Augmentative Communication System Selection

Member Name	Indiana Health Coverage Programs (IHCP) Member ID	Date of Birth

Address	City	State	ZIP

Section A – To be completed by physician. Use additional sheets as needed.

Medical diagnosis and history:

Physician Signature _____ Name _____

Provider ID _____ Phone _____

Address _____

Section B - To be completed by speech-language pathologist. Use additional sheets as needed.
Please describe current functional abilities in terms of:

Communication skills:

Motor status:

Sensory status:

Cognitive status:

Social/emotional status:

Language status:

Plan of care with the device (include family involvement in the plan and frequency of meeting with the speech-language pathologist):

Information is also needed on the following:

Educational ability and needs:

Vocational potential:

Anticipated duration of need:

Prognosis regarding oral communication skills:

Prognosis with a particular device: (Has there been a trial period with this or a similar device?)

Recommendation: (Why this particular device? What other kinds of equipment have been used?)

_____ Name _____

Physician Signature

_____ Phone _____

Address