Laura Dozer Center Therapy Clinic:
1802 W. Parkside Lane, Phoenix, AZ 85027
UCP Downtown-East Therapy Clinic@ Ability 360:
5035 E. Washington St., Ste 108, Phoenix AZ 85034
UCP Therapy Referral Team:
P: 602-682-1844 l F 602-944-1658l therapyreferrals@ucpofcentralaz.org

UCP United Cerebral Palsy of Central Arizona

POSSIBILITIES REALIZED.™

UCP OF CENTRAL ARIZONA SPEECH GENERATING DEVICE

ASSESSMENT CHECKLIST

The following pieces of information are **required** before scheduling an SGD evaluation:

- ☐ Pre-Assessment Review form (enclosed)
- ☐ Client Information form (enclosed- must include all 3 signatures from client/parent/legal guardian)
- ☐ A copy of the client's insurance, Medicaid card (copy BOTH sides of the card)
- ☐ Referring physician's name and contact information, (we will request a prescription from the referring physician for the evaluation. Please be sure the physician has seen the patient in the last 180 days)

If available, please bring the following:

- ☐ Results of a vision screening or test as well as glasses and/or corrective lenses
- ☐ Results of a hearing screening or test as well as hearing aids, cochlear implants, etc.
- ☐ Scores from any receptive/expressive language testing
- ☐ Results from any psychological (cognitive) testing
- ☐ Individualized Education Programs (IEP) and Educational Team Reports (ETR) are helpful for school-age children and IFSP
- ☐ Mobility device child uses most often in home and/or school setting (e.g., walker, wheelchair, other)
- ☐ Additional supports needed (e.g., cervical collar, hand braces, AFOs)

CLIENT INFORMATION

Date: ___/___/___ Email:_____

Child Name:_____
Last *First* *MI*

Address: _____/_____/_____/_____
Street *City* *State* *Zip*

Sex: F ☐ M ☐ Date of Birth:___/___/_____

PARENT/GUARDIAN CONTACT INFORMATION

Name:_____ Relationship: _____
Last *First* *MI*

Address: _____/_____/_____/_____
Street *City* *State* *Zip*

Home Phone:_____ Cell Phone:_____ Work Phone:_____

ADDITIONAL PARENT/GUARDIAN CONTACT INFORMATION (IF APPLICABLE)

Name:_____ Relationship: _____
Last *First* *MI*

Address: _____/_____/_____/_____
Street *City* *State* *Zip*

Home Phone:_____ Cell Phone:_____ Work Phone:_____

EMERGENCY CONTACT INFORMATION

Name:_____ Relationship: _____
Last *First* *MI*

Address: _____/_____/_____/_____
Street *City* *State* *Zip*

Home Phone:_____ Cell Phone:_____ Work Phone:_____

REFERRAL SOURCE (HOW WERE YOU REFERRED TO UCP OF CENTRAL AZ AAC PROGRAM)_____

_____

INSURANCE INFORMATION:

PRIMARY INSURANCE COMPANY: _____ / _____
POLICY HOLDER'S NAME

SECONDARY INSURANCE COMPANY _____ / _____
POLICY HOLDER'S NAME

DOES YOUR INSURANCE COMPANY REQUIRE PRIOR AUTHORIZATION FOR AUDIOLOGY AND/OR SPEECH THERAPY SERVICES:

☐ YES ☐ NO

PLEASE BRING YOUR INSURANCE CARDS AND LETTERS OF AUTHORIZATION FOR SERVICES TO EACH VISIT.
THE RECEPTIONIST WILL MAKE COPIES AND RETURN THEM TO YOU PRIOR TO YOUR THERAPY SESSSION.

THANK YOU IN ADVANCE FOR YOUR ASSISTANCE IN HELPING US PROVIDE THE BEST POSSIBLE SERVICE

I HEREBY ACKNOWLEDGE THAT THE ABOVE PROVIDED INFORMATION IS TO MY KNOWLEDGE TRUE AND ACCURATE:

_____ _____ _____
PRINTED NAME OF CLIENT/PARENT/LEGAL GUARDIAN RELATIONSHIP DATE

_____
SIGNATURE OF CLIENT/PARENT/LEGAL GUARDIAN

NOTICE OF PRIVACY PRACTICES & PERMISSIONS TO SHARE HEALTH INFORMATION

BY SIGNING BELOW, I AM ACKNOWLEDGING THAT I HAVE RECEIVED A COPY OF THE UCP OF CENTRAL ARIZONA'S NOTICE OF PRIVACY PRACTICES AND CONSENT TO UCP'S AAC PROGRAM LEAVING MESSAGES ON MY VOICE MAIL/MESSAGE RECORDING DEVICE REGARDING APPOINTMENT SCHEDULING AND/OR REQUESTS TO CONTACT THE CENTER.

_____ _____ _____
PRINTED NAME OF CLIENT/PARENT/LEGAL GUARDIAN RELATIONSHIP DATE

_____
SIGNATURE OF CLIENT/PARENT/LEGAL GUARDIAN

IF YOU WOULD LIKE TO AUTHORIZE DISCLOSURE OF YOUR PERSONAL HEALTH INFORMATION TO PARTIES OTHER THAN YOUR REFERRING PHYSICIAN AND PRIMARY CARE PHYSICIAN, YOU WILL NEED TO COMPLETE A HIPAA SUPPLEMENTAL DISCLOSURE FORM. PLEASE REQUEST A COPY OF THIS FORM FROM THE RECEPTIONIST.

AUTHORIZATION FOR TREATMENT, ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION

I HEREBY REQUEST AND CONSENT TO TREATMENT AN SERVICES REASONABLE AND PROPER BY TODAY'S STANDARDS PROVIDED BY A SPEECH-LANGUAGE PATHOLOGIST AND/OR AUDIOLOGIST OF UCP OF CENTRAL ARIZONA AAC PROGRAM AND AUTHORIZE PAYMENT DIRECTLY TO UCP OF CENTRAL ARIZONA'S AAC PROGRAM AND/OR DME BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME BY MEDICAIDOR ANY OTHER INSURANCE COMPANY, FOR UCP OF CENTRAL ARIZONA'S AAC PROGRAM SERVICES, AND I ASSUME RESPONSIBILITY FOR ANY UNPAID BALANCE INCLUDING NON-COVERED SERVICES EXCEPT LIMITED BY LAW. I ALSO HEREBY AUTHORIZE UCP OF CENTRAL ARIZONA AAC PROGRAM TO RELEASE ANY INFORMATION TO MY REFERRING PHYSICIAN AND/OR PRIMARY CARE PHYSICIAN, HEALTH CARE FINANCING AGENCY, OR ITS AGENTS, TO THIRD PARTY PAYORS AND ANYONE ASSISTING THE PROVIDER IN OBTAINING PAYMENT INCLUDING BILLING, CODING AND COLLECTION AGENTS, PROVIDER'S ATTORNEY, CONSULTANTS, AND TO MY INSURANCE COMPANY AS ACQUIRED IN THE COURSE OF MY EXAMINATION, EVALUATION OR TREATMENT. THIS AUTHORIZATION WILL REMAIN UNTIL REVOKED BY ME IN WRITING.

A COPY OF THIS UCP OF CENTRAL ARIZONA AAC PROGRAM'S FINANCIAL POLICY IS DISPLAYED IN THE RECEPTION AREA. SHOULD YOU WISH TO HAVE A COPY OF THE FINANCIAL POLICY PLEAE REQUEST ONE FROM THE RECEPTIONIST.

I HAVE REVIEWED AND ACCEPTED THE FINANCIAL POLICY AND AUTHORIZATION, ASSIGNMENTAND INFORMATION RELEASE.

_____ _____ _____
PRINTED NAME OF CLIENT/PARENT/LEGAL GUARDIAN RELATIONSHIP DATE

AUGMENTATIVE-ALTERNATIVE COMMUNICATION
PRE-ASSESSMENT REVIEW

Child's Name: _____

Date of Birth: _____

Parent/Guardian: _____

Medical Diagnosis: _____

Date of Onset: _____

Speech/Language Diagnosis: _____

Primary Insurance: _____

Secondary Insurance: _____

Primary Care Physician: _____

Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Person referring client for AAC evaluation: _____

Phone: _____

Relation to Client: _____

Please complete as many items as possible:

EDUCATIONAL BACKGROUND

Education level (specify current grade):

☐ preschool ☐ elementary

Name and location of school:_____

COMMUNICATION NEEDS

How often is your child frustrated with his or her current means of communication?

☐ Almost always ☐ 75% ☐ 50% ☐ 25% ☐ Almost never

Where would your child benefit from improved communication?

☐ At home ☐ At work ☐ At school ☐ In the community

Other:_____

With whom would your child benefit from improved communication?

☐ Family members ☐ Peers ☐ Teachers ☐ Caregivers ☐ Healthcare providers

☐ Others:_____

COMMUNICATION SKILL

Does your child desire communication? ☐ YES ☐ NO

Describe evidence for desire for communication? _____

Does the individual initiate interaction?

☐ Frequently ☐ Occasionally ☐ Seldom ☐ Rarely

Does your child ask questions? ☐ YES ☐ NO

Describe how:_____

Does your child respond to communication?

☐ Frequently ☐ Occasionally ☐ Seldom ☐ Rarely

Does your child have a consistent way of communicating "yes" and/or "no"? ☐ YES ☐ NO

Describe how:_____

Does your child use sounds and/or gestures to draw attention and then depends on others to develop the message?

☐ YES ☐ NO ☐ Sounds ☐ Gestures

Describe and note limitations:_____

_____

_____

_____

Can your child use speech to communicate effectively with some individuals? ☐ YES ☐ NO

Describe and note limitations:

Can your child use sign language effectively with those who understand it? ☐ YES ☐ NO

Describe and note limitations:

Has your child tried augmented communication techniques? ☐ YES ☐ NO

Describe and note limitations:

Does your child have a non-electronic communication board? ☐ YES ☐ NO
(e.g., real pictures, symbols/icons)

Describe and note limitations:

Does your child have an electronic communication device? ☐ YES ☐ NO
(e.g., tablet with communication app)

Describe and note limitations:

SPEECH SKILLS

Speech is understood to familiar others: ☐ Seldom ☐ 10% ☐ 50% ☐ 75%

Describe:

Speech is understood by strangers: ☐ Seldom ☐ 10% ☐ 50% ☐ 75%

Describe:

PROGNOSIS FOR SPEECH

Does your child receive speech therapy? ☐ YES ☐ NO

Describe the frequency and type of intervention:

Has speech therapy helped your child? What improvements have you seen?

CURRENT LANGUAGE SKILLS

Speaks in: ☐ single words ☐ short phrases ☐ sentences ☐ non-verbal

Understands: ☐ very little ☐ simple language ☐ most of what is said

When was your child last evaluated for speech therapy? What were the results?_____

_____

_____

CURRENT LITERACY SKILLS

Describe your child's educational history (e.g., how many years have they attended their current school/program?)_____

_____

_____

Does your child have experience with letters and/or words? ☐ YES ☐ NO

Describe: _____

Does your child read? ☐ YES ☐ NO

Describe: _____

Does your child spell? ☐ YES ☐ NO

Describe: _____

If not yet reading and spelling, what is the prognosis for literacy? ☐ Good ☐ Fair ☐ Poor ☐ Unsure

Describe:_____

_____

CURRENT PRELITERACY SKILLS (answer only if your child is not literate):

Can your child identify pictures? ☐ YES ☐ NO

Describe: _____

Does your child have experience with other symbol systems?

☐ Mayer-Johnson PCS ☐ Symbol Stix ☐ Minspeak ☐ Other (describe) ☐ No

Describe symbol use:_____

Can your child identify road signs or other advertising? ☐ YES ☐ NO

CURRENT MOTOR SKILLS

How does your child move from place to place?

☐ Rolls, scoots, crawls, or creeps on floor

☐ Walks, but holds onto furniture, walls, caregivers, or uses devices for support

☐ Walks without support

☐ Other (describe)

Describe:_____

Describe the mobility device that your child uses the most throughout the day in the home and/or school setting?
(Check all that apply)

☐ None/Not Applicable

☐ Walker

☐ Gait trainer

☐ Cane

☐ Crutches

☐ Manual Wheelchair

☐ Electric Wheelchair

☐ Other (describe)

Describe:_____

What is the make/model of equipment (if known)?_____

☐ NA

Does the child require additional support for head control?
(Check all that apply)

☐ None/Not Applicable

☐ Cervical Collar

☐ HeadPod Head Support System

☐ Other (describe)

Describe:_____

How does the child carry toys/objects from place to place?
(Check all that apply)

☐ Changes physical location purposefully? YES / NO

☐ Moves objects along floor

☐ Carries objects small enough to be held in one hand

☐ Carries objects large enough to require two hands

☐ Carries fragile or spillable objects

If so, can your child carry a 10" tablet that weighs about 3 pounds? ☐ YES ☐ NO

Can you child activate a toy using their hands? ☐ YES ☐ NO

Describe the type of work surface your child uses: ☐ desk ☐ adapted desk ☐ wheelchair tray

☐ play table ☐ kitchen table

☐ Other (describe):_____

Does your child have experience with keyboards of any kind? ☐ YES ☐ NO

- ✓ If Yes, type: ☐ full QWERTY/computer keyboard ☐ alphabetical order
  ☐ fewer keys than a full keyboard ☐ alternative keyboard such as Intellikeys

Describe use: _____

Can your child access a phone or tablet with fingers or hands? ☐ YES ☐ NO

- ✓ If Yes, type check any needed adaptions: ☐ requires assistance ☐ independent
  ☐ depends on key size ☐ other (describe):_____
- ✓ If No, would head movement be an option? ☐ YES ☐ NO ☐ Maybe

Does your child tire easily? ☐ YES ☐ NO

Describe:_____

CURRENT SENSORY SKILLS

Has your child had a hearing test before? ☐ YES ☐ NO

✓ If Yes, please attach all test results.

Does your child need help to locate or find objects that are obvious to others? ☐ YES ☐ NO

Does your child prefer to work or play in **bright lighting** or **low-lighting** rooms? ☐ BRIGHT ☐ LOW

Does your child display the need to touch everything and get the feeling of everything? ☐ YES ☐ NO

Does your child avoid touching certain textures? ☐ YES ☐ NO

If so, what?_____

Does your child put objects/hands in mouth frequently? ☐ YES ☐ NO

Does your child resist eye contact from parent or others? ☐ YES ☐ NO

Does your child become easily frustrated? ☐ YES ☐ NO

Is your child distressed by changes in schedule or routines? ☐ YES ☐ NO

Is your child very impulsive and rushes through activities? ☐ YES ☐ NO

CURRENT VISION STATUS

Is vision with normal limits? ☐ YES ☐ NO

If No, describe status, use of glasses/other devices:_____

Has your child had a vision test before? ☐ YES ☐ NO

✓ If Yes, please attach all test results.

CURRENT COGNITIVE STATUS

Does your child follow directions (e.g., give me your cup, sit down/stand up, and come here)? ☐ YES ☐ NO

Describe:_____

How long can your child remain at a table?_____ How many minutes:_____

Can your child finish a task they start? ☐ YES (with assist) ☐ YES (independent) ☐ NO

Does your child become easily distracted? ☐ YES ☐ NO

Describe:_____

TECHNOLOGY

Complete the following IF your child has tried a communication device or if you have observed skills related to these functions. If not, please skip to page 11.

Does your child have experience with a computer or tablet? ☐ YES ☐ NO

What kind? ☐ PC using Microsoft Windows ☐ Apple computer using MacOS

✓ ☐ iPad or other Apple handheld device ☐ Android-based tablet/handheld device

How does your child currently use the computer/tablet/handheld device?

☐ games ☐ word processing ☐ Internet ☐ email

Other (describe):_____

How does your child access the computer?

☐ mouse ☐ joystick ☐ single-switch scanning ☐ other

Other (describe):_____

Has your child experimented with tablet apps for communication? ☐ YES ☐ NO

☐ Proloquo2Go ☐ TouchChatHD ☐ GoTalkNow

☐ Verbally ☐ SonoFlex ☐ GridPlayer

☐ Cough Drop ☐ Snap+CoreFirst ☐ PODD

Other (describe use):_____

VOCABULARY ENCODING

If you are familiar with AAC, please note which vocabulary access techniques would benefit your child:

☐ I don't know ☐ levels and locations ☐ dynamic screens ☐ Minspeak

☐ traditional point ☐ other (describe):_____

Describe your child's experience with these techniques:_____

_____

RATE ENHANCEMENT

Please note which feature would benefit your child:

☐ I don't know ☐ symbol sequencing ☐ dynamic display ☐ word lists

☐ word prediction ☐ icon prediction ☐ predictive scanning

☐ other (describe):_____

Describe your child's experience with these features:_____

_____

DEVICE OUTPUT

Please note which feature would benefit your child:

☐ I don't know ☐ recorded voice (digitized speech) ☐ synthesized speech

☐ output printed on a screen ☐ other (describe):_____

Describe your child's experience with these features:_____

_____

KEYBOARD AND KEY SIZE

Your child may benefit from keyboard alterative such as the following:

☐ I don't know ☐ large-format keyboard ☐ keyguard ☐ extra spacing between keys

☐ limited number of keys ☐ large keys ☐ other (describe):_____

DISPLAY FEATURES

Your child may benefit from these display characteristics:

☐ I don't know ☐ enhanced screen size ☐ use of black and white

☐ use of color ☐ other (describe):_____

COMMUNICATION OPPORTUNITIES

Completing this will help us prepare more relevant materials to use during the evaluation. Please select activities that reflect the individual's daily routines and interests. At the bottom, include vocabulary that is relevant to these activities.

COMMUNITY

☐ Eating at a restaurant
Favorite:_____
Food choices: _____
☐ Attending a worship service
☐ Riding the bus
☐ Shopping for groceries
Store:_____
Items purchased: _____
☐ Shopping for preferred items (clothes, electronics, etc.)
Preferred items:_____
☐ Going to the library
Books/authors:_____
DVDs/Audio: _____
☐ Going to the bank
☐ Going to the post office
☐ Going to the doctor/therapist
☐ Going to the park
Activities:_____
☐ Going to the movies
Preferred movies:_____
Genre: _____
☐ Going bowling
☐ Other:_____
_____

HOME

☐ Eating meals
Which meals:_____
With whom:_____
☐ Doing laundry
☐ Washing dishes
☐ Making bed
☐ Taking care of pets
Type/Name:_____
☐ Cleaning a room
☐ Getting the mail
☐ Taking a bath/shower
☐ Getting dressed
Preferred clothing:_____
☐ Yard work/gardening
Activities:_____
☐ Playing games
Favorite game:_____
☐ Watching TV
Favorite show:_____
Favorite channel:_____
☐ Watching movies
Favorite movie:_____
☐ Playing/watching sports
Favorite teams:_____
Favorite players:_____
☐ Listening to music
Favorite types:_____
Favorite songs:_____
Favorite groups:_____
☐ Cooking
Types of foods:_____
☐ Having a snack
Favorites:_____
☐ Other:_____
_____
_____

SCHOOL

- ☐ Eating breakfast or lunch
- ☐ Taking a break
- ☐ Meeting/group work
  - Describe:_____
- ☐ Extracurricular
  - Activities:_____
- ☐ Reading
  - Topics:_____
- ☐ Science
  - Topics:_____
- ☐ Math
  - Topics:_____
- ☐ Recess
  - Activities:_____
- ☐ Completing a project
  - Tasks:_____
- ☐ Watching videos
  - Which:_____
- ☐ Attending therapy
  - Type:_____
  - Frequency:_____
- ☐ Arriving at school
  - Time:_____
  - Mode of transport:_____
- ☐ Other:_____

_____

_____

SUGGESTED VOCABULARY:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____