Assistive Technology

PRODUCTS AND SERVICES

Communication Devices Program
Electronic Communication Device Prescription Form

Deer Lodge Centre (DLC)
2109 Portage Ave.
Winnipeg, MB R3J 0L3
Phone: (204) 831-3430
Fax: (204) 885-2524

Date: D D | M M M | Y Y Y Y

FOR OFFICE USE ONLY
Received: D D M M M Y Y Y Y

PLEAE READ BEFORE PROCEEDING: All sections are to be complete prior to sending to CDP for approval. Incomplete Prescriptions may be returned to prescribing clinician.

1. CLIENT INFORMATION	
Client Last Name:	Client First Name:
Date of Birth: D D | M M M | Y Y Y Y	Personal Health Identification Number (PHIN):
2. PRESCRIBING CLINICIAN INFORMATION	
Speech-Language Pathologist (SLP) Name:	Occupational Therapist (OT) Name:
SLP Employer:	OT Employer:
SLP Phone/ Fax/ email:	OT Phone/ Fax/ email:

3. CURRENT COMMUNICATION METHOD(S)

Indicate all methods client currently uses to communicate:

- ❑ Verbal (please comment below on speech intelligibility and functionality) □ Gestures (please comment below)
- ❑ Electronic AAC (Give device name and approx. age):_____
  - ❑ Software / App and Profile: _____
- ❑ Non-electronic Communication Aide(s):_____
- ❑ Other: _____

Comments:

4. ROLES AND RESPONSIBILITIES FOR INTERVENTION AND FOLLOW-UP ACTIVITIES

Name	Relationship to Client/ Role	Contact phone #

Client Last Name: _____ Client First Name: _____ PHIN: |_|_|_|_|_|_|_|_|_|_|

5. ASSESSMENT INFORMATION

COGNITION □ No apparent deficits (proceed to next section)

Attention:

Memory:

Problem-solving skills:

Formal Screening: □ MoCA (Score:) □ MMSE (Score:) □ Other:

Implications for use of equipment (e.g., ability to navigate between screens, locate vocabulary, etc):

HEARING □ No apparent deficits (proceed to next section)

Hearing Aid: □ Right Ear □ Left Ear □ Both
□ If using, Bluetooth capable: □ Yes □ No

Functional ability of the **client** to hear the auditory output of an electronic device:	Functional ability of **communication partner(s)** to hear auditory output of an electronic device:

Implications for use of equipment/ Compensation Plan:

VISION □ No apparent deficits (proceed to next section)

If client is blind/visually impaired please comment on implications for functional use of equipment below:

i. **Acuities**: □ Within Functional Limits □ Unknown
Corrective Lenses: □ Glasses (complete below) □ Contact Lenses
□ Single □ Bifocals □ Progressives

ii. **Perceptual Abilities**: □ Within Functional Limits □ Unknown
□ MVPT (attach report/ summary) □ TVPS (attach report/ summary)
□ Other: _____

iii. **Visual Motor Integration**: □ Within Functional Limits □ Unknown
□ Comment on specific difficulties noted:_____
_____

iv. **Vision Disturbances**: □ Within Functional Limits □ Unknown
□ Diplopia □ Blurred Vision □ Burning Eyes □ Headache □ Nystagmus □ Cortical Visual Impairment
□ Other: _____

Implications for use of equipment/ Compensation Plan:

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ACCESS METHOD(S)	□ No apparent deficits (proceed to next section)
Support available for set-up/ take-down: □ Yes □ No (provide compensation plan below)	
❑ Direct selection using a body part. Specify body part(s):	❑ Direct selection using a tool. Specify tool:
❑ Head Mouse Selection Method: ❑ Blink ❑ Dwell (time): _____ ❑ External Switch (type/ site): _____	❑ Eye Tracking Selection Method: ❑ Blink ❑ Dwell (Time): _____ ❑ External Switch (type/ site): _____
❑ Switch Scanning ❑ Scanning type: □ Linear □ Row/Column □ Group □ Inverse □ Two Switch □ Other: _____ ❑ Switch type(s): _____ ❑ Switch site(s):	
❑ Other:	
Implications for use of equipment/ Compensation Plan:	

MOBILITY AND POSITIONING	□ No apparent deficits (proceed to next section)
Support available for set-up/ take-down: □ Yes □ No (provide compensation plan below)	
Indicate all mobility devices used:	
❑ Ambulatory ❑ Cane ❑ Walker ❑ Scooter ❑ Bed-bound ❑ Other:	❑ Manual wheelchair (complete section below) ❑ Power wheelchair (complete section below) Wheelchair make and model: _____ Wheelchair Track System: □ Unitrack □ Slide □ Other: _____ Wheelchair Frame Type: □ Square □ Round Wheelchair Frame has holes: □ Yes □ No
Environment Doorway width sufficient: □ Yes □ No (provide compensation plan below)	
Transfer Method: □ Independent □ Requires Assistance □ Mechanical	
Equipment to be used with: □ Manual Chair: □ Tilt □ Recline □ Power Chair: □ Tilt □ Recline □ Bed: □ Standard □ Hospital □ Furniture: □ Recliner □ Sofa □ Other: _____	
Implications for use of equipment/ Compensation Plan:	

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RECEPTIVE LANGUAGE □ No apparent deficits *(proceed to next section)*
Vocabulary:
Syntax:
Following Directions:
Comprehension of Questions:
Implications for use of equipment:
EXPRESSIVE LANGUAGE □ No apparent deficits *(proceed to next section)*
Vocabulary:
Syntax:
PRAGMATICS/ SOCIAL LANGUAGE □ No apparent deficits *(proceed to next section)*
Communication style: ❑ Active (i.e. frequently initiates communication; appears motivated to communicate) ❑ Passive (i.e. rarely initiates; appears less motivated to communicate) ❑ Other:
Communication Functions Demonstrated by Client: ❑ Greetings ❑ Comments ❑ Requests ❑ Questions ❑ Sharing information Other:
Implications for use of equipment:

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LITERACY □ No apparent deficits *(proceed to next section)*
Reading:
Writing:
Spelling:
Symbols:
Implications for use of equipment:
IMPLICATIONS/ DISCUSSION
Linguistic Competency: □ Emergent □ Emergent Transitional □ Context-Dependent □ Transitional Independent □ Independent **Comments:**
Operational Competency: □ Emergent □ Emergent Transitional □ Context-Dependent □ Transitional Independent □ Independent **Comments:**
Social Competency □ Emergent □ Emergent Transitional □ Context-Dependent □ Transitional Independent □ Independent **Comments:**
Strategic Competency □ Emergent □ Emergent Transitional □ Context-Dependent □ Transitional Independent □ Independent **Comments:**

Client Last Name: _____ Client First Name: _____ PHIN: |_|_|_|_|_|_|_|_|_|_|

ADDITIONAL INFORMATION (not captured elsewhere)

8. COMMUNICATION GOALS
1.
2.
3.
4.

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9. SGD SELECTION	
Communication Equipment:	Hardware: Software: User Profile:
Alternate Access/ Selection Method (including head mouse, stylus, keyguard, software settings):	
Mounting System:	
Protective Case:	

Name and signature of Speech Language Pathologist (SLP) Assessor/ Device Prescriber:

_____ _____ _____

Printed Name * SLP Signature Date

Name and signature of Occupational Therapist (OT) Assessor/ Device Prescriber:

_____ _____ _____

Printed Name * OT Signature Date

** It is my professional opinion that this individual meets the eligibility requirements for the CDP and that the prescribed equipment is the best option available at this time.*

PRESCRIPTION APPROVAL (CDP Internal Use)

Prescription Reviewed By:

_____ _____ Date Approved:_____

SLP Printed Name SLP Signature

_____ _____ Date Approved:_____

OT Printed Name OT Signature