# AAC Evaluation Referral Packet

**Assistive Technology Services**
**Advancing Opportunities**

**Please use this packet if requesting an Augmentative Communication Evaluation.**

- **Submit forms as described in the Checklist**
  (form entitled “1: AAC Evaluation Referral Packet: Checklist”)

- **Review responsibilities in the cover letter**

**Questions? Call Judy Nigl:**
**888-322-1918, x595.**

# 1: AAC Evaluation Referral Packet: Checklist

| Student Name: | District: | Date: |
|---|---|---|
| | | |

Thank you for requesting an Augmentative Communication (AAC) Evaluation with Advancing Opportunities. Helping someone learn a new way to communicate is a complex and ongoing process. The following is a list of documents we need to complete the process as efficiently as possible.

**This entire packet must be completed** before the evaluation can be scheduled.
Please provide all requested information and return to:

Advancing Opportunities
Attn: ATS Administrative Assistant
1005 Whitehead Road Extension, Suite #1
Ewing, NJ 08638
(f) 609-882-4054

Please Send:

- ❑ Student Referral Form
- ❑ AAC Evaluation Referral Packet: Checklist (this form)
- ❑ AAC Evaluation Questionnaires (SLP, OT, Teacher & Aide, and Parent)
- ❑ IEP
- ❑ Relevant reports (current speech and language evaluation, reports from prior AAC or AT evaluations)

**Signature of Person(s) Completing This Form**

Name (print):_____

Signature: _____ Date:_____

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To the Child Study Team Case Manager:

An augmentative communication evaluation is a team process. That means we do not do this alone—we need to work with the IEP team. Here's an outline of what we will need to begin.

Before the Evaluation

- ☐ **Decide what you expect the student outcome to be for the evaluation**
  "What would you like to see the student do, that they cannot do now?"
- ☐ **Identify related goals from the student's IEP**

***Step 1: Intake and Pre-Evaluation***

| **Our Responsibilities** | **Your Responsibilities** |
|---|---|
| Background information is gathered from IEP team members by phone, email, referral packet | ☐ Send all information described in the Checklist **(form 1)** |
| Evaluation is scheduled. | Arrange for team members to be available<br>☐ For Team Meeting<br>(parent, yourself, speech therapist, at least 1 teacher, and any other members who would be implementing recommendations)<br>☐ At least 1 staff person to work with us (preferably SLP) during the 2 hour evaluation.<br>If at the school, arrange for rooms for:<br>☐ Team meeting, and<br>☐ Evaluation itself |

**Advancing Opportunities**
1005 Whitehead Road Extension
Suite 1
Ewing, New Jersey 08638

Telephone: 609-882-4182
Toll Free: 888-322-1918
TTY: 609-882-0620
Fax: 609-882-4054

www.advopps.org info@advopps.org

***Step 2: Day of the Evaluation***

| Our Responsibilities | Your Responsibilities |
|---|---|
| Outline of Eval:<br>♦ Team Meeting: 30 minute meeting with IEP team and family member if needed<br>♦ Observation: 15-30 min<br>♦ Evaluation: 2 hours, with student, and at least 1 school staff person (preferably SLP)<br>♦ Wrap-up: Wrap-up meeting with IEP team and family member to discuss findings and next steps | ☐ Present for team meeting<br>☐ Speech-Language Pathologist present for evaluation<br>☐ Available for wrap-up |

***Step 3: Device Trial***

A trial period (4 weeks) with the recommended communication system or device is a necessary step. This will help determine whether or not the new system will be compatible with the person's needs.

(Note: If purchasing under medical insurance a trial period is required)

| Our Responsibilities | Your Responsibilities |
|---|---|
| | ☐ Decide whether you wish to receive recommended technical assistance/training<br>☐ Return Student Referral for Assistive Technology Services form |
| ♦ Ship by UPS to person indicated or deliver device in person<br>♦ Provide Technical Assistance/Training, if approved | ☐ Arrange for staff to be released for technical assistance training during the trial period, and to spend time getting to know the device on their own. |
| | ☐ Measure performance of student during trial |
| ♦ We will provide a UPS shipping label via email attachment | ☐ Have device re-packaged and ready to be returned for the date indicated on the loan form. |
| | ☐ Communicate to us the results of the trial |

***Step 4: Implementing and Supporting AAC Device Use In Daily Life***

Determining a communication system is just the beginning. Success of an AAC user is determined primarily by implementation and use by communication partners throughout the environment. Learning an AAC system is similar to learning a new language. In order to learn any language, exposure through modeling to vocabulary, sentence structures, and motivating interactions is essential.

Implementation begins with a written action plan that provides detailed information about how the AAC system will be used, what training and support are needed and who will be responsible.

# Student Referral for Assistive Technology Services
# To Advancing Opportunities

School District: _____ Date: _____

**- Please use black ink -**

***Signature or Initials:***_____

**Student** (One form per student, please. If service is not for a particular student, leave blank.)

| | |
|---|---|
| **Name:** | **Grade:** |
| **Parent/Guardian Name:** | **Relationship:** |
| **Home Add:** | |
| **City:** | **State: NJ Zip: County:** |
| **Phone:** | |
| **E-Mail:** | |
| **DOB:** | **Gender: Medical Diagnosis:** |
| **Educational Classification:** | |

## Child Study Team Case Manager

| | |
|---|---|
| **Name:** | |
| **Address:** | |
| | |
| **City:** | **State: NJ Zip:** |
| **Phone #:** | **Fax:** |
| **E-Mail:** | |

## Service Requested (please choose **ONE from each line**)

| | | |
|---|---|---|
| ☐ **Evaluation**<br>*(Eval Packet required)*<br><br>Hands-on and on-site, we work with the IEP team to help determine what technology would support the student in meeting their goals | ☐ **Teleconsult**<br>*(Eval Packet required)*<br><br>A consultation through web conferencing to assist IEP teams to understand their assistive technology choices. | ☐ **____ Hours of Support/Training**<br>*(2 hour minimum per visit)*<br>Also called "Technical Assistance;" can include assistance with set-up, training, integrating device use into classroom. |
| ☐ **Augmentative Communication (AAC)**<br>A way of helping people who do not speak or who are difficult to understand learn to communicate more effectively. Examples of AAC are sign language, pictures, written language and voice output devices. | ☐ **Assistive Technology (AT)**<br>All other evaluations, including computer access, technology to support reading and writing, educational accommodations, accessibility, etc. | |

## What would you like to see the student do, that they cannot do now?

| |
|---|
| |
| |

| | |
|---|---|
| **School:** | |
| ❑ **District School** ❑ **Out-of-District School** | |
| **Principal:** | |
| **Address:** | |
| **City:** **State: NJ Zip:** | |
| **Phone #:** | |

## Key School Staff (i.e., teacher, aide, therapists; people who would implement recommendations)

| Title | Name | Phone # | E-mail |
|---|---|---|---|
| Special Ed Teacher | | | |
| Occupational Therapist | | | |
| Speech Therapist | | | |
| | | | |

## Additional information we should know:

| |
|---|
| |
| |
| |

## To make a referral:

Step 1: Get authorization and PO for service from Director of Special Services;

Step 2: For Evaluations and Consults, **current IEP, relevant reports**, and an AT or AAC **Eval or Consult Packet** is required.

If you do not have an AT or AAC **Eval Packet**, please email or call us: jnigl@advopps.org, 888-322-1918, x 595.

Step 3: Complete this form and mail or fax to:

Advancing Opportunities
Attn: ATS Administrative Assistant
1005 Whitehead Road Ext, **Suite #1**
Ewing, NJ 08638

(f) 609-882-4054

The child study team case manager will be contacted in order to gather further background information, confirm all the people involved, and schedule services.
If you have any questions, please give us a call: 888-322-1918

**Teachers & Aide**

# 2a. Augmentative Communication Evaluation Questionnaire

Assistive Technology Services, Advancing Opportunities**-Please use black ink**

| Student Name: | District: | Date: |
|---|---|---|
| Person Completing Form: | Phone Number: | |
| Relationship to Student: | Does the student have a para? Yes ☐ No ☐ | |
| E-mail: | | |

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

Does the student demonstrate functional object use? Please describe.

Does the student demonstrate behaviors (positive and negative) that impact his/her performance? Please describe.

Does the student read or write? Please describe

What hand does the student use predominantly?
____ Left ____ Right _____ Both

Can the student understand:
☐ Single Words ☐ Phrases ☐ Routine Directions

One-step directions ☐ With prompts ☐ Independently
Multiple-step directions ☐ With prompts ☐ Independently

Can the student recognize (please specify):
☐ Letters_____
☐ Words_____

Is the student using visual language supports? Yes ☐ No ☐
Visual Schedule ☐ Contingency board ☐

What picture symbol system is used? _____

Does the student currently use an AAC system?

What other forms of Assistive Technology does the student currently use?

Are there any other students in the classroom that use AAC?

What activities/classes does the student enjoy?

What activities/classes does the student NOT enjoy?

What would you like to see the student do that he or she cannot presently do?

SLP

# 2b. Augmentative Communication Evaluation Questionnaire

Assistive Technology Services, Advancing Opportunities

(This section to by completed by: Speech-Language Pathologist)**-Please use black ink**

| | | |
|---|---|---|
| Student Name: | District: | Date: |
| Therapist Name: | Phone Number: | |
| E-mail: | | |
| Therapy sessions per week:<br>Group _____ Individual _____ | Number of sessions in:<br>Classroom_____ Therapy Room _____ | |

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

How does the student currently communicate? Please be specific

Does the student have a reliable and consistent Yes and No response? Please describe how the student indicates yes/no.

Does the student easily fatigue? Please describe

Can the student understand:

☐ Single Words ☐ Phrases ☐ Routine directions

One-step directions ☐ With prompts ☐ Independently

Multiple-step directions ☐ With prompts ☐ Independently

Can the student recognize (please specify):

☐ Letters_____

☐ Words_____

Does the student currently use an AAC system? ☐ Yes ☐ No

System type/app:_____iPad Model:_____

Type of symbols:_____

Number of symbols per page/overlay:_____

Size of symbols:_____

Access method:_____

Has any form of AAC been attempted/used previously? ☐ Yes ☐ No

☐ Signs

☐ Picture Exchange Communication System (PECS)

☐ Paper Communication Book/Board

☐ iPad app: _____

☐ Device brand/model: _____

Please describe attempts and successes/failures with AAC:

Does the student have any hearing difficulties:_____

_____

Does the student have any vision difficulties:_____

_____

Does the student have any motor difficulties:_____

_____

What behaviors (positive/negative) does the student demonstrate that impact his/her communication?

What would you like to see the student do that he or she cannot presently do?

Please highlight the student's strengths in:

Receptive language: _____

_____

Expressive language: _____

_____

Pragmatics: _____

_____

OT

# 2c. Augmentative Communication Evaluation Questionnaire

Assistive Technology Services, Advancing Opportunities

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

| Student Name: | District: | Date: |
|---|---|---|
| Therapist Name: | Phone Number: | |
| E-mail: | | |
| Therapy sessions per week:<br>Group _____ Individual _____ | Number of sessions in:<br>Classroom_____ Therapy Room _____ | |

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

☐ has limited use of upper extremities

☐ has no use of upper extremities

| Describe: |
|---|
| |

For students with limited or no use of upper extremities, what part of the body do they have the best control over?

☐ hand ☐ arm ☐ leg ☐ foot ☐ head ☐ eyes ☐ other

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? |
|---|---|---|
| | | |
| | | |
| | | |

| Describe positioning throughout the day (i.e. specialized seating, Rifton chair…) |
|---|
| |

**Additional Information**

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

| Please include any other important information about the student: |
|---|
| |

Parent

# 2d. Augmentative Communication Evaluation Questionnaire

Assistive Technology Services, Advancing Opportunities

(This section to be completed by: Parent/Guardian)**-Please use black ink**

| Student Name: | District: | Date: |
|---|---|---|
| Parent's E-mail: | Primary Phone: | |

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

Mother's Name:_____ Father's Name:_____

Siblings Names & ages:_____

Language(s) spoken at home: ☐ English ☐ Other:_____

Besides immediate family members, whom else does your child frequently interact with:

How is your child's hearing (please specify):

How is your child's vision (please specify):

How does your child communicate with you and other family members?

What are the challenges with their current means of communicating?

Does your child demonstrate frustration with communication? Please give examples.

*Augmentative and Alternative Communication (AAC) is a way of helping people who do not speak or are difficult to understand to more effectively communicate. Examples of AAC are sign language, pictures, written language and voice output devices.*

What forms of AAC has your child used:

Do you feel he/she was successful? Yes ☐ No ☐
Why?

What does your child enjoy doing? (Toys, games, movies, sports, favorite characters)

What would you like to see your child do that he or she cannot do now?

Does your child use any special equipment? If so, please specify:

What else should we know about your child?

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## Consent for Release

I, _____, do hereby consent to permit Advancing Opportunities to make still or moving pictures of me and/or record my voice, distribute said likeness and make such use thereof as they desire for media coverage. I will also allow the publication of information about my past experiences and myself with Advancing Opportunities, in any articles, press releases or other forms of publicity or public information. I realize that in so consenting, I hereby release and discharge Advancing Opportunities their employees and volunteers from any liability claims or demands, in law or in equity, that I might have against any of them by reason of such photography, voice recording and information and subsequent use thereof.

Sign Name:
_____

Print Name:
_____

Date:
_____

_____
Parent/Guardian Signature if the individual is a minor)

This document is valid for two years from the date of signature

**Advancing Opportunities**
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