



# 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? <input type="checkbox"/> Yes <input type="checkbox"/> No—Medical Record Number: _____
Parent/Guardian name:	
Parent/Guardian address: <i>Same as patient</i> <input type="checkbox"/>	Phone: Alternate phone: Email address:
Primary language spoken at home: <input type="checkbox"/> English <input type="checkbox"/> Other: Interpreter needed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Who referred you to our program?
<b>PURPOSE OF VISIT:</b> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No ( <i>If not, feel free to complete the remainder of this form; however, know that this may not be an appropriate program/referral</i> )	
<b>What specific questions and/or goals do you have for this visit?</b>   	

MEDICAL INFORMATION
Please note that leaving information blank may delay our ability to offer an appointment
Medical and/or developmental diagnoses: _____
<i>Check box if dx is unknown/undetermined</i> <input type="checkbox"/>
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, <u><i>if you feel comfortable, please share with us any language/terminology that you prefer related to you/your child's identity, diagnosis, or disability:</i></u>
Does your child have seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If yes, please describe type and frequency:</i>

Patient name: \_\_\_\_\_

**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)*

- |   |  |
|---|--|
| <input type="checkbox"/> None<br><input type="checkbox"/> Adapted/conventional stroller<br><input type="checkbox"/> Walker/gait trainer<br><input type="checkbox"/> Wheelchair: <i>(Check details below)</i><br><input type="checkbox"/> Manual chair—Self-propelled? <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Power chair—Driven by: <input type="checkbox"/> Joystick <input type="checkbox"/> Head array <input type="checkbox"/> Other:<br><input type="checkbox"/> Any other support(s): | <input type="checkbox"/> Stander<br><input type="checkbox"/> AFOs<br><input type="checkbox"/> Trunk support<br><input type="checkbox"/> 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

**How long will your child pay attention to an activity he/she is interested in?**

*If yes, please describe:*

## 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?**

- Facial expressions/eye contact *(Check all that apply)*
- 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? \_\_\_\_\_

<b>EDUCATION/THERAPY SERVICES</b>	
<b>Name of school (or EI agency):</b>	<b>Grade:</b>
<b>Primary school/EI contact person:</b>	
<b>Phone and/or email:</b>	
<b>Type of classroom:</b> <input type="checkbox"/> Integrated/inclusion <input type="checkbox"/> Partially integrated <input type="checkbox"/> Substantially-separate <hr/> <b>Therapy services: (Check all that apply)</b> <input type="checkbox"/> Speech therapy: _____ min/week <input type="checkbox"/> Physical therapy: _____ min/week <input type="checkbox"/> Occupational therapy: _____ min/week <input type="checkbox"/> Other: _____	<b>IEP/IFSP goals for communication:</b> (please summarize)       <b>(Please remember to bring your child’s current IEP or IFSP to the evaluation.)</b>

<b>FINANCIAL/INSURANCE INFORMATION</b>	
<b>Health insurance provider:</b>	
<b>Policy holder's name:</b>	<b>Date of birth:</b>
<b>Policy number for patient:</b>	<input type="checkbox"/> HMO <input type="checkbox"/> PPO
<b>Primary Care Physician Name:</b> <b>Phone number:</b> <b>*We will require a referral from your MD*</b>	<b>Primary Care Physician address:</b>
<b>Secondary health insurance provider (if applicable):</b>	
<b>Secondary health insurance provider:</b>	
<b>Policy holder's name:</b>	<b>Date of birth:</b>
<b>Policy number for patient:</b>	
<b>If the student's school will be billed directly for the clinic visit(s), please complete the following:</b>	
<b>School system name:</b>	
<b>Contact person:</b> <b>Phone number:</b> <b>Email address:</b>	<b>School system address:</b>
<i>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).</i>	

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

**Mail:** Attn:

**Fax:** 781-216-2252

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