# Repair Speech/Language Evaluation

IMPORTANT: This document is intended for use for the repair of a Speech Generating Device (SGD).

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|---|---|
| **Client's name:** | |
| **Address:** | |
| **Date of birth:** | |
| **Check all that apply:** | ☐ Insurance Client ID Number: ____________<br>☐ Medicare Client ID Number: ____________<br>☐ Medicaid Client ID Number: ____________ |
| **Medical diagnosis/Speech diagnosis:** | |
| **Place of residence:** | ☐ Home ☐ Skilled Nursing ☐ Nursing Facility<br>☐ Custodial Living ☐ ICFMR ☐ Hospital |
| **Is Client Enrolled in a Hospice** | ☐ Yes ☐ No |

**Current Communication Impairment: Type of communication impairment**

**Physical status:**
**Examples of medical need for device**

**Daily communication needs:**
**Describe the daily functional use of the SGD.**

**Brief description of need for repair:**

**SLP Signature:**
**License Number:**

RSLE 03-29-12 adn