

Central State Hospital

620 Broad St.
Milledgeville, GA 31062

The individual's Identification

ASSISTIVE TECHNOLOGY EVALUATION

NAME: *List individual's first and last name*

ADMISSION DATE: *List date of admission*

ID#: *List ID number*

SOURCE(S) OF INFORMATION:

Interview with the following: (Check only those which apply)

Individual Staff member(s) *Specify staff name and any pertinent identifying information (e.g., staff familiar with individual, works on unit, trusted or preferred by individual)*

Family member(s) or friends *Specify who was interviewed and how (e.g., by phone) and when if not interviewed during evaluation*

Review of records (specify): *Document which parts of the record were reviewed, including previous assessments, evaluations, reports from consultations, diagnostic tests and/or lab work, treatment plans, and progress notes.*

REASON FOR EVALUATION: *List reason for evaluation and/or presenting problem(s)*

PERTINENT DIAGNOSIS: *List all diagnoses that are relevant to presenting problem(s) and current functional status.*

PERTINENT HISTORY: *Document clinical and/or personal history that may be relevant in assessing current functional status and in considering assistive technology interventions.*

HIGH RISK CONDITIONS: *List any medical, behavioral, and psychological risk conditions identified.*

PSYCHOSOCIAL FUNCTION: *For each item, check the most appropriate box and provide additional information as clinically indicated*

Affect: Appropriate Labile Flat Depressed Excited Anxious Delusional Hostile

Cooperation: Cooperative Refused to participate in evaluation Limited: *List clinically significant limitations in cooperation (e.g., individual was initially cooperative but refused to participate when assessment activities became challenging) and strengths (e.g. individual was able to cooperate within cognitive and communicative capacity)*

COGNITIVE FUNCTION:

Orientation and Environmental Awareness: *Describe the individual's awareness of the physical environment and orientation to daily schedule and activities.*

Attention: *Describe whether the individual is able to attend to questions, task directions, presented evaluation activities, and observed tasks.*

Problem solving: *Discuss individual's problem solving abilities as they relate to assistive technology (e.g., able to determine when batteries are dead on AAC device and change batteries with physical assistance).*

Safety awareness: *Discuss individual's safety awareness as it relates to assistive technology (e.g., does not remember to lock brakes prior to transitions)*

SENSORY AND PERCEPTUAL FUNCTION: *For each item, check the most appropriate box and provide additional information as clinically indicated*

Visual acuity: Functional Limited Functional with corrective lenses Refuses prescribed corrective lenses Blind **Visual**

perception: Functional Visual field cut Spatial bias Limited visual perception and/or understanding of spatial concepts: *List any specific perceptual deficits (e.g., spatial bias, visual field cuts) and discuss resultant impact on assistive technology access, switch placement and use (e.g., strong left spatial bias; place AAC access switch on left side. Needs verbal cueing*

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to self propel without veering to left)

Auditory acuity: Functional Limited Functional with corrective device Refuses prescribed corrective device Deaf

Sensory processing: Functional Hypo- or hyper-responsiveness noted or reported: *List any types of sensory input that the individual verbalizes or demonstrates an aversive reaction to, as well as any difficulties registering and processing sensory information which may affect assistive technology selection, fabrication and/or implementation (e.g., seeks vestibular input-may benefit from a rocking wheelchair).*

SEATING AND POSITIONING: Indicated Not indicated *Complete this section only if clinically indicated; if it is not indicated, check "not indicated" box and go to next section.*

Current supports: None List type, usage, adaptations: *List assistive technology systems and/or equipment (e.g. wheelchair for seating, positioning and mobility) as well as a description of type (e.g., standard make and model, custom), and schedule of use.*

Mat assessment: Indicated Not indicated *Complete this section only if clinically indicated; if it is not indicated, check "not indicated" box and go to next section.*

Supine resting posture: *Describe the individual's response to supine resting posture.*

Alignment: *Describe observed alignment unsupported and with various levels and types of support as clinically indicated.*

Tone and movement patterns: *Describe observed limitations in muscle tone and movement on attaining and/or maintaining alignment for optimal positioning.*

Musculoskeletal involvement: *Describe observed musculoskeletal limitations on attaining and/or maintaining alignment for optimal positioning.*

Wheelchair positioning assessment and simulation: Indicated Not indicated *Complete this section only if clinically indicated; if it is not indicated, check "not indicated" box and go to next section.*

Posture: *Describe individual's sitting posture in current wheelchair or seating system.*

Functional ability: *Describe individual's ability to access, propel and/or care for current wheelchair or seating system.*

Simulation findings: *Discuss results of simulation, including length of time in various positions, functional benefits and/or drawbacks of each position, and clinical observations (e.g. drop in O2 saturation, signs of individual discomfort or happiness). Document recommendations and clinical justification.*

Laptray and arm rest recommendations: *Document recommendation and clinical justification for laptray and armrest use; list any specific instructions for use schedule (e.g., remove laptray during meals to enable individual to sit at table, use laptray only as a working space for functional activities during mall art group)*

Bed positioning: Not indicated List equipment, turning schedule, positioning specifications: *If clinically indicated, describe bed position(s), as well as schedule, frequency of turning, and equipment or techniques for attaining and maintaining indicated positions.*

Alternate positioning: Not indicated Sidelying Quadraped on forearms Prone on forearms Other: *List any other devices utilized.*

Results: *If clinically indicated, assess individual for additional alternate positioning options. Discuss results, including length of time in various positions, functional benefits and/or drawbacks of each position, and clinical observations (e.g. drop in O2 saturation, signs of individual discomfort or happiness). Document recommendations and clinical justification. Describe alternate position(s), as well as schedule, frequency of turning, and equipment or techniques for attaining and maintaining indicated positions.*

Impact of alternate positioning on functional ability, participation and socialization: *Discuss the implications for alternate positioning on participation in daily activities and include a description on how each position facilitates and supports or limits functional performance (e.g., quadraped on forearms position provides proximal arm support to allow individual to participate in games requiring functional distal hand use; right elevated sidelying position is ideal for sedentary leisure activities such as watching movies.*

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ENVIRONMENTAL CONTROL: Indicated Not indicated *Complete this section only if clinically indicated; if it is not indicated, check "not indicated" box and go to next section.*

Current supports: None List type, usage, adaptations: *List assistive technology switches and/or equipment for environmental control; discuss mounting and access as well as function(s) of current equipment (e.g., uses big mac switch mounted to wheelchair to activate radio mounted beside headrest).*

Needs access to: Lights Doors Computer Television Music Appliances Other: *List activities and/or equipment that the individual requires access to in order to engage in vocational, educational, self care, and/or leisure and enrichment activities.*

Describe switch and/or EC device trials and level of ability and/or assistance needed: *Discuss results of trials, including level of interest, level of functional ability, assistance required, the need for training, and functional and preference related priorities. Document recommendations as well as clinical justification.*

Describe optimal placement and/or mounting of environmental control device(s): *Discuss specifics in terms of EC mounting and placement in terms of practicality, durability and functional accessibility.*

ALTERNATIVE AND AUGMENTATIVE COMMUNICATION: Indicated Not indicated *Complete this section only if clinically indicated; if it is not indicated, check "not indicated" box and go to next section.*

Current communication method(s): Eye gaze Vocalizations Facial expressions Gestures Sign Language Vocalizations Picture system Yes/no responses AAC Device: *List current AAC system and/or device as well as a description of type, and schedule of use.*

Words: *List any words that the individual is able to meaningfully and effectively use for communication.*

Sentences or phrases: *List any sentences or phrases that the individual is able to meaningfully and effectively use for communication.*

Body Language: *Describe body movements that the individual uses for expressive communication and communicative intent.*

Describe AAC trials and level of ability and/or assistance needed: *Discuss results of trials, including level of interest, level of functional ability, assistance required, the need for training, and functional and preference related priorities. Document recommendations as well as clinical justification.*

Describe optimal placement and/or mounting of AAC device(s): *Discuss specifics in terms of AAC mounting and placement in terms of practicality, durability and functional accessibility.*

Signature and date

Sign evaluation and list the date that the evaluation was finalized and completed.