SAMPLE

*Be sure to delete instruction items found in red before signing and submitting.
*Blue items require a choice to be made or are examples for additional programs or diseases. Delete what doesn't apply. Please change all text back to black before submitting.

SPEECH / LANGUAGE EVALUATION FORM

I. DEMOGRAPHIC INFORMATION

Client's name: Date of Evaluation:
Date of birth: Age:
Medical Diagnosis:
Date of Onset:
Primary 1nsurance:
Physician:
Speech-Language Pathologist:

II. CURRENT COMMUNICATION IMPAIRMENT

Type of Communication Impairment: Profound Dysarthria

Severity of Impairment: This patient's needs cannot be met using natural communication methods or low-technology aids. (*expand*)

Current Methods of Communication and Reason for Inadequacy: _____ is unable to verbalize words. The patient is able to use his/her eyes to look at the words yes and no, or at pictures on a piece of paper to answer questions asked by family or staff, but is unable to initiate requests to have his/her needs met. The family tries to guess his/her needs by asking simple questions, which require a yes or no answer. (*expand*)

Anticipated Course of Impairment: It is anticipated that _____ will need a dedicated Speech Generating Device/Dedicated Communication Device (Eyegaze Edge) to communicate his/her basic wants and needs, as current methods of communication are not adequate for functional communication needs.

Speech & Language Skills: Receptive language skills are judged to be within normal limits. Present expressive skills are non-existent. _____'s potential for effective expressive language through an appropriate adaptive method are very good using his/her eyes.

Cognitive Ability: _____'s ability to sustain focused attention, selective attention, and alternating are very good. Memory and nonverbal problem-solving skills, including appreciation for humor appear within normal limits. S/He adapts well to using augmentative communication devices and is easily trained in using short cuts to increase communicative effectiveness and speed.

Vision Status: _____'s visual acuity is within functional limits without the need for visual aides. Visual tracking is accurate and consistent and s/he has excellent volitional control of eye movement.

Hearing Status: Hearing acuity is judged to be within functional limits for hearing in one on one interaction and for hearing conversation in group settings.

Physical Status: _____ is unable to volitionally move any part of any limb.

III. DAILY COMMUNICATION NEEDS

Specific Daily Functional Communication Needs: Using the LC Technologies' Eyegaze Edge, _____ will have the ability to:

1. maintain interaction for social and emergency occasions when necessary.

2. participate in medical decision making such as reporting medical status, complaints, asking questions of medical providers and discussing choices.

3. fulfill family roles such as participating in family decision making, family leisure activities.

4. participate in activities that promote psychosocial well-being such as support groups and community activities.

Ability to Use Low Tech Strategies: An assessment of most viable physical skills was performed by the rehabilitation team including Occupational and Physical therapy, as well as by the Physician, to assess for any modality that could be used to operate a communication device at this time. _____ has lost all functional mobility in his/her arms, legs, hands, feet, fingers, or toes. S/He has excellent eye control. The Eyegaze Edge offeres the most accurate form of communication access even when patient's eyes are fatigued or when he/she is tired. It also accomodates an array of eye issues (ptosis of the eyelid, dry eyes, partial loss of volitional control, and more).
(*expand*)

IV. FUNCTIONAL COMMUNICATION GOALS

Using the Eyegaze Edge, the:

1. Patient will demonstrate communication of basic needs to family with 95% accuracy using the system within the first 4 weeks.

2. Family and caregivers will demonstrate appropriate trouble shooting and maintenance of the device using resources as appropriate within 4 weeks.

V. DURABLE MEDICAL EQUIPMENT AND ACCESSORY REQUIREMENTS

The following components and accessories will be needed so that the patient will have full access to the Eyegaze Edge to communicate his/her basic needs:

1. Edge Talker: #421M-T (HCPCS code: E2510)
2. Eyegaze Edge Camera Assembly: #421M-C (HCPS code: E2599)
3. Adjustable Table Mount: #500M-A: (HCPCS code: E2512) (Or can substitute wheelchair mount or rolling mount. If recommending more than one, list each and justify reason for two mounts in section V).
4. Put additional items here like Grid 2 or Lights and Appliances (both are HCPS code: E2599).

V. RECOMMENDATION AND RATIONALE FOR DEVICE SELECTION

*Please note: You must supply written justification for optional programs, such as Grid 2 or Lights and Appliances. Examples are below.

_____ requires use of the Eyegaze Edge to meet functional daily communication needs. The Eyegaze Edge was selected because of _____'s ability to move his/her eyes as the best, most reliable movement given his/her current physical status. The Eyegaze Edge is the only eye-operated device that can be used in any position including side lying. It is also the only device that works for someone with ptosis of the eyelid (droopy eyelid) or extremely large pupils. Due to the progressive nature of ALS, ptosis of the eyelids is a common occurrence. Use of other devices do not provide _____ with the speech, accuracy, ability, or long term reliability to communicate basic needs. _____ demonstrated the need for various message unit types. Letters and single words allow him/her to communicate regarding specific and novel topics. Phrases and sentences allow for more efficient communication of routine utterances. S/He also tried ___(*list and explain*).

Examples for optional programs and mounts:
The Grid software provides additional tool for more efficient communication output through acceleration techniques of word prediction, abbreviation expansion, and pre-stored messages. It also give the user the ability to create, store, and manipulate his/her own phrases. The Grid software has been fully integrated into the Eyegaze software for seamless manipulation. These features can only be fully realized when utilizing The Grid software with the Eyegaze Edge. The Grid also allows button, font, and color; font and button size; and the number and arrangement of buttons to be easily modified. All of these features allow for the device to be customized for each individual. This is necessary to allow _____ to communicate his/her needs without assistance.
Lights and Appliances is necessary for _____ because it has a call bell enabling him/her to get caregivers attention. This is necessary because user is tracheostomized and ventilator dependent and needs a way to alert others if something is not working properly.
Du to pressure relief and medical needs, it is also essential patient is placed in additional positions throughout the day including supine and sidelying in bed and in a reclined position. _____ needs to be able to communciate in all positions. The wheelchair mount will allow access within the home and during medical appointments. The table mount will allow access while in bed or recliner. Both mounts will allow him/her to express his/her needs in all positions and in all contexts.

The patient's family, who care for him/her at home, are very supportive. They are frustrated with attempts to try to determine _____'s needs. Furthermore, s/he is very motivated to communicate and has suffered without appropriate communication.

VI. Speech Language Pathologist Statement/Assurance of financial independence

(SLP may not be an employee or have financial relationship with the supplier of the SDG.):

I, *(Name of SLP)*, am not an employee of the supplier of the SGD, nor do I have financial relationship with the company that supplies the device.

Signature of licensed SLP (including credentials):

SLP Name (please print): _____
SLP Phone Number: _____
ASHA Certification Number: _____
State License Number: _____

VII. Physician Involvement Statement

This report was forwarded to the treating physician: **Yes** No

Please complete the following:

Name of Physician: _____

Address of Physician: _____

NPI: _____

Date: _____

Please forward this form with original signatures to:
LC Technologies, Inc. 10363 Democracy Lane, Fairfax, VA 22030
Questions? 800-393-4293 (Toll free) or 703-385-8800