

Central State Hospital

620 Broad St.  
Milledgeville, GA 31062

ASSISTIVE TECHNOLOGY EVALUATION

NAME: \_\_\_\_\_

ADMISSION DATE: \_\_\_\_\_

ID#: \_\_\_\_\_

SOURCE(S) OF INFORMATION:

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

Individual  Staff member(s): \_\_\_\_\_

Family member(s) or friends: \_\_\_\_\_

Review of records (specify): \_\_\_\_\_

REASON FOR REFERRAL: \_\_\_\_\_

DIAGNOSIS: \_\_\_\_\_

PERTINENT HISTORY: \_\_\_\_\_

HIGH RISK CONDITIONS: \_\_\_\_\_

PSYCHOSOCIAL FUNCTION:

Affect:  Appropriate  Labile  Flat  Depressed  Excited  Anxious  Delusional  Hostile

Cooperation:  Cooperative  Refused to participate in evaluation  Limited: \_\_\_\_\_

COGNITIVE FUNCTION:

Orientation and Environmental Awareness: \_\_\_\_\_

Attention: \_\_\_\_\_

Problem solving: \_\_\_\_\_

Safety awareness: \_\_\_\_\_

SENSORY AND PERCEPTUAL FUNCTION:

Visual acuity: Functional

Visual perception:  Functional  Visual field cut  Spatial bias

Limited understanding of spatial concepts: \_\_\_\_\_

Auditory acuity: Functional

Sensory processing:  Functional  Hypo- or hyper-responsiveness noted or reported: \_\_\_\_\_

SEATING AND POSITIONING:  Indicated  Not indicated

Current supports:  None  List type, usage, adaptations: \_\_\_\_\_

Mat assessment:  Indicated  Not indicated

Supine resting, prone, and/or sidelying posture(s): \_\_\_\_\_

Alignment: \_\_\_\_\_

Tone and movement patterns: \_\_\_\_\_

Musculoskeletal involvement: \_\_\_\_\_

Bed positioning:  Not indicated  List equipment, turning schedule, positioning specifications: \_\_\_\_\_

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Alternate positioning:  Not indicated  Sidelying  Quadraped on forearms  Prone on forearms

Other: \_\_\_\_\_

Results: \_\_\_\_\_

Impact of alternate positioning on functional ability, participation and socialization: \_\_\_\_\_

Wheelchair positioning assessment and simulation:  Indicated  Not indicated

Posture: \_\_\_\_\_

Functional ability: \_\_\_\_\_

Simulation findings: \_\_\_\_\_

Laptray and arm rest recommendations: \_\_\_\_\_

ENVIRONMENTAL CONTROL:  Indicated  Not indicated

Current supports:  None  List type, usage, adaptations: \_\_\_\_\_

Needs access to:  Lights  Doors  Computer  Television  Music  Appliances

Other: \_\_\_\_\_

Describe switch and/or EC device trials and level of ability and/or assistance needed: \_\_\_\_\_

Describe optimal placement and/or mounting of environmental control device(s): \_\_\_\_\_

ALTERNATIVE AND AUGMENTATIVE COMMUNICATION:  Indicated  Not indicated

Current communication method(s):  Eye gaze  Vocalizations  Facial expressions  Gestures  Sign Language

Vocalizations  Picture system  Yes/no responses

AAC Device: \_\_\_\_\_

Words: \_\_\_\_\_

Sentences or phrases: \_\_\_\_\_

Describe AAC trials and level of ability and/or assistance needed: \_\_\_\_\_

Describe optimal placement and/or mounting of AAC device(s): \_\_\_\_\_

ANALYSIS OF FINDINGS:  Not indicated; please refer to Integrated Therapy Services Analysis of Findings

Individual's priorities and life goals: \_\_\_\_\_

Present functional status: \_\_\_\_\_

Environments, modalities, preferences, and/or strategies that support learning and/or performance or may hinder performance: \_\_\_\_\_

Implications for Discharge Planning: \_\_\_\_\_

Recommendations for additional assessments or evaluation:  None  List: \_\_\_\_\_

Recommended Goal(s):  
\_\_\_\_\_

Recommended Objective(s):  
\_\_\_\_\_

Recommended Intervention(s):  
\_\_\_\_\_

**Georgia Department of Behavioral Health and Developmental Disabilities**

**Central State Hospital**

620 Broad St.  
Milledgeville, GA 31062

**ASSISTIVE TECHNOLOGY EVALUATION**

The individual's Identification

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**Signature and date**

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**Signature and date**

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**Signature and date**