
- Right Hand
- Single digit
- Eye
- Head
- Foot
- Other: _____

B) Consumers writing/typing abilities:

- Fatigues easily
- Difficulty holding pen
- Writing illegible
- Other: _____

Writing or typing is considered:

- Functional
- Not functional to meet needs

IV. Alternate Access

Type of alternate access method tried:

- Eye Gaze System Head Mouse Head pointer Switches

Specific name/type of access method used :

V. Functional Vision

- passed vision screening wears glasses, vision corrected
 visually impaired

Describe: _____

VI. Acuity-Auditory Comprehension

- passed hearing screening needs amplification hearing impaired

Describe: _____

VII. Current Communication Skills

A) Receptive Language Skills

During an activity does the consumer show understanding of:

- nouns verbs pronouns adjectives words, phrases
 complete sentences 1 step directions 2 step directions
 3 + step directions

B) Expressive Language Skills

- Vocalizations semi-intelligible speech yes/no words/phrases
 Complete sentences full messages

C) Communication Interaction Skills

- communicates with peers aware of partners attention asks questions
 repairs communication breakdown initiates communication

VIII. Symbol System

A) Representation

AAC Systems include vocabulary represented by a variety of symbols from real objects to the written word. Has the consumer used symbolic communication?

tried successfully tried unsuccessfully has not been tried

Describe symbols/symbol system used:

Does the individual have literacy skills? Approximate reading level _____

IX. Other considerations

Please list any other goals, concerns, preferences, or information you feel would be helpful to the assistive technology assessment team and were not addressed in the *Background Information Form*:

X. Permission

In order to ensure an effective assessment it may be helpful for UCP SD-ATC staff to videotape and/or take pictures of the consumer, which can be later reviewed by the team. The information gained may also be useful in training others in the use of assistive technology. Please check any of the following you authorize and sign below:

A) Permission for Assessment Purposes

You have my permission to

- Photograph
- Video

_____ for review by the assessment team.
(Name)

B) Permission for training purposes

You have my permission to

- Use photographs taken of
- Use video taken of

_____ for training purposes.
(Name)

C) Denial of Permission

- I do not authorize the use of pictures or video for any use by UCP SD-ATC.

D) Signature

X _____ X _____
Consumer signature Parent/legal guardian signature
(if applicable)