Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg
Caring for Health / *À l'écoute de notre santé*

Assistive Technology
PRODUCTS AND SERVICES
Communication Devices Program
Speech Generating Device
Prescription Form

Health Sciences Centre (HSC)
59 Pearl Street
Winnipeg, MB R3E 3L7

Deer Lodge Centre (DLC)
2109 Portage Avenue
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

Complete and fax this form to the Communication Devices Program after you have completed all assessments and/or device trials and have determined what equipment your client will require.

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. CLIENT ELIGIBILITY

Client must meet all eligibility criteria. Check to confirm.

- ☐ Resident of Manitoba
- ☐ Age 18 or older
- ☐ Severe Communication Disorder (speech not understood by majority of listeners)
- ☐ Client/caregiver capable of caring for device
- ☐ Potential for using equipment as assessed by Speech-Language Pathologist/Occupational Therapist

3. PRIMARY CLINICIAN INFORMATION

Speech-Language Pathologist (SLP) Name:	Employer:
SLP Office Phone:	SLP Cell Phone:
SLP Fax:	SLP email:
Duration of Involvement with Client:	Ability to Follow the Client Every 6 Months: ☐ Yes ☐ No
Comments:	
Occupational Therapist (OT) Name:	Employer (if different from SLP):
OT Office Phone:	OT Cell Phone:
OT Fax:	OT email:
Duration of Involvement with Client:	Ability to Follow the Client Every 6 Months: ☐ Yes ☐ No
Comments:	

4. ASSESSMENT INFORMATION

HEARING

Functional ability of the **client** to hear the auditory output of a speech-generating device (SGD): ☐ Adequate ☐ Inadequate	Functional ability of **communication partner(s)** to understand auditory output of a device: ☐ Adequate ☐ Inadequate
Comments:	

Routing Instructions

1. Primary SLP and/or OT complete all applicable sections of this form.
2. Fax completed form to the CDP at: 1-204-885-2524.
3. Faxed copy of this form to be filed in the client's health record.

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VISION

If client is blind/visually impaired (not corrected with eyeglasses) comment on implications for functional use of SGD.

MOBILITY AND POSITIONING

Has OT assessed client for SGD mounting? ☐ Yes ☐ No

Do you need additional assessment/consultation from CDP OT? ☐ Yes ☐ No

Indicate all mobility devices used:

☐ Ambulatory
☐ Cane
☐ Walker
☐ Scooter
☐ Bed-bound
☐ Other:

☐ Manual Wheelchair
☐ Power Wheelchair
Wheelchair Make and Model: _____
Wheelchair Track System: ☐ Unitrack ☐ Slide ☐ Other: _____
Wheelchair Frame Type: ☐ Square ☐ Round
Wheelchair Frame has Holes: ☐ Yes ☐ No

Implications for Portability and Mounting:

Comments:

ACCESS

Has OT assessed access method? ☐ Yes ☐ No

Do you need the CDP OT to assess the client's access method? ☐ Yes ☐ No

☐ Direct selection using a body part.
Specify body part(s):

☐ Direct selection using a tool.
Specify tool:

☐ Scanning
Scanning Type: _____
Switch Type(s): _____
Switch Site(s): _____

☐ Head Mouse

☐ Eye Gaze*. Describe product used:

Comments:

CURRENT COMMUNICATION METHODS

Indicate all methods client currently uses to communicate.

☐ Verbal (please comment below on speech intelligibility and functionality)
☐ Gestures
☐ Speech-Generating device (Give device name and year purchased): _____
☐ Low-tech Augmentative and Alternative Communication: _____

Comments:

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RECEPTIVE LANGUAGE (Brief, functional description is sufficient)
☐ No apparent deficits *(proceed to next section)*
Vocabulary:
Syntax:
Following Directions:
Comprehension of Questions:
Comments/Implications for use of SGD:

EXPRESSIVE LANGUAGE (Brief, functional description is sufficient)
☐ No apparent deficits *(proceed to next section)*
Vocabulary:
Syntax:
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:
Comments/Implications for use of SGD:

LITERACY (Brief, functional description is sufficient)
☐ No apparent deficits *(proceed to next section)*
Reading:
Writing:
Spelling

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COGNITION (Brief, functional description is sufficient)
☐ No apparent deficits *(proceed to next section)*
Attention:
Memory Skills:
Problem-solving Skills:
Implications for use of an SGD (e.g., ability to navigate between screens, locate vocabulary):

5. COMMUNICATION ENVIRONMENT

List environments where client will most frequently use SGD.

6. DEVICE REQUIREMENTS

Check all device/software features required by client.

- ☐ Static display
- ☐ Dynamic display
- ☐ Scanning capability
- ☐ Large screen
- ☐ Small screen
- ☐ Very light weight/portable
- ☐ Real (physical) keyboard with text-to-speech
- ☐ On screen keyboard with text-to-speech
- ☐ Message window
- ☐ Word prediction
- ☐ Ability to support more than one language
- ☐ Synthesized (computer-generated) speech
- ☐ Digitized (recorded) speech
- ☐ Pre-programmed whole messages
- ☐ Single words for novel message creation
- ☐ Morphology
- ☐ Large vocabulary for independent communication in multiple activities/environments
- ☐ Limited vocabulary for restricted number of activities/ environments
- ☐ Estimated number of cells/screen _____
- ☐ Other:

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

Name	Relationship to Client	Role	Contact Phone #

8. INITIAL COMMUNICATION GOALS

1.

2.

3.

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9. SGD SELECTION

Speech Generating Device:	
Switches or Other Access Methods (including head mouse, stylus):	
Mounting System:	
Keyguard or Other Equipment (If client requires keyguard, specify size and type of keyguard):	
Name and Signature of SLP Assessor and Device Prescriber:	Printed Name _____ SLP Signature _____ Date: _____ *I have completed this assessment and it is my professional opinion that this individual meets the eligibility requirements for the CDP and that the prescribed equipment is the best communication option available at this time.*
Name and Signature of Other Assessor(s): (e.g. SLP, OT, Rehab Engineer, etc.)	Printed Name _____ Signature _____ Profession _____ Date _____

PRESCRIPTION APPROVAL (CDP Internal Use)

Prescription Reviewed By:

SLP Printed Name _____ SLP Signature _____ Date Approved: _____

OT Printed Name _____ SLP Signature _____ Date Approved: _____

Notes:

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