Good Shepherd Rehabilitation Hospital
Dornsife Pediatric Outpatient Center
Department of Speech and Language Pathology
Augmentative and Alternative Evaluation Questionnaire

******Please note: the information you provide is essential to your child receiving the best possible evaluation and recommendations. This questionnaire is lengthy and may take considerable time and thought by all members of the child's family. Please fill it out completely and return in the addressed envelope. Once your questionnaire has been received and reviewed, we will be in touch to schedule your evaluation. Your assistance is greatly appreciated by our staff and your child.******

Background Information

Child's Name: ______________________________

Date of Birth: ______________________________

Parents/Guardian(s): ______________________________

Referring Physician: ______________________________

Medications: ______________________________

Allergies: ______________________________

Diagnosis: ______________________________

Communication Needs:

1. Who does your child need to communicate with on a daily basis?

2. Where does your child need to communicate (locations/places)?

Communication Skills

1. How does your child communicate his/her needs and wants right now?

2. Has your child ever used speech generating device? If so, what type and how long was it trialed? Would you rate this trial successful or not successful? Why?

3. How effectively is your child understood by you? By others?

4. How well does your child understand you? Does he/she following 1-step commands? Does he/she answer yes/no questions?

Other Information

1. Is your child ambulatory? Or do they require the use of a wheelchair? If wheelchair is needed, please indicate the type of wheelchair used.

2. Can your child read or write? If so, what is there current literacy level?

3. When and where was your child's vision last tested? What were the results of this test?

4. When and where was your child's hearing last tested? What were the results of this test?

5. How are your child's fine/gross motor skills?

6. Who is your current treating speech and language therapist? (eg: school, private, early intervention) Please provide all speech and language therapist's names, phone numbers, and the address of the facility at which they see your child.