Augmentative Alternative Communication Program
Address: 3141 N. 3rd Avenue, Suite 100 Phoenix, AZ 85013
Office: 602-470-5532
Fax: 602-381-7576
Email: augcomm@dmgaz.org

AUGMENTATIVE ALTERNATIVE COMMUNICATION (AAC) REFERRAL

Patient Name: _____

Date of Birth *(mm/dd/yyyy)*: _____ Age*:* _____ Sex: ☐ Male ☐ Female

Home Address: _____ City: _____ State _____ Zip Code _____

Parent/Guardian Name: _____ Phone Number: _____ Email: _____

What language does the family speak? _____ Does the family need an interpreter? ☐Yes ☐No

Patients Primary Care Physician (PCP): _____ Primary Care Physician Phone: _____

What is the patient's diagnosis? _____

INSURANCE INFORMATION

Insurance Payer: _____ ID Number: _____

Does the patient have other insurance coverage? ☐Yes ☐No (*if yes, please provide below)*

Name of Insurance Company: _____ Policy Holder Name: _____

Policy Number: _____ Policy Holder Date of Birth: _____ Policy Holder SS#: _____

REFERRAL SOURCE INFORMATION

Relationship to patient: _____ Name (Last, First): _____

Phone Number: _____ Email Address: _____

Referral Source Company Name (if applicable): _____

DDD Care Coordinator (Last, First) _____ Phone: _____

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CURRENT SKILLS

Patient presently communicates using *(check all that apply)*:

☐ Complete words	☐ Incomplete words	☐Vocalizations	☐Echolalia
☐ Eye gaze	☐ Gestures	☐Facial expressions	☐Sign language
☐ Picture symbol board	☐ Scripted	☐Spelling/word board	☐Speech
☐ Communication device	☐ Other:		

Does this patient already use communication device? ☐Yes ☐No

(*If yes, please list Make and Model*): _____

Is this device being used in all settings? ☐Yes ☐No

Is this device being used solely as a communication device? ☐Yes ☐No

Is the patient resistant to using this or any other device? ☐Yes ☐No

Describe the resistance:

_____

Does this patient require assistance to use the device? ☐Yes ☐No

Describe the assistance needed:

_____

Did the patient receive training on this device? ☐Yes ☐No

Is this a request for re-evaluation? ☐Yes ☐No (*if yes, describe why*):

_____

SENSORY AND MOTOR

Vision:

☐unaided and functional for use of AAC ☐corrected (*glasses, etc.*) functional for AAC

☐vision modifications needed (*please explain*):

_____

Hearing:

☐unaided and functional for use of AAC

☐hearing aids (☐left, ☐right ☐both)

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☐hearing modifications needed (*please explain*): _____

Motor Mobility:

☐no assistive devices ☐cane/walker ☐manual wheelchair

☐power wheelchair ☐scooter

Head Control:

☐complete ☐partial ☐no

Head, Functional Movement:

☐complete ☐partial ☐no

Hand Control:

☐complete ☐partial ☐no Hand, Functional Movement: ☐complete

☐partial ☐no

Hand, Accuracy for Touching Targets:

☐phone keyboard ☐computer keyboard ☐other keyboard, size: _____

RECOMMENDED OBJECTIVE/MEDICAL NECESSITY FOR AAC DEVICE OR ASSISTIVE TECHNOLOGY (AT)

Main objective for an evaluation (*check all that apply*):

☐ Explore options for augmentative communication devices.

☐ Explore options to help with cueing systems during functional activities, *(i.e., memory, schedule, etc.)*

☐ Explore options for AT for self-care or home living activities.

☐ Look at ways to access items in the environment such as TV, music, appliances, etc.

☐ Explore what types of switches might work best for the individual to access communication, leisure items, household items, computer use, etc.

☐ To help the individual be positioned more effectively for activities.

☐ To look at mounting solutions on the person's wheelchair for AT access.

☐ To help the person integrate AT systems so that systems work together effectively

(IE: controlling a wheelchair, environmental control devices, communication devices)

Do you recommend the involvement of an additional therapist for the evaluation of the speech generating device?

☐Occupational Therapist

☐Physical Therapist Rational: _____

☐Other (*please explain*): _____

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CURRENT THERAPY SERVICES

Has the patient received habilitative speech therapy previously? ☐Yes ☐No

If yes, date of last visit: _____

Type	Frequency	Therapist Name	Email	Phone Number
Speech Therapy				
Occupational Therapy				
Physical Therapy				
Other:				

PATIENT TEAM MEMBERS (family, community, professionals, etc.)

Name	Relationship	Present at Evaluation
		☐
		☐
		☐
		☐