Information Form for an Augmentative Communication Evaluation:

**Physical Therapist**

Student’s name: ______________________
Name of person completing form: ______________________

Please consider the abilities for the abovementioned student and select the option(s) that best describe(s) him/her in each category. Your input is very valuable and will be useful in successfully completing the augmentative communication evaluation.

**Seating/Positioning:**
- [ ] Sits in regular chair
- [ ] Sits in adapted chair
- [ ] Sits in wheelchair
- [ ] Has difficulty with head control
  Best position for head control is: ______________________

**Current fine motor abilities:** Student has voluntary, isolated, controlled movements using: (Check all that apply)
- [ ] Left hand
- [ ] Right hand
- [ ] Eye(s)
- [ ] Left arm
- [ ] Right arm
- [ ] Head
- [ ] Left leg
- [ ] Right leg
- [ ] Mouth
- [ ] Left foot
- [ ] Right foot
- [ ] Tongue
- [ ] Finger(s)
- [ ] Eyebrows
- [ ] Other: ______________________

**Mobility:** (Check all that apply)
- [ ] Walks independently
- [ ] Uses manual wheelchair
- [ ] Walks with assistance independently
- [ ] Uses power wheelchair
- [ ] Walks with appliance only
- [ ] Uses wheelchair for long distances
- [ ] Has difficulty walking
- [ ] Uses elevator key independently
- [ ] Has difficulty walking up stairs
- [ ] Is pushed in manual wheelchair
- [ ] Has difficulty walking down stairs
- [ ] Learning to use power wheelchair
- [ ] Needs extra time to reach destination wheelchair
- [ ] Needs help to transfer in and out of wheelchair
- [ ] Crawls, rolls, or creeps independently
- [ ] Transfers independently
Concerns about mobility: (Check all that apply)
- Student seems extremely tired after ambulating, requires a long time to recover
- Student seems to be having more difficulty than in the past
- Student complains about pain or discomfort
- Changes in schedule require more time to travel
- Changes in location or building are making it more challenging to get around
- Transition to new school will require consideration of mobility needs
- Other: ________________________________________________________________

Summary of student’s abilities and concerns related to mobility:
___________________________________________________________________
___________________________________________________________________

Range of motion: Student has specific limitations to range:
- Yes    - No
Describe the specific range in which the student has the most motor control:
___________________________________________________________________
___________________________________________________________________

Reflexes and muscle tone: Student has abnormal reflexes or abnormal muscle tone:
- Yes    - No
Describe briefly any abnormal reflex patterns or patterns of low or high muscle tone which may interfere with the student’s voluntary motor control.
___________________________________________________________________
___________________________________________________________________

Reliable muscle groups:
Describe muscle groups the student can use consistently and accurately.
___________________________________________________________________
___________________________________________________________________

Signature: ________________________________ Date: _____________
School/Program: ________________________________

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