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 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
☐ 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.

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Reliable muscle groups:

Describe muscle groups the student can use consistently and accurately.

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Signature: ______________________________ **Date:** _____________

School/Program: ______________________________________

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