

SPEECH / LANGUAGE EVALUATION FORM

I. DEMOGRAPHIC INFORMATION

Client's name:	Date of Onset:
Date of birth:	Date of Evaluation:
Age:	Speech-Language Pathologist:
Medical Diagnosis & ICD Code:	Physician:
Speech Diagnosis & ICD Code:	

II. CURRENT COMMUNICATION IMPAIRMENT

Type of Communication Impairment:

Severity of Impairment:

Anticipated Course of Impairment:

Speech & Language Skills:

Cognitive Ability:

Vision/Hearing Status:

Physical Status:

III. CURRENT COMMUNICATION SKILLS

Current methods of communication:

Specific Daily Functional Communication Needs:

IV. DEVICE TRIALS

Previously Considered Communication Methods:

Device Trials:

V. DURABLE MEDICAL EQUIPMENT AND ACCESSORY REQUIREMENTS

Based on this evaluation, the following equipment is recommended:

1. E2510 Eyegaze Edge Talker with Eyeworld Communication Software
2. E2599 Eyegaze Edge Eye Tracking Package
3. E2512 Eyegaze Edge Mounting Package

VI. RECOMMENDATION AND RATIONALE FOR DEVICE SELECTION

VII. FUNCTIONAL COMMUNICATION GOALS

VIII. Training Schedule

IX. Physician Involvement Statement

This report was forwarded to the treating physician: Yes No

Date Forwarded:

Name of Physician:

Address of Physician:

Phone number of Physician:

NPI:

X. Speech Language Pathologist Statement/Assurance of financial independence

(SLP may not be an employee or have financial relationship with the supplier of the SDG):

I, (Name of SLP), am not an employee of the supplier of the SGD, nor do I have financial relationship with the company that supplies the device.

Signature of licensed SLP (including credentials): _____

SLP Name (please print):

SLP Phone Number:

ASHA Certification Number:

State License Number:

Please fax or mail this report with original signatures to:

Eyegaze Inc.
Attention: Funding Manager
10363 Democracy Lane
Fairfax, VA 22030

Fax: 703-385-7137

If using an encrypted email server, this completed evaluation report may be emailed to funding@eyegaze.com

Questions? 1-800-393-4293 or 703-385-8800