Children's Hospital Boston at Waltham

Department of Otolaryngology
and Communication Enhancement
9 Hope Avenue
Waltham, Massachusetts 02453

About the Augmentative Communication Program
The goal of the Augmentative Communication Program (ACP) is to identify solutions including systems, devices, and strategies that meet a person's needs for more effective communication at home, school, work, and in the community.

Who can benefit from ACP services?
ACP offers services for individuals with complex communication needs. Some of the persons seen at the ACP present with the following conditions:

- autism spectrum disorders
- cerebral palsy
- developmental delays
- metabolic and genetic conditions
- degenerative and neuromuscular conditions
- traumatic brain injury
- spinal cord injury
- acquired language disorders
- apraxia of speech
- dysarthria

How the program works
ACP staff includes speech language pathologists and occupational therapists with expertise in the area of augmentative communication. Scheduling with the appropriate clinician(s) will be based on intake information provided. The following areas of functioning are typically considered within an evaluation:

- speech
- language
- other means of communication
- vision and visual processing
- physical movement abilities
- Seating and positioning
- alternative inputs (i.e. keyboard, mouse, or switch)
- Positioning supports (trunk supports, wrist supports, AFOs)

Following an evaluation, clinician(s) recommend appropriate communication approaches and systems, which are customized to meet individual needs. Recommendations typically include low-tech solutions, which may be combined with a speech generating device, computer software, and/or an alternative keyboard or mouse. ACP clinicians welcome input from and collaboration with care providers, early intervention and school personnel, local professionals, and private therapists.

Location and hours
ACP is located on the second floor of Children's Hospital Boston at Waltham, 9 Hope Avenue, Waltham, Massachusetts. It is open 8:30 am to 5:00 pm Monday through Friday (excluding holidays).

To schedule an appointment
Enclosed please find an intake packet (to be completed by parents/caregivers/service providers). We ask that you send these materials as soon as possible to allow us to schedule your appointment with the appropriate clinician(s). Please refer to the top of this page for our mailing address. These forms are also available for download in PDF format from our website at www.childrenshospital.org/acp.

Please mail/fax the following materials prior to the appointment:

- Intake packet (enclosed)
- Recent communication evaluations

Please bring the following documents to the appointment:

- Copy of current IFSP/IEP/ISP
- Previous evaluations/re-evaluations (speech-language, developmental, neurological, cognitive/psychological)

In addition, we request you bring the following to the appointment:

- Materials used to support communication (e.g., **communication book, photographs, visual schedules, electronic communication devices, etc**.)
- Materials the individual finds motivating (e.g., toys, food, videos, etc.)
- Current eyeglasses and hearing aids
- Adaptive stroller or wheelchair (with tray) or other supportive seating

We encourage anyone supporting your individual's communication or education program to attend this meeting if at all possible.

Thank you for contacting the Augmentative Communication Program. We look forward to working with you and your individual.

If you need additional information, please contact ACP's Scheduling Coordinator at 781-216-2209.

Children's Hospital Boston at Waltham

Center for Communication Enhancement
Augmentative Communication Program
Pre-Visit Intake Form

Patient Information	
Name:	Date of birth:
Medical Record Number:	New to Children's Hospital? ☐ Yes ☐ No
Today's date:	Name of person completing this form:
Who referred you to our program? _____	_____ Relationship to patient: _____

Parent/Guardian Information	
Name(s):	
Address: Street: _____ City, State: _____ Zip Code: _____-_____	Patient's address: (If different from parent/guardian) Street: _____ City, State: _____ Zip Code: _____-_____
Telephone Number(s): Home: _____ Work/cell: _____	
Email address:	Primary language spoken at home: Need an interpreter? Yes/No

Purpose of Visit
What specific questions do you have? _____
Are you interested in looking at a specific augmentative communication strategy (e.g., device, technique, symbols, etc.)? _____

Medical Information	
Developmental Diagnoses (e.g., autism, global developmental delay, etc.):	**Medical Diagnoses:**
Medications: (please list name and purpose) *Example: Depakote for seizures*	
Hearing: Has your child's hearing been tested? Yes/No When: _____ Where: _____ Results: _____ Does your child wear hearing aids, use an FM system or have a cochlear implant? Yes/No	**Vision:** Has your child's vision been tested? Yes/No When: _____ Where: _____ Results: _____ Does your child wear glasses? Yes/No
Seizures? Yes/No If yes, please specify type and frequency:	Does your child experience difficulty **sleeping**? Yes/No If yes, please describe:
Feeding/Swallowing: Does your child exhibit problems with feeding/swallowing? Yes/No If yes, please specify: ☐ Dysphagia ☐ Selective ("picky") eater ☐ Drooling ☐ Other (please specify): _____ _____	_____ _____ _____ _____

Educational/Work Setting	
Name and description:	
Address:	Phone Number:
Student/Teacher Ratio:	Grade (if appropriate):

Special Services: (fill in all that apply)

Type of Therapy	*School, therapist's name, (# sessions x minutes/week)*	*Private, agency name, therapist's name, (# sessions x minutes/week)*
Example	*Mary Smith 2x30 minutes/week*	*Anywhere Rehab, Bob Jones 1x60 minutes/week*
Speech Therapy		
Occupational Therapy		
Physical Therapy		
Special Education		
ABA		
Other:		

Behavior	
Describe typical behavior:	List preferred toys, foods, songs, videos, etc.
How long will your child pay attention to an activity he/she is interested in?	Describe your child's personality (e.g., easygoing, rigid, happy, etc.)
Is your child able to easily transition between activities and environments? ☐ Yes ☐ No	Is your child motivated to interact with peers? ☐ Yes ☐ No
Please comment on your child's pretend play skills (e.g., combing doll's hair, pushing train on tracks, etc.): _____ _____ _____ _____	Does your child exhibit aggressive/self-injurious behaviors? ☐ Yes ☐ No If yes, please describe: _____ If Yes, is he/she currently receiving behavioral intervention? ☐ Yes ☐ No If yes, please describe: _____

Communication

Does your child currently: (Check all that apply)

- ☐ Understand simple directions? Example: _____
- ☐ Understand names for people and objects?
- ☐ Understand names for body parts?
- ☐ Answer simple questions? Example: _____
- ☐ Understand prepositions (in, under, on)?
- ☐ Understand color and size words?

Which of the following describe(s) how your child communicates? (Check all that apply)

- ☐ Pointing, gesturing, vocalizing
- ☐ Eye contact, facial expressions
- ☐ Babbling
- ☐ Pulls person to desired object
- ☐ Objects/tangible symbols
- ☐ Pictures
- ☐ Communication boards/book
- ☐ Sign language
- ☐ Single words
- ☐ Two word phrases
- ☐ Three to four word sentences
- ☐ Sentences with some errors
- ☐ Grammatically correct sentences
- ☐ Writing
- ☐ Communication device(s) – If yes, please complete page 6
- ☐ Other (please specify): _____

Please provide examples of your child's communicative messages (e.g., vocalizations, signs, picture symbol use, etc.):

If your child uses communication boards/books/devices to communicate, please provide additional information regarding:

Symbol type:

- ☐ Text
- ☐ PECS(Picture Exchange Communication System)
- ☐ Mayer-Johnson PCS
- ☐ Photographs
- ☐ Other

Number of symbols per page/display: _____

Presentation:

- ☐ Removable icons
- ☐ Static grid

Access:

- ☐ Point
- ☐ Symbol exchange
- ☐ Other: _____

Does your child communicate to: (Check all that apply)

- ☐ Ask for wants/needs?
- ☐ Get your attention?
- ☐ Label people, things, or pictures around him/her?
- ☐ Ask questions?
- ☐ Greet people?
- ☐ Ask for help?
- ☐ Share information?

What does your child do when not understood? Please explain (e.g., repeats message, modifies message, stops trying to communicate, etc.):

If your child speaks, do you have difficulty understanding his/her speech? If yes, please explain:

Do others have difficulties understanding his/her speech?

**Please mail copies of previous communication evaluations in advance of scheduled appointment

Communication Device(s):

Please complete if your child is using/has used a communication device

History of speech generating device use:

Name of device:
_____

Age of device: _____

Is the device currently being used? Yes/No

If no, please explain why:
_____

_____

_____

Parent knowledge of device:

- ☐ New device, no experience
- ☐ Basic skills (on/off, navigation)
- ☐ Can program
- ☐ Can operate
- ☐ Can customize
- ☐ Advanced programming

Environments where device is used: (Check all that apply)

- ☐ Structured school activities
- ☐ In therapy
- ☐ In the community
- ☐ At home during structured tasks
- ☐ Spontaneously at home for social interaction
- ☐ Spontaneously at school
- ☐ Spontaneously in the community

Device use: (Check all that apply)

- ☐ Initiates communication with system
- ☐ Uses system to ask and answer questions
- ☐ Needs direction/prompting
- ☐ Single key is used to express a full message
- ☐ Able to participate in a conversation using the device
- ☐ Functional spelling skills
- ☐ Uses system as a backup to speech
- ☐ Makes wants/needs known with device
- ☐ Uses device socially (e.g., greetings, questions, comments, etc.)
- ☐ Navigates device with assistance
- ☐ Navigates independently
- ☐ Explores device but doesn't use functionally

IEP Goals for device use:

Access: (Check all that apply)

- ☐ Direct selection (touchscreen, keyboard)
- ☐ Keyguard (yes/no)
- ☐ Scanning
  - Type of switch: _____
  - Number of switches: _____
  - Type of scanning: _____
- ☐ Joystick
- ☐ Headmouse
- ☐ Eyegaze
- ☐ Other: _____

Physical Status:	
Gross motor status: ☐ Walks independently with no balance or safety concerns ☐ Walks independently but needs supervision for safety ☐ Walks independently using assistive device (i.e. crutches, walker, cane) ☐ Can walk for short distances with physical assistance of another person ☐ Unable to walk	**Fine motor status:** ☐ Has no problem using both hands for feeding, writing, and other fine motor tasks ☐ Has functional use of right hand only ☐ Has functional use of left hand only ☐ Has great difficulty functionally using hands ☐ Can write for short periods of time after which it becomes fatiguing and effortful ☐ Can isolate a finger or thumb to activate a 1" target
Positioning supports: (Check all that apply) ☐ AFOs ☐ Trunk support: o Soft spinal orthosis o Benik trunk support o Leckey waistcoat o Other: _____ ☐ Wrist supports	**Positioning/assisted transportation:** ☐ Uses a stroller which is pushed by someone else ☐ Uses a manual wheelchair which is pushed by someone else ☐ Drives a power wheelchair using a joystick, head switch array, chin controller ☐ Stander ☐ Walker or gait trainer ☐ Other specialized positioning equipment
Can most easily control movements of: ☐ Eyes ☐ Head	☐ Right hand ☐ Left hand ☐ Foot

Computer:	
School: Platform: (circle one) Windows/Mac Operating System: Windows 2000, XP, Vista, OSX	*Home:* Platform: (circle one) Windows/Mac Operating System: Windows 2000, XP, Vista, OSX
Does your child use a computer at school? Yes/No	Do you have a working computer your child uses at home? Yes/No
How frequently does your child use the computer at school?	How frequently does your child use the computer at home?
Purpose(s) of computer use: (Check all that apply) ☐ Educational tool ☐ Reward ☐ Communication (e.g., computer-based voice output device, specialized software)	Purpose(s) of computer use: (Check all that apply) ☐ Educational tool ☐ Reward ☐ Communication (e.g., computer-based voice output device, specialized software)
Please list your child's preferred software programs:	
How does your child access the computer? (Check all that apply) ☐ Mouse ☐ Adaptive access (e.g., IntelliKeys, touch window, etc.)	☐ Keyboard ☐ My child does not independently access the computer

Financial/Insurance Information

Primary Insurance Information:

Health Insurance Provider:	Policy Holder's Name:
Policy Number(s) for Patient:	Group Number:
	HMO or PPO (circle one if applicable)
Primary Care Physician Name:	Phone Number:
Street Address:	City, State:
Zip Code:	

Secondary Insurance Information (if applicable):

Health Insurance Provider:	**Policy Holder's Name:**
Policy Number(s) for Patient:	**Group Number:**

If the student's school will be billed directly for clinic visit(s), please complete the following:

School system name: _____

Address:

Street: _____

City, State: _____

Zip Code: _____-_____

Contact person: _____ Telephone: _____

Email address: _____

ALSO: Please include a letter from the school system stating the intention to be financially responsible for this appointment. The letter should include the following information: student's name, date of birth, the name of our center (Augmentative Communication Program, Children's Hospital Boston at Waltham)