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**ASSISTIVE TECHNOLOGY EVALUATION
SCREENING FORM – REFERRAL AGENCY**

To be completed by the person making this referral, or other professional familiar with the consumer’s need for assistive technology. This information will be used to help us prepare for the evaluation. If you have questions about how we use it, please ask us at any time. Please make your answers as SPECIFIC as possible; circle more than one choice when appropriate; write additional information on additional paper. **The more we know about the consumer’s abilities and goals, the more efficient the evaluation will be, and the better the result.**

Last name: _____ First name: _____ Today’s date: _____
Date of birth: _____ Male/Female Address: _____
Ph: _____ e-mail: _____
Person completing this form: _____ Relationship to consumer: _____

PURPOSE OF EVALUATION:

What kind of assistive technology does the consumer need?
Augmentative communication / Computer access / Other (describe below)

IMPORTANT: Describe the problems assistive technology may help with. What do you expect or hope the consumer will be able to **do** with assistive technology that s/he cannot do now? (Add paper as needed)

If s/he has any assistive technology now, describe it: _____
Does s/he use it? Yes /No If not, why not? _____
What problems (if any) are there with it? _____

If the consumer had a previous assistive technology evaluation, state:

Date: _____ Where: _____
For what kind of technology?
Augmentative communication / Computer access / Other: _____

(If there was a written report, please attach a copy, or make arrangements for us to receive a copy.)

PERTINENT BACKGROUND INFORMATION

Diagnosis: _____ How long has s/he had this diagnosis? _____

If s/he take **medication**, what is it for? _____

Describe any **safety** issues we should know about (e.g., ventilator, seizures, etc.) _____

Any **vision** problems? (describe): _____ Glasses? Yes / No

Any **hearing** problems? (describe): _____ Hearing aid? Yes/No

Walking: Walks independently / Walks assisted (describe) _____ /Doesn't walk

Wheelchair: Power chair or scooter / Manual chair / None Self propel? Yes /No Laptray? Yes /No

If chair will be replaced soon, When? _____ Why? _____

Hand function: Right handed/Left handed Weakness, tremor, paralysis, or other problems?

(describe) _____

Can s/he: Hold a pen? Yes / No Feed self? Yes / No / Need help
Press buttons (as on a telephone)? Yes /No Comb own hair? Yes / No / Need help

Communication: Speech impairment? (describe) _____

Primary language? _____ Other language(s): _____

Cognition: Any problems with memory?: Short term / Long term
Any trouble following directions? Rarely or never / Occasionally / Often
Any trouble concentrating or sticking to a task? Rarely or never / Occasionally / Often

Education: Highest level completed: _____ In school now or soon? Yes / No
Trouble: Reading? Yes /No Doing basic arithmetic? Yes / No
Learning disability? Yes /No Describe _____

Does s/he have a personal care attendant? Yes /No If so, how often? _____

When was the last time the consumer received any:

- Occupational therapy Never / Over a year ago / Less than a year ago / Receiving now or soon
- Speech/language therapy Never / Over a year ago / Less than a year ago / Receiving now or soon
- Physical therapy Never / Over a year ago / Less than a year ago / Receiving now or soon
- Vocational eval./training Never / Over a year ago / Less than a year ago / Receiving now or soon
- Other rehab/therapy Never / Over a year ago / Less than a year ago / Receiving now or soon

describe: _____

COMPUTER ACCESS SCREENING INFORMATION
To be completed ONLY for consumer needing COMPUTER ACCESS services
(see next page for Augmentative Communication section)

What will the consumer use a computer **for**?

Word processing /Graphics /Internet /Education /Other (specify): _____

Does s/he **own** a computer now? If so, what **type**? _____

How much **experience** does s/he have with personal computer applications?

Word processing	Almost none / A little / Quite a bit / A lot
Computer graphics	Almost none / A little / Quite a bit / A lot
Internet	Almost none / A little / Quite a bit / A lot
Educational programs	Almost none / A little / Quite a bit / A lot
Games	Almost none / A little / Quite a bit / A lot
Other: _____	Almost none / A little / Quite a bit / A lot

What **SPECIFIC** difficulties is the consumer having (or is expected to have) with using a computer because of the disability? (For example: arm gets tired; can't read screen; hit 2 keys at once ; mouse moves when pressing button; etc.) **Describe ALL difficulties:**

Describe any **special computer equipment** or software s/he has used because of the disability (For example: special keyboard, left-handed mouse, typing stick, keyboard tray; talking word processor, etc.)

Does s/he have **pain** when using a computer? Don't know/No/Yes (where): _____

How long before pain starts? _____ How long before s/he stops due to pain? _____

Has s/he been treated for the pain? No / Yes What does the doctor say? _____

Where will the consumer use the computer? (circle all that apply)

A) Home / Work / School / Other _____

B) Lying on bed, couch /Standing /Office chair /Kitchen-type chair /Easy chair, couch /Wheelchair

C) Computer will be on: A desk / A table / In lap / A computer workstation / On laptray

AUGMENTATIVE COMMUNICATION SCREENING INFORMATION

To be completed ONLY for consumer needing AUGMENTATIVE COMMUNICATION services

(see previous page for Computer Access section)

Current methods of communication (circle all that apply):

- Speech
- Yes-no responses
- Gestures, facial expressions
- Manual communication board
- Electronic communication device (name) _____
- Other: _____
- Sounds
- Sign language
- Writing
- Eye gaze

Who can **understand** the consumer’s communication, and how well?

- Strangers Nearly always / Part of the time / Almost never / (not applicable)
- Teachers Nearly always / Part of the time / Almost never / (not applicable)
- Peers, friends Nearly always / Part of the time / Almost never / (not applicable)
- Parents Nearly always / Part of the time / Almost never / (not applicable)
- Siblings Nearly always / Part of the time / Almost never / (not applicable)
- Other Nearly always / Part of the time / Almost never / (not applicable)

What does the consumer do when s/he is **not understood** (circle all that apply)?

- Keep trying to communicate the same message
- Get angry / become distressed or tearful
- Stop trying to communicate
- Change the message to make self understood
- Get person who understands him/her to translate
- Other: _____

Does the communication problem affect the consumer’s: Social life? / Work or school life? / Family life?

Describe **effects**: _____

If the consumer has an electronic communication device:

Does s/he use it? Yes /No If not, why not? What problems (if any) is s/he having with it?
