TherapyOne *Reaching the One*

Augmentative/Alternative Communication (AAC) and Assistive Technology (AT) Services
P.O. Box 27, Mesa, Arizona 85211 Phone: 480-668-1917 Fax: 480-668-2750

AUG COM (AAC) REFERRAL QUESTIONNAIRE

Instructions: This form is to be completed by the patient's speech therapy provider who is familiar with their speech and language skills. All questions should be answered. The speech therapy provider(s) must sign and date the form before submitting. This form can be submitted via email (valerie@therapyone.com) or fax (480-668-2750).

Patient Name (First, Last):_____

Date of Birth: _____ Age: _____ Gender: _____

Address (Number & Street): _____

City: _____ Zip Code: _____ Phone Number: _____

Parent/Guardian Name: _____ Email: _____

Parent/Guardian Name: _____ Email: _____

Patient Speech Diagnosis:_____

Patient Medical Diagnosis: _____

Primary Care Provider: _____ Phone Number: _____

What language(s) are spoken at home? _____ Is an interpreter needed? ◯Yes ◯No

Name of Speech Therapy Provider completing this questionnaire? _____

Speech Provider Employer: _____

Email: _____ Phone Number: _____

How long have you provided speech therapy to this patient? _____

In your opinion, would this patient benefit from a communication device? ◯Yes ◯No

Explain why or why not:

PRIOR AAC USE

Has the patient had a communication device of their own: ◯ Yes ◯ No

If Yes, 1. What is the make and model of the device?

2. How long has the patient had the device?

3. Which communication program (software or app) was being used?

4. How many message keys per page were being used?

5. Describe how successful the device was for the patient:

Has the patient used a communication device which was not their own (i.e. school device or therapist-owned device)?

◯ Yes ◯ No If yes, explain:

Other forms of Augmentative & Alternative Communication attempted/used (check all that apply):

Unaided AAC: ◯ Sign Language ◯ Facial Expressions ◯ Body Language ◯ Gestures ◯ Other:

Aided AAC: ◯ Low-tech Symbol Board ◯ Choice Board ◯ Communication Book ◯ Keyboard/Alphabet Chart ◯ Other:

Describe why these forms of AAC are not meeting the patient's communication needs:

MOTOR SKILLS

Describe the patient's gross-motor skill level (i.e. ability to walk, balance, ability to sit, ability to hold/carry an AAC device):

Does the patient have a wheelchair? ◯ Yes ◯ No If yes, is it: ◯ Manual ◯ Power

Describe the patient's fine-motor skill level (i.e. general hand use, grasp/release, hand strength):

Can the patient use an isolated finger to press a button or item on a screen? ◯Yes ◯No

Explain:

HEARING

Describe patient's current hearing function:

Date and results of most recent hearing assessment/screening:

Does/has the member use(d) assistive hearing devices? ◯Yes ◯No

If Yes, explain:

VISION

Describe patient's current vision function and any vision diagnosis:

Date and results of most recent vision assessment/screening:

Does the patient wear eyeglasses/corrective lenses? ◯Yes ◯No

Does the patient wear his/her eyeglasses/corrective lenses in all necessary settings? ◯Yes ◯No

If No, explain:

If the patient has Cortical Vision Impairment (CVI), provide information from the most recent vision assessment, including their level on the CVI scale:

SENSORY PROCESSING

Describe the patient's attention skills:

Sensory tools and strategies currently used:

Does the patient seek out certain sensory activities?

Does the patient avoid certain sensory activities?

Describe any behaviors the evaluators should be aware of or that would affect the outcomes of the AAC evaluation:

ASSISTIVE TECHNOLOGY

Which assistive technology tools/strategies are currently being used (i.e. switches, switch toys, adapted writing tools, software, etc.)?

EXPRESSIVE LANGUAGE

Patient currently communicates using:

- ◯ complete words
- ◯ gestures
- ◯ scripted
- ◯ eye gaze
- ◯ incomplete words
- ◯ facial expressions
- ◯ spelling
- ◯ other:
- ◯ vocalizations
- ◯ signs
- ◯ speech
- ◯ echolalia
- ◯ picture symbol board
- ◯ SGD

Describe patient's expressive language skills, including any standard scores:

SPEECH PRODUCTION

Describe the patient's current speech production:

Percentage of intelligible speech for familiar listeners:

Percentage of intelligible speech for non-familiar listeners:

RECEPTIVE LANGUAGE

Describe the patient's receptive language skills, including any standard scores:

Name of Speech Therapy Provider completing this form:

Signature (including credentials): Date:

Name of Supervising Speech & Language Pathologist (if applicable):

Signature (including credentials): Date: