School Augmentative Communication Intake Form

Date: _____

IDENTIFYING INFORMATION

Student Name: _____
Date of Birth: _____ Age: _____
Address: _____
Parents/Guardians: _____
Telephone: _____ Home: ☐ Cell: ☐
Email: _____

Primary language spoken at home: _____

PERSON COMPLETING FORM

Name: _____
Relationship to Student: _____
Contact information: Email: _____ Phone Number: _____

SCHOOL INFORMATION

Name of School: _____
Address: _____
Contact Person: _____
Contact information: Email: _____ Phone Number: _____

Grade Level/Type of Classroom (self-contained, resource, etc.): _____

REPORT

Person to Receive Report: _____

Email: _____

SERVICES REQUESTED

☐ **AAC Evaluation**	Working at the school directly with the student and team to determine appropriate AAC options for the student. The evaluation includes a comprehensive report.
☐ **AAC Consultation**	A consultation to support teams with implementation of AAC options. Include assistance with set-up, training, and integrating use of AAC into classroom and attendance at IEP meetings (3-hour minimum charge per visit)
☐ **Training**	Training in a specific topic, such as programming an AAC device or teaching staff how to use support strategies (3-hour minimum charge per visit)

If you have a question about services, or a student with Assistive Technology needs, please contact Kristi Peak-Oliveira at kpoliveira@eastersealsma.org

PURPOSE OF REFERRAL

_____

MEDICAL DIAGNOSIS* (required)

_____

COMMUNICATION

Which of the following does the student use to communicate? Please check all that apply:

☐ Eye contact	☐ Gestures, Pointing	☐ Picture symbols
☐ Eye pointing	☐ Pulling person to desired object	☐ Single words
☐ Facial expressions	☐ Sign language	☐ Communication boards/book
☐ Vocalizations	☐ Photographs	☐ Spoken words
☐ Two word combinations	☐ Complete sentences	☐ Communication device
☐ Short phrases	☐ Write or type	☐ Other

VOICE OUTPUT COMMUNICATION

Is the student using a voice output device? Yes: ☐ No: ☐

If yes, please describe:

_____

FINE AND GROSS MOTOR FUNCTION

Please describe any concerns regarding motor status:

Fine Motor:

_____

Gross Motor:

_____

Does the student use a wheelchair? Yes: ☐ No: ☐

Please describe (manual, power, manufacturer, model):

_____

VISION AND HEARING

Please describe any concerns regarding vision and hearing:

Vision:

_____

Hearing:

_____

Other Service Providers: Please list any Occupational Therapy, Physical Therapy, Speech Language Therapy, ABA, TVI, etc. If these specialists should be contacted prior to the evaluation please include their contact information.

Provider: _____ Contact: _____

Provider: _____ Contact: _____

Provider: _____ Contact: _____

Provider: _____ Contact: _____

ADDITIONAL INFORMATION OR CONCERNS:

_____

PLEASE ATTACH ANY RELEVANT REPORTS – INCLUDING THE IEP - WITH INFORMATION RELATING TO COMMUNICATION, COGNITION, OR OVERALL DEVELOPMENTAL LEVEL.

Once the form is completed, please return via email to ATIntakes@eastersealsma.org

Please direct any questions to Kristi Peak-Oliveira, Assistant Director of AT Services, at kpoliveira@eastersealsma.org or 617-226-2861

Thank you for choosing Easter Seals services!