Boston Children's Hospital

Augmentative Communication Program

Pre-Visit Intake Form: Pediatric

Name of person completing this form: _____

Relationship to patient: _____ **Today's date:** _____

PATIENT INFORMATION	
Patient name:	**Date of birth:**
Patient address:	**New to Boston Children's Hospital?** ☐ Yes ☐ No—Medical Record Number:
Parent/Guardian name:	
Parent/Guardian address: *Same as patient* ☐	**Phone:** **Alternate phone:** **Email address:**
Primary language spoken at home: ☐ English ☐ Other: **Interpreter needed?** ☐ Yes ☐ No	**Who referred you to our program?**
PURPOSE OF VISIT: **The ACP works with people who have difficulty using speech. The purpose of the visit is to consider and evaluate augmentative and alternative communication (AAC) systems and strategies – not speech and language testing or therapy. Are you interested in learning more about AAC and exploring this in your visit?** ☐ Yes ☐ No *(If not, feel free to complete the remainder of this form; however, know that this may not be an appropriate program/referral)*	
What specific questions and/or goals do you have for this visit?	

MEDICAL INFORMATION

Please note that leaving information blank may delay our ability to offer an appointment

Medical and/or developmental diagnoses: _____

Check box if dx is unknown/undetermined ☐

The Americans with Disabilities Act website states: "Words are powerful. The words you use and the way you portray individuals with matters." The Center for Communication Enhancement at Boston Children's Hospital couldn't agree more. Accordingly, *if you feel comfortable, please share with us any language/terminology that you prefer related to you/your child's identity, diagnosis, or disability*:

Does your child have seizures? ☐ Yes ☐ No

If yes, please describe type and frequency:

Vision:

☐ Normal/no concerns

☐ Vision impaired—please describe:

Hearing:

☐ Normal/no concerns

☐ Hearing impaired—please describe:

Date of most recent vision assessment:

Date of most recent hearing assessment:

Does your child wear glasses? ☐ Yes ☐ No

Does your child use any of the following:

☐ Hearing aid(s) ☐ FM system

☐ Cochlear implant(s)

PHYSICAL STATUS

Gross motor:

☐ Walks independently

☐ Walks using an assistive device (e.g., walker, cane, gait trainer)

☐ Can walk for short distances with assistance

☐ Unable to walk

Fine motor/hand use:

☐ Has no difficulty using both hands for functional daily tasks (e.g., eating, dressing, writing)

Right hand use:

☐ No difficulty ☐ Some difficulty ☐ Great difficulty

Left hand use:

☐ No difficulty ☐ Some difficulty ☐ Great difficulty

Assisted transportation/positioning supports: *(Check all that apply)*

☐ None

☐ Adapted/conventional stroller

☐ Walker/gait trainer

☐ Wheelchair: *(Check details below)*

☐ Manual chair—Self-propelled? ☐ Yes ☐ No

☐ Power chair—Driven by: ☐ Joystick ☐ Head array ☐ Other:

☐ Any other support(s):

☐ Stander

☐ AFOs

☐ Trunk support

☐ Wrist supports

BEHAVIOR/INTERESTS

Describe typical behavior/personality:	**Please list preferred toys, songs, activities, foods, etc.**
Is your child able to easily transition between activities and environments? ☐ Yes ☐ No	**Is your child motivated to interact with peers?** ☐ Yes ☐ No
Does your child exhibit aggressive/self-injurious behaviors? ☐ Yes ☐ No *If yes, please describe:*	**How long will your child pay attention to an activity he/she is interested in?**

COMMUNICATION

Does your child currently: *(Check all that apply)*

- ☐ Respond to his/her name?
- ☐ Understand cause and effect?
- ☐ Anticipate familiar routines? *Example(s):* _____
- ☐ Follow simple directions? *Example(s):* _____
- ☐ Understand names for common objects?
- ☐ Understand basic categories?
- ☐ Answer simple questions? *Example(s):* _____
- ☐ Understand conversational discourse?

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

- ☐ Express wants/needs?
- ☐ Gain your attention?
- ☐ Greet or bid farewell?
- ☐ Label people, things, or pictures in his/her environment?
- ☐ Ask questions?
- ☐ Ask for help?
- ☐ Share information?

COMMUNICATION (Continued)

Which of the following naturalistic strategies does your child currently use to communicate? *(Check all that apply)*

- ☐ Facial expressions/eye contact
- ☐ Gestures (e.g., pointing, reaching)
- ☐ Physical communication (e.g., pulling a person to a desired object)
- ☐ Sign language — *Estimated number of signs used?* _____
  Example(s): _____
- ☐ Vocalizations
- ☐ Babbling
- ☐ Spoken single words (or word approximations) — *Estimated number of words used?* _____
  Example(s): _____
- ☐ Spoken multi-word sentences
  Example(s): _____

If your child uses speech to communicate, do you or others have difficulty understanding his/her speech? ☐ Yes ☐ No — *If yes, please describe:*

Does your child currently use any of the following "aided" strategies to communicate?

☐ Tangible symbols/objects *(Check all that apply)*

☐ Picture Communication Strategies — *Specify:*

☐ Photographs ☐ Symbols (e.g., Mayer-Johnson, SymbolStix) ☐ Both

Are the pictures: ☐ removable? ☐ static? *Number of pictures per page/display:* _____

☐ Simple Voice Output Communication Aid (VOCA) (e.g., Step-by-Step Communicator, Big Mack, etc.)

Please specify type of VOCA and use(s): _____

☐ Speech-generating device (SGD)

Type of device: _____ *Age of device:* _____

Number of buttons per page: _____ *Is the device currently being used?* ☐ Yes ☐ No

If no, please explain why: _____

☐ iPad — *Primary function:* ☐ Leisure ☐ Education ☐ Communication

If used for communication, what application? _____

☐ Computer — ☐ Windows PC ☐ Mac

Primary function: ☐ Leisure ☐ Education ☐ Communication — *Specify:* _____

How does your child access his/her primary aided communication strategy?

☐ Direct touch ☐ Head mouse ☐ Joystick

☐ Switch/scanning ☐ Eye gaze ☐ Other: _____

Please describe how your child is currently using his/her primary aided communication strategy:

Typical frequency of use (e.g., hours/day at school/home): _____

Does your child initiate use of the system? ..... ☐ Yes ☐ No

Does your child require prompting/support to use the system? ..... ☐ Yes ☐ No

Does the parent/primary caregiver know how to operate the system? ..... ☐ Yes ☐ No

Does the parent/primary caregiver know how to program the system? ..... ☐ Yes ☐ No

Who primarily programs/updates the system? _____

EDUCATION/THERAPY SERVICES

Name of school (or EI agency): | **Grade:**

Primary school/EI contact person:

Phone and/or email:

Type of classroom:

☐ Integrated/inclusion

☐ Partially integrated

☐ Substantially-separate

Therapy services: *(Check all that apply)*

☑ Speech therapy: _____ min/week

☑ Physical therapy: _____ min/week

☑ Occupational therapy: _____ min/week

☑ Other:

IEP/IFSP goals for communication:

(please summarize)

(Please remember to bring your child's current IEP or IFSP to the evaluation.)

FINANCIAL/INSURANCE INFORMATION	
Health insurance provider:	
Policy holder's name:	**Date of birth:**
Policy number for patient:	☑ **HMO** ☑ **PPO**
Primary Care Physician **Name:** **Phone number:** ***We will require a referral from your MD***	**Primary Care Physician address:**
Secondary health insurance provider *(if applicable)*:	
Secondary health insurance provider:	
Policy holder's name:	**Date of birth:**
Policy number for patient:	
If the student's school will be billed directly for the clinic visit(s), please complete the following:	
School system name:	
Contact person: **Phone number:** **Email address:**	**School system address:**
Note: 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, and the name of our center (Augmentative Communication Program, Boston Children's Hospital).	

★ **Please return this intake packet when completed to schedule an appointment.** ★

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