

**SAMPLE
SPEECH GENERATING DEVICE EVALUATION
FOR MEDICARE**

I. DEMOGRAPHIC INFORMATION

Name: _____ History Number: _____
Date of Birth: _____ Account Number: _____
Medical Diagnosis: _____
Medicare: _____ Date: _____
Date of Onset: _____
Mailing Address: _____

II. CURRENT COMMUNICATION IMPAIRMENT

Circle: Aphasia Apraxia Dysarthria Anarthria

(This is a sample of what Medicare wants in the evaluation. The following blank lines are for patient's name).

A. Severity

This patient's needs cannot be met using natural communication methods or low-technology speaking aids. _____ has no useable speech. _____ is unable to produce intelligible utterances.

B. Anticipated Course of Impairment

Circle:

Stage 1: No detectable speech disorder

Stage 2: Obvious speech disorder, intelligible

Stage 3: Reduction in speech intelligibility

Stage 4: Natural speech supplemented with Speech Generating Device (SGD)

Stage 5: No useful speech (Speech Generating Device only)

Patient is currently at stage 5 and will remain at this level due to the degenerative nature of the disease.

C. Language Skills

_____ has the ability to formulate messages and converse using augmentative communication systems. _____ demonstrates good use of semantics and syntax.

D. Cognitive Ability

_____ attention, memory and nonverbal problem-solving skills are within functional limits. _____ sustained attention for a two-hour evaluation; recalled how to turn on and off the device and how to do simple short cuts to navigate between two screens.

_____ has also demonstrated some programming with a loaner DynaMyte.

E. Vision Status

_____ demonstrated good visual skills on the DynaMyte and because he/she is active and ambulatory the small size makes it easy to take into the community. Visual tracking was 100% on the assessment portion of the DynaMyte.

F. Hearing Status

Hearing was functional for communication in one on one and in-group settings and for the synthesized voice of the DynaMyte.

III. DAILY COMMUNICATION NEEDS

A. Specific Daily Functional Communication Needs

Using the speech-generating device (SGD), _____ will have the ability:

1. To participate in activities that promote psychosocial well-being such as emergency situation, support groups and community activities.
2. To fulfill family roles such as participating in family decision making, family leisure activities and communication with extended family by phone.
3. To participate in medical decision making such as reporting medical status, complaints, asking questions of medical providers and discussing choices for end of life care and communicating with medical providers by phone.

B. Ability to Use Low-Tech Strategies

Attempts to use low-tech aids revealed difficulty with use of letter board since _____ does not spell. He/she had difficulty with recall of letters indicated to spell words and phrases.

The use of a SGD could be used over the telephone and without the burden of communication on the listener. Other forms of treatment for improved speech are not indicated due to the progressive nature of his diagnosis.

IV. FUNCTIONAL COMMUNICATION GOALS

Pt. has already demonstrated use of the device without cues in various community settings using a loaner. Pt. will program two pages without cues with 95% accuracy to communicate needs to caregiver within the first 3 weeks.

Pt. will demonstrate communication of information to spouse with 95% accuracy using the SGD within the first 3 weeks.

Pt. and caregiver will complete a 6-hour training class for programming and use of the SGD in the community.

V. USE OF THE DEVICE

1. Cognitive

The patient demonstrates the ability to read, comprehend, spell, recall instructions and sequences and create complete messages with the SGD. He/she demonstrates the ability to use the SGD selected as well as the required accessories to communicate functionally.

2. Physical

The patient is ambulatory and can access the communication device by using direct selection.

_____ was able to demonstrate use of the device to communicate needs during the evaluation.

He/she has used the device during clinic to communicate to physicians and therapists without difficulty.

VI. RECOMMENDATION AND RATIONAL FOR DEVICE SELECTION

The patient requires use of the DynaMyte 3100 to meet functional daily communication needs. He/she was able to demonstrate use with limited error productions. _____ also attempted to use an eyegaze board, a laptop with onscreen keyboard, LightWriter and DynaVox 3100. The DynaMyte was selected because of _____ ability to use touch, the portability of the device and the ability to create multiple pages to communicate at home, church and in the community where _____ remains active. Use of the other devices did not provide the speed, accuracy and ability to communicate novel utterances in addition to preset icons/words. Use of the keyboard in alphabetical order was helpful, as _____ was not familiar with a standard QWERTY keyboard prior to his

disability. Due to the degenerative nature of the disease _____ will require the use of the plate switch for access. The memory card is necessary to save the program from the original device. The carrying case is required for protection of the device as _____ travels in the community.

This device fits the following:

CODE	SPEECH OUTPUT	MESSAGE TYPE	ACCESS METHOD	MESSAGE TECH
E2510	Synthesized	Message formulation	Multiple access methods	Spelling and other methods
E2512 MOUNT				
E2599 ACCESSORY				

VII. PATIENT AND FAMILY EDUCATION

The patient, _____ and caregiver were educated on use of the DynaMyte 3100 and basic information was reviewed with the patient demonstrating comprehension. The patient and the family selected the DynaMyte and related accessories and agreed to support the use of this equipment at home and in the community.

VI. INTERVENTION SCHEDULE

_____ has completed a 1-hour individual training with a loaner DynaMyte and is using it on a consistent basis. Training will include a 6-hour group class for use of this SGD and individual follow-up every 3 months in Neuromuscular/ALS clinic.

 (Name of SLP) MA CCC-SLP
 Speech Language Pathologist, (Name of Facility)

“I am not an employee of and do not have a financial relationship with the supplier of the SGD recommended.”

 (Doctors name), PhD, MD
 Medical Director, (Name of Facility)

“I agree with the above recommendations and acknowledge receipt of this evaluation prior to the equipment order.”