COMMUNICATION PROSTHESIS PAYMENT REVIEW SUMMARY

1. PATIENT INFORMATION

Name:

Street:

City: **State:** **Zip:**

Birthdate:

Health Ins #:

Medical Diagnosis:

Speech Diagnosis:

2. FACILITY INFORMATION

Facility:

Address:

City:

State: **Zip:**

Telephone:

Physician:

Specialty:

Speech-Language Pathologist:

3. DEVICE INFORMATION

Item Description:

Manufacturer:
Distributer:

4. PHYSICAL STATUS PER DOCUMENTATION

	Adequate	Inadequate	N/A
General Medical Status:	☐	☐	☐
Respiratory:	☐	☐	☐
Hearing:	☐	☐	☐
Vision:	☐	☐	☐
Head Control:	☐	☐	☐
Trunk Stability:	☐	☐	☐
Arm Movement:	☐	☐	☐
Ambulation:	☐	☐	☐
Seating/Positioning (for SGD use):	☐	☐	☐
Ability to access SGD (switches, etc.)			
Summary:	☐	☐	☐

5. COGNITIVE PREREQUISITES

	Yes	No
a. Attempts to communicate with consistent response mode	☐	☐
b. Functional Yes/No	☐	☐
c. Understands communication will cause an action to occur:	☐	☐
d. Understands symbols (pics, signs, etc.) stand for verbal communication:	☐	☐
e. Prognosis to develop intelligible speech:	Poor ☐	Absent ☐ Guarded ☐
f. Demonstrates memory of verbal instruction:	☐	☐
g. Standardized test scores (if applicable):	☐	☐

6. SELECTION OF DEVICE

a. Patient's current means of communication:

b. Other SGDs considered and rationale for elimination:

c. Rationale for selection of specific SGD:

d. Indicators for success with recommended SGD:

7. PROGNOSIS

a. Communication ability:

b. Independence within environments:

c. Placement in least restrictive environment:

d. Academic ability:

e. Vocational Training/retraining:

We hereby certify that we do not have a financial relationship or other affiliation with a vendor, manufacturer or manufacturer's representative of speech generating devices (SGDs) and their accessories.

Physician Signature Date

Speech-Language Pathologist Signature Date