

Speech Evaluation Form

I. **Demographic Information**

Patient Name:

Client Advocate:

Address:

Phone #:

DOB:

Medicare/Medicaid ID#:

Primary Diagnosis:

ICD-9:

Onset:

Secondary Diagnosis:

ICD-9:

Onset:

Speech Language Pathologist Name:

Phone #:

Address:

Email Address

Date of Evaluation:

Physician Name and Address:

Phone #:

Fax #

NPI#

License #

II. **Current Communication Impairment**

A. General Statement of Patient's condition-diagnosis: List medications, if applicable

1. **Type of Communication impairment:** Check all that applies

Dysarthria	
Aphasia	
Apraxia	
Aphonia	

2. **Severity of impairment:** List impairment checked above with the corresponding severity.

Mild	
Mild-Moderate	
Moderate	
Moderate-Severe	
Severe	

3. **Anticipated Course of Impairment:** Check which applies

No detectible Speech Disorder	
Obvious Speech Disorder, intelligible	
Reduction in speech intelligibly	
Natural Speech supplemented with SGD's	
No useful Speech (SGD only)	
Loss of Speech	

B. Comprehensive Assessment

1. **Hearing Status**

Does the patient possess the hearing ability to effectively use a SGD to communicate functionally? Yes _____ No _____

Does the client use a hearing aid? Yes _____ No _____

2. **Vision Status**

Does the patient possess the visual ability to effectively use SGD to communicate effectively? Yes _____ No _____

Does the client wear prescribed eyeglasses? Yes _____ No _____

3. **Physical Status**

Does the patient possess the physical ability to effectively use a SGD and required accessories to communicate? Yes _____ No _____

	Comments
Motor Skills	
Ambulatory Status	
Direct Selection	
Scanning	

4. Language Skills

Linguistic Impairment Severity: Check which applies

Mild	
Mild-Moderate	
Moderate	
Moderate-Severe	
Severe	

Assessment tools/tests used in evaluation:

Assessment test	
Evaluation	

Current communication ability: Check which applies

Sign Language	
Gestures	
Pictures	
Words	
Writing/Spelling	
Verbal Speech	

Additional Comments: _____

5. Cognitive Ability

Impairment Level: Check which applies

No Impairment	
Mild Impairment	
Moderate Impairment	
Significant Impairment	

Abilities with an SGD: Check which applies

	Poor	Fair	Good	Excellent
Memory				
Attention				
Problem Solving Skills				

Comments: _____

III. Daily Communication Needs

1. Specific Communication Needs:

a. Client interacts daily with: Check all that applies

- Family _____
- Caretaker _____
- Health Care Professionals _____
- Community _____

b. Clients needs: Check which applies

- Request Emergency Aid _____
- Obtain Medical Care _____
- Advocate for him/herself _____
- Express pain/reaction to medication _____
- Express hunger/thirst _____
- Express likes/dislikes _____

Additional Needs: _____

2. Ability to meet communication needs with Non-SGD treatment:

a. Speech Therapy

Date Began _____ Date Ended: _____

Current Prognosis without a SGD: Check which applies

- Poor _____
- Fair _____
- Good _____
- Excellent _____

Future Prognosis without a SGD: Check which applies

- Poor _____
- Fair _____
- Good _____
- Excellent _____

b. Low Tech Strategies used during therapy sessions:

Results of Low Tech Strategies: Check which applies

- Poor _____
- Fair _____
- Good _____
- Excellent _____

Can the patients daily communication needs be met by low tech AAC or no-tech AAC technique? Yes _____ No _____

IV. Functional Communication Goals: Level of communicative independence the patient is expected to achieve outside the therapeutic environment with an SGD.

Check all that apply:

_____ Client will independently communicate physical needs and emotional status to immediate family/caretaker on daily basis, as needed.

Expected length of time to achieve goal: Circle which applies

Immediate Short Term Long Term

_____ Client will describe her physical symptoms and ask any questions when interacting with his/her physician and other health care professionals.

Expected length of time to achieve goal: Circle which applies

Immediate Short Term Long Term

_____ Client will engage in social communication exchanges with immediate family and extended members in person and by use of the telephone.

Expected length of time to achieve goal: Circle which applies

Immediate Short Term Long Term

_____ Client will engage in social communication exchanges with friends at home and in other community settings.

Expected length of time to achieve goal: Circle which applies

Immediate Short Term Long Term

_____ Client will engage in decision making of his/her own personal affairs.

Expected length of time to achieve goal: Circle which applies

Immediate Short Term Long Term

V. Rationale for Device Selection

A. General Features of recommended SGD and accessories:

Input/output features

1. **Direct Selection:** Check all that apply to client

_____ Keyboard access ability

_____ Touchscreen

_____ Other, Please Specify

2. **Scanning:**

A. Switch Access Capability:

_____ Single _____ Double _____ Other, please specify

Comments: _____

B. Method:

_____ Linear _____ Row-Column _____ Group

_____ Other, Please specify

Comments: _____

C. Ques:

_____ Auditory _____ Visual

Comments: _____

3. Symbols

_____ Pictures _____ Words/Phrases

_____ Other, Please Specify

Comments: _____

4. Other Features

a. Portability Access: Check which applies

Carrying Case _____

Wheelchair Mounting: _____

(Please provide name and manufacturer of wheelchair)

b. Battery time required-*If Medicare is a payer, please use ABN form*

Long life _____

Additional Battery _____

c. Misc. *Please list all that are necessary-If Medicare is a payer please use ABN form*

Example: Environmental Control, Additional RAM, additional switch, additional mount or mount pieces, larger screen size, etc.

B. Recommended Device and Accessories

The client's ability to meet daily communication needs will benefit from an acquisition and use of the HCPCS category:

_____ E2500= Speech Generating Device, digitized speech, using pre-recorded messages, less than or equal to 8 minutes recording time. *Mini Message Mate*

_____ E2502= Speech generating Device, digitized speech, using pre-recorded messages, greater than 8 minutes but less than or equal to 20 minutes recording time. *Message Mate's*

_____ E2504= Speech generating device, digitized speech, using pre-recorded messages greater than 20 minutes but less than or equal to 40 minutes recording time.

_____ E2506=Speech Generating device, digitized speech, using pre-recorded messages, greater than 40 minutes recording time.

_____ E2508= Speech generating device, synthesized speech requiring message formulation by spelling and access by physical contact with the device. *Say-it! SAM Communicator V2*

_____ E2510=Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access. *Freedom SGD, Say-it! Sam Tablet XP1 or SM1, Conversa, Freedom Lite Convertible, Freedom Lite*

_____ Other please describe: _____

C. Trials with SGD's

Device #1

Name of Device:

Features:

Client Success: circle all that apply

Poor Difficult Good Easy

Explain: _____

Device #2

Name of Device:

Features:

Client Success: circle all that apply

Poor Difficult Good Easy

Explain: _____

Device #3

Name of Device:

Features:

Client Success: circle all that apply

Poor Difficult Good Easy

Explain: _____

D. Specific Recommended Device

A. (Reference quote provided by Sales Representative, if applicable)

Name of Device:

Accessories:

Vendor:

E. Patient and Family Support of SGD

Please identify if the client and family members/caretakers are motivated and agree with the device selected.

F. Physician Involvement

A copy of this report was forwarded to the clients treating physician and he/she will generate a prescription for the recommended device and accessories.

VI. Treatment Plan

- The client will receive 4 hours of training with the local sales representative.
- The client will receive _____ therapy sessions with the Speech Language Pathologist once they receive the device.

VII. Signatures/SLP Assurance

The Speech Language Pathologist performing this evaluation is not an employee of and does not have a financial relationship with the manufacturer/supplier of the device.

SLP Name

ASHA #
State License #