[if possible, print on letterhead]

ADDENDUM TO AAC EVLAUTION REPORT - TRIAL SUMMARY

(THIS MAY ALSO BE PART OF AN EVALUATION)

Date of Addendum:

Date of Original Evaluation:

Date of Trial/Rental Period (if applicable):

CLIENT INFORMATION

Name:

Date of Birth:

Medical Diagnosis:

Speech Diagnosis:

BACKGROUND INFORMATION

(IN THIS SECTION, SUMMARIZE THE CLIENT'S BACKGROUND INFORMATION, INCLUDING MEDICAL AND SPEECH DIAGNOSES. YOU CAN USE THE BACKGROUND INFORMATION FROM THE ORIGINAL AAC EVALUATION REPORT PLUS ANY RELEVANT UPDATES).

IF THE TRIAL WAS DELAYED BEYOND REQUIRED TIMELINE DUE TO COVID-19, EXPLAIN THE DELAY:

Example: *The original evaluation was dated XXX. The purchase request has extended beyond the required 6-month timeline. The reason the trial/addendum was delayed is XXX (Be specific. This will vary. Examples include extended school/clinic closure, client/family illness, difficulty with scheduling/paperwork, or other precautionary measures to prevent the spread of COVID-19).*

It is the professional opinion of this SLP that client's medical status and medical communication needs remain the same as the original evaluation. As such, the information and recommendation in the original evaluation are still valid.

SPEECH GENERATING DEVICE (SGD) TRIAL:

(IN THIS SECTION, SUMMARIZE THE DEVICE(S) TRIALED, THE TRIAL LENGTH, COMMUNICATION PARTNERS, MESSAGES COMMUNICATED, AND THE TRIAL LOCATION. DUE TO THE FACT THAT THE TRIAL LOACTION WAS A SINGLE SITE (E.G., HOME, SCHOOL, CLINIC/HOPSITAL),

1) EXPLAIN WHY THE DEVICE WAS ONLY USED IN ONE SITE, AND

2) DISCUSS THE MULTIPLE PLACES THE DEVICE WAS USED WITHIN THE SINGLE SITE

- *SCHOOL (CLASSROOM, CAFETERIA, NURSE'S OFFICE, PLAYGROUND, ART ROOM, SPEECH ROOM, FIELD TRIP)*
- *HOME (BEDROOM, BATHROM, KITCHEN/DINING ROOM, E-LEARNING, OUTSIDE, TELETHERAPY, TELEVISIT)*
- *CLINIC/HOSPITAL (THERAPY ROOM, CAFETERIA, HALLWAY, PHONE CALLS, ROLE PLAYING)*

Example*:*

The XXXX device was trialed from DATE to DATE. The device trial was conducted at the XXXX (e.g., client's home, client's school, hospital/clinic). The reason it was conducted in this setting is XXXX (e.g., precautionary measures due to illness/sickness, device liability, stay at home orders). Skills are transferrable from setting to setting. Therefore, the skills demonstrated with the device in this setting are transferrable to other settings, including XXXX (e.g., community, school, home, medical office). The device was used with the following people: XXXXX. The SLP was involved in supporting the trial, gathering data, and observing the use of the device directly or via video/ virtual sessions. The family was involved by identifying important medical communication needs, role playing, and reporting data.

USE OF SGD TO COMMUNICATE ESSENTIAL MEDICAL NEEDS

COMMENT ABOUT HOW THE CLIENT PRODUCED MESSAGES ON THE DEVICE (E.G., SINGLE WORDS, SPELLING, PREPROGRAMMED MESSAGES). PROVIDE EXAMPLES OF AT LEAST 10 MEDICALLY RELEVANT MESSAGES THE CLIENT DEMONSTRATED, INCLUDING THE INFORMATION OUTLINED IN THE CHART BELOW.

Function of Communication	Example of Message Generated	Communication Partner(s)	Place within the site	Can client do this without the device with unfamiliar communication partners?
Relay personal info	*"My name is Joe."* *"I am 20 years old."*	*Mom, SLP*	*Living room via Teletherapy with SLP*	*No*
Request bathroom	*"I need to use the bathroom"* *"go potty"*	*Teacher*	*Bathroom/Classroom*	*No*

FOLLOWING THE 10 EXAMPLES IN THE CHART, EXPLAIN HOW THE DATA GATHERED DURING THE TRIAL IN ONE SITE CAN GENERALIZE TO OTHER SITES. DISCUSS HOW SINGLE WORDS SUCH AS "UP, GO, EYE, MOUTH" CAN HELP THE PERSON IMPROVE COMMUNICATION ABOUT MEDICALLY RELEVANT INFORMATION TO PRIMARY CAREGIVERS

Example:

XXXX identified colors, this allows him/her to pick out colors, participate in decisions and choices across his/her environments including, but not limited to home/school/community at large. This ability to participate in decision making and choice making also reduces frustration/self-injurious behaviors when he/she doesn't get what she wants, and reduces frustration at not being able to communicate the choices or decisions he/she wants across all his/her communication environments. XXXX said 'mouth' to indicate need for suctioning for swallow precautions, which is medically necessary for his/her safety and must be communicated across home/school/community environments whenever and where ever the need for suctioning arises; etc.

OPERATIONAL SKILLS & INTRINSIC FACTORS

(*IN THIS SECTION, FIRST DESCRIBE THE OPERATIONAL SKILLS THE CLIENT DEMONSTRATED WITH THE DEVICE. EXAMPLES INCLUDE TURNING THE DEVICE ON/OFF, CARRYING THE DEVICE, CLEARING THE DISPLAY WINDOW, ADDING WORDS TO THE DEVICE, NAVIGATING ACROSS MULTIPLE PAGES, ADJUSTED VOLUME). THEN DESCRIBE THE INTRINSIC FACTORS THAT SUPPORT THE CLIENT'S ABILITY TO USE THE DEVICE. EXAMPLES INCLUDE ATTENDING TO DEVICE, INITIATING TO USE DEVICE, INCREASING INDEPENDENCE, INCREASED MOTIVATION, ETC.*

RECOMMENDATION

(IN THIS SECTION REITERATE YOUR RECOMMENDATION FOR PURCHASE. NOTE THE FAMILY'S ROLE DURING TRIAL AND THEIR AGREEMENT WITH RECOMMENDATION).

Example: "*Following the SGD trial, the (DEVICE NAME) has been found to be the most cost-effective SGD to meet (CLIENT's) medical communication needs. It is recommended that the following items be purchased for (CLIENT) which are needed for the proper and most functional use, positioning, and care of the SGD:*

- *E2510 (DEVICE NAME)*
- *E2599 (ACCESSORIES- KEYGUARDS, TOUCHGUIDES, SYMBOLS, VOICES) if any*
- *E2512 (MOUNT, SPECIFY) if any*

The family is in agreement with the recommendation. They were involved in the trial and completed virtual training with the device company consultant.

INDIVIDUAL TREATMENT & IMPLEMENTATION PLAN

(DISCUSS THE PLAN TO SUPPORT THE SUCCESSFUL USE OF THE DEVICE. INCLUDE WHO WILL BE TRAINED AND HOW THE CLIENT WILL LEARN TO USE THE DEVICE.)

Example:

The SLP will meet online with the family to set up the device. The family will also meet with the consultant for the company. The client will receive individual therapy 1/week for 45 minutes once school is in session or via teletherapy. The family will participate in monthly team planning calls to discuss progress.

LIST AT LEAST 3 GOALS FOR THE CLIENT TO ***MEET ESSTENTIAL MEDICAL NEEDS****.* INCLUDE ESTIMATED TIME FOR COMPLETION.

PHYSICIAN INVOLVEMENT STATEMENT:

(IN THIS SECTION INDICATE THE REPORT WAS SUBMITTED TO PHYSICIAN)

Example: *"This addendum was forwarded to the treating physician (NAME, ADDRESS, PHONE NUMBER) on (DATE). The physician has completed a Certificate of Medical Necessity for the recommended equipment.*

STATEMENT OF INDEPENDENCE AND SLP SIGNATURE

The speech-language pathologist performing this evaluation is not an employee of and does not have a financial relationship with the supplier of any SGD.

(YOUR NAME), CREDENTIALS
Speech-Language Pathologist
ASHA Certificate Number:

_____ _____

Signature Date