Communication Technology Resources, LLC
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PEDIATRIC AAC EVALUATION INTAKE FORM

*Please attach most recent copies of **speech-language, OT and educational reports** and current **IEP**
(Note: An appointment will not be scheduled until all support material is received.)

I. GENERAL INFORMATION

- Referring School or Agency: _____
- Address: _____
- Scheduling Contact Person: _____Today's Date: _____
- Phone Number: _____ E-Mail: _____
- Indicate the questions you would like to have addressed during this meeting _____

_____

II. STUDENT INFORMATION

- Child's Name: _____Date of Birth: _____
- Medical Diagnosis: _____ Educational Classification _____Sex: ___
- Parent/Guardian's Name: (Last) _____ (First) _____
- Address: _____
- Home Phone: _____ Cell Phone: _____E-Mail: _____
- Physician's Name/ Address: _____

III. PRESENT EDUCATIONAL PLACEMENT

- School/Facility**:** _____
- Address: _____
- City: _____ State: _____ Zip: _____
- Case Manager: _____Phone: _____ E-Mail:_____

IV. COMMUNICATION INFORMATION

- Please estimate the percentage of time the student/client demonstrates the following skills:

  a. Responds to speakers _____%

  b. Understands what is said to him/her _____% **Recep. Vocab. Age Score** _____

  c. Follows simple directions _____%

	w/ Familiar Listeners	**w/ Unfamiliar Listeners**
d. Makes needs and wants known	_____%	_____%
e. Initiates communication	_____%	_____%
f. Speaks in words	_____%	_____%
g. Makes sounds	_____%	_____%
h. Uses own gestures to communicate	_____%	_____%
i. Uses facial expression or body language	_____%	_____%
j. Uses PECS	_____%	_____%
k. Uses a manual communication board	_____%	_____%
l. Uses a voice-output device	_____%	_____%

- If student/client uses a voice output device, specify device name and when device was acquired:

  _____

- Does the student/client have a functional yes/no for acceptance/ negation? _____**Yes**___ **No**
- Can the student/ client use yes/no to answer open-ended questions? (i.e. Did your mom drive you to school today? Do you put milk in your coffee?)

  _____**Yes**_____**No**_____**Inconsistent**

- What is the student/client's primary mode of communication? _____
- Is the student/client aware of his/her speech limitations? _____
- How does the student/client indicate that he/she wants to communicate? _____
- What are the current therapy goals for the student/client? _____
- What are the most important communication needs at home? _____
- What are the most important communication needs in the school/vocational setting? _____

  _____

- Can the student/client recognize: (Check all that apply)

  _____ Objects _____ Photos _____Pictures _____ Line Drawings

- Is the student/client able to read? _____ **Yes** ____**No** **Estimated Grade Level** _____
- Is the student/client able to spell? _____**Yes** ____**No** **Estimated Grade Level** _____

V. PHYSICAL/MEDICAL

- Speech Diagnosis: _____
- Onset of medical condition/ diagnosis: _____
- Seizures (type/frequency): _____
- Current Medications: _____
- Adaptive equipment (e.g., splints, switches, lap tray): _____

  _____
- Does the he/ she use a wheelchair? ___Yes ___No Type: _____
- Is motor function of upper extremities adequate to consistently and reliably:

  _____write _____sign/gesture _____point _____activate a switch ?
- Is vision normal? _____Yes _____No (Attach vision eval. reports) _____Not Known
- Is hearing normal? ____Yes _____No (Attach audiological reports) _____ Not Known
- Describe any other significant problems: _____

VI. BEHAVIORAL CHARACTERISTICS

	Adequate	**Inadequate**
a. Attention	_____	_____
b. Frustration Tolerance	_____	_____
c. Impulse Control	_____	_____

- Describe other behaviors that may interfere with learning? _____

  _____
- Estimate attending skills for structured tasks: _____

  _____

VII. ENVIRONMENTAL INFORMATION

- Who is requesting use of AAC techniques? _____ Family _____School _____Other

  (specify) _____

VIII. SUPPORT MATERIAL

- If the student/client is **non-ambulatory, please include a photograph** of the individual in his/her seating system to assist us in determining access needs.
- If referring agency or family feels that the **student/client's** performance during the session would not reflect actual abilities, you may include a brief video with this packet.

IX. FUNDING SOURCE

_____Self- Pay _____ School District

PERSON/AGENCY RESPONSIBLE FOR PROCESSING PAYMENT:

- Name: _____
- Title**:** _____
- Address: _____
- : _____
- City: _____ State: _____ Zip: _____
- Phone: _____ E-Mail:_____

X. APPOINTMENT INFORMATION

a. **Participants planning to attend this appointment: (parents, Therapist, CST, Teacher)**
Name(s) and relationship:

_____

_____

_____

c. **For off-site evaluations:**

School Name _____

School Address _____

City _____State _____ Zip _____

Office Phone _____

XI. Please send completed packet and support material to:

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Highlands, NJ 07732
JoanBruno@CTR-NJ.com