

**Information Form for 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:** (Check all that apply)

- Sits in regular chair with feet on floor
- Sits in regular chair with support under feet
- Sits in adapted chair
- Sits in wheelchair

**Desk Accessibility:**

- Uses regular desk
- Uses desk with height adjusted
- Uses adapted table
- Uses wheelchair for desktop
- Has difficulty using table or desk

**Description of Seating:**

- Seating provides trunk stability
- Seating allows feet to be on the floor
- Seating provides 90/90/90 position
- Has difficulty with head control

Best position for head control is: \_\_\_\_\_

**Summary of student's abilities and concerns related to seating and positioning:**

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**Current fine motor abilities:** Student has voluntary, isolated, controlled movements using: (Check all that apply)

- |                                       |                                     |                                 |
|---------------------------------------|-------------------------------------|---------------------------------|
| <input type="checkbox"/> Left hand    | <input type="checkbox"/> Right hand | <input type="checkbox"/> Eye(s) |
| <input type="checkbox"/> Left arm     | <input type="checkbox"/> Right arm  | <input type="checkbox"/> Head   |
| <input type="checkbox"/> Left leg     | <input type="checkbox"/> Right leg  | <input type="checkbox"/> Mouth  |
| <input type="checkbox"/> Left foot    | <input type="checkbox"/> Right foot | <input type="checkbox"/> Tongue |
| <input type="checkbox"/> Finger(s)    | <input type="checkbox"/> Eyebrows   |                                 |
| <input type="checkbox"/> Other: _____ |                                     |                                 |

**Range of motion:** Student has specific limitations to range:

- Yes       No

Describe the specific range in which the student has the most motor control:

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**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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