

2c. Augmentative Communication Evaluation Questionnaire

Assistive Technology Services, Advancing Opportunities

(This section to be completed by: Occupational Therapist)-**Please use black ink**

Student Name:	District:	Date:
Therapist Name:		Phone Number:
E-mail:		
Therapy sessions per week: Group Individual Classroom		

Directions: Please respond to relevant questions, and skip any questions that you do not have an answer to. Return Questionnaire to: Child Study Team Case Manager

Fine Motor Ability

The student :

can use fingers to press small targets (ie, 1" square targets)

has trouble using fingers to press small targets

Describe:

has limited or no use of upper extremities

For these students, what part of the body do they have the best control over?
 hand arm leg foot head leg

Describe:

Accuracy and Fatigue of these movements?

Mobility

The student is ambulatory ambulatory w/mobility aide uses wheeled mobility

Mobility Aide Make	Model	Will be replaced soon?

Wheelchair Users: Please describe positioning throughout the day.
(especially times when student is in seating other than wheelchair)

Additional Information

What assistive technology, supports, or strategies have you already tried?

Please include any other important information about the student: