

**Augmentative Communication Service (ACS)
Guided Assessment – Daily Communication Partners**

Client Name:

Date of Birth:

GC#:

This Guided Assessment is intended to provide the child's team with information about the child to help plan steps in the initial assessment process and for further team planning. The term "child" is used it refers to any child or youth who has a complex communication need.

Complete all sections that are appropriate to the child. Omit any sections that you feel you cannot complete.

It is suggested that each team member from the child's Daily Communication Partners (e.g., parent(s), child care worker, teacher, educational assistant, etc.) provide input on this form.

The ACS at the Children's Treatment Centre has resources available for daily communication partners and local teams. Direct consultation may or may not be necessary. For many children, this information is enough for daily communication partners to begin to develop appropriate communication goals and decide on appropriate strategies and tools.

Referral to the Children's Treatment of Chatham-Kent ACS is appropriate if all of the following criteria are met:

- the child/youth is younger than 21 years of age
- the child/youth is a direct accessor (is able to point directly to items)
- the child/youth is an intentional communicator with picture discrimination (combination of core and fringe vocabulary)
- the child/youth has more than one communication function beyond requesting the child/youth's receptive language (understanding) is significantly better than expressive language abilities
- child/youth's communication system is used and supported at home (in addition to daycare, school, or other environments)

If a child has complex physical needs which make it difficult for him/her to point to books or displays directly with his/her finger, then the child may need "alternate access". Children requiring alternate access should be referred directly to the Thames Valley Children's Centre ACS Expanded Level Clinic.

Form Completed by:

Name	Role	Date Completed
		YYYY-MM-DD

Child's Name:

Date of Birth:

**Augmentative Communication Service (ACS)
Daily Communication Partners – Guided Assessment**

Local Team Members:

Role	Name	Where they work (agency / address)	Phone number and e-mail address
Parent(s)/Guardian(s)			
Teacher & School/Daycare			
Resource Teacher			
Assistants			
Speech-Language Pathologist			
Occupational Therapist			
Physical Therapist			
Service Coordinator			
Other Agency/Specialist			
Other Agency/Specialist			
Other Agency/Specialist			

CHILD

1. How well do you feel the child communicates?
<p>Please rate:</p> <p><input type="checkbox"/> Very poorly <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> Excellent</p> <p>Comments:</p>

What is the child's diagnosis?

Who made the diagnosis and when?

Are there any hearing/vision concerns?

1. Does the child use a mobility device(s) or other support(s)?:

Support	Yes	No	Comments
Walker	<input type="checkbox"/>	<input type="checkbox"/>	
Wheelchair (power or manual)	<input type="checkbox"/>	<input type="checkbox"/>	
Crutches, canes	<input type="checkbox"/>	<input type="checkbox"/>	
AFOs, splints	<input type="checkbox"/>	<input type="checkbox"/>	
Stroller	<input type="checkbox"/>	<input type="checkbox"/>	
Supportive seating (wheelchair insert, special chair)	<input type="checkbox"/>	<input type="checkbox"/>	
Hand splints	<input type="checkbox"/>	<input type="checkbox"/>	
Other: specify	<input type="checkbox"/>	<input type="checkbox"/>	

2. How does the child access materials?

Access Ability	Yes	No	Comments
Is the child able to point to small pictures in books directly with his/her finger(s)?	<input type="checkbox"/>	<input type="checkbox"/>	
Is the child's independent pointing to objects, pictures, or words easy for most partners to understand?	<input type="checkbox"/>	<input type="checkbox"/>	
Is the child able to push buttons or individual computer keys?	<input type="checkbox"/>	<input type="checkbox"/>	
Is the child able to use a mouse/track pad/track ball?	<input type="checkbox"/>	<input type="checkbox"/>	

Which finger/body part does the child use most often (and accurately) for pointing?

3. Language / Learning Skills:

Skill Area	Comments / Description
Describe the child's current classroom/grade placement (i.e., regular, special, amount of integration, etc.).	
Describe in your own words what you think the child understands.	
Describe in your own words how the child expresses thoughts/ ideas.	
Describe in your own words the child's literacy and numeracy skills.	

4. Behavioural:

Are there any behaviours (positive and negative) that significantly impact the child's performance?

Behaviour	Comment / Describe
<input type="checkbox"/> motivation <input type="checkbox"/> arousal level <input type="checkbox"/> aggressive <input type="checkbox"/> attention <input type="checkbox"/> self-stimulatory <input type="checkbox"/> sensory seeking <input type="checkbox"/> other _____ <input type="checkbox"/> other _____	

5. Communication interaction skills:

a. How often does the child communicate with people?

FREQUENTLY OCCASIONALLY NEVER

Comments:

b. How does the child indicate **YES** and **NO**?

<input type="checkbox"/> Shakes head	<input type="checkbox"/> Vocalizes	<input type="checkbox"/> Uses word approximations
<input type="checkbox"/> Points to board	<input type="checkbox"/> Facial Expression/Gestures	<input type="checkbox"/> Does not respond consistently
<input type="checkbox"/> Signs	<input type="checkbox"/> Eye gazes	<input type="checkbox"/> Does not respond consistently
<input type="checkbox"/> Other (describe):		

c. Can a **person unfamiliar** with the child understand the child's YES and NO responses?

<input type="checkbox"/> FREQUENTLY <input type="checkbox"/> OCCASIONALLY <input type="checkbox"/> NEVER
Comments:

d. Can a **person unfamiliar** with the child understand the child's communication attempts?

<input type="checkbox"/> FREQUENTLY <input type="checkbox"/> OCCASIONALLY <input type="checkbox"/> NEVER
Comments:

e. Describe strategies the child uses if **not understood**: [i.e., keeps trying, changes message, points to location, gestures, starts to cry, etc.]

6. Parent/Guardian Feedback on Child's Preferences:

Preferences	Describe as many as possible (write specific examples)	The child shows this by doing.... (How do you know?)
Likes / Favourites		
Most favourite activities (something the child always likes to do)		
Most favourite objects (something the child always likes)		
Dislikes / Frustrations		
The child does not like...		
The child becomes frustrated when...		

Other Comments about the child's likes and dislikes:

8. **Different reasons the child communicates:** [check all that apply]

Does the child...?	How Frequently?		
	Never	Occasionally	Frequently
...interact and take his/her communication turn with:			
1. familiar partners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. with peers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. with unfamiliar partners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...address you when he/she wants you to help him/her achieve a goal? (i.e., vocalizes or pulls your hand when wanting to be positioned, fed, take a ride, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...refuse an offered object, food, clothing, or anything that he/she dislikes? (i.e., shakes head, frowns, and/or vocalizes when handed undesired food item)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...direct your attention for the purpose of having you notice an object or event? (i.e., vocalizes with excitement and looks at you when seeing a fire truck or police car racing down the street)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...answer questions...?			
1. YES/NO questions (i.e., shakes or nods head when asked "Do you want to go outside?")	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. CHOICE questions (i.e., stares or points at picture or object when asked "Do you want to eat a banana or drink juice?")	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. WH questions (i.e., points at kitchen when asked "Where do you want to go?")	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...greet or show a social response upon appearance of a family member or in response to other's greetings? (i.e., looks towards person entering the room and smiles), signal thanks and/or wave goodbye?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...make a comment while attending to objects or actions? (i.e., touches picture of "upset" to tell you about how he is feeling)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...express his/her opinion or judges the value of something or someone? (i.e., shows dissatisfaction with facial expression to indicate refusal toward a particular cloth item)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...comment about past events? (i.e., tells you that he/she got hurt at school by pointing at his/her leg and then to picture of school)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...ask questions? (i.e., during dinner time, points to sibling's empty chair, vocalizes while looking at you, and then waits for a response)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...use a sense of humour? (i.e., expresses or does something silly with the only purpose to evoke laughter or amusement)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...try repairing communication breakdowns? (i.e., corrects him/herself, provides new information to make him/herself clear or expresses non comprehension)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...try justifying his actions? (i.e., says no, then touches his/her head and frowns when asked to go out to indicate that he/she does not want to go because he/she is having a headache)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
... make predictions? (ie. looks outside and asks for a coat on a cloudy day)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ENVIRONMENT AND PARTNERS

1. Where does the child spend time? (check all that apply and describe activities in the environment)

<input type="checkbox"/> Home	
<input type="checkbox"/> Daycare	
<input type="checkbox"/> School	
<input type="checkbox"/> After School Care	
<input type="checkbox"/> Community	
<input type="checkbox"/> IBI/ABA	
<input type="checkbox"/> Respite	
<input type="checkbox"/> Other	

TASKS

1. What are the daily or regular activities (tasks) that the child is expected or desired to be able to do that he/she is currently unable to due to lack of augmentative and alternative communication tools or strategies?

TOOLS

1. What augmentative and alternative communication tools does the child currently use (be specific)?

Type of Tool	For Input (partner uses to help child understand)	For Output (child uses to help partner understand)
No Tech Strategies: (i.e., gestures, eye gaze, facial expressions, body language, partner strategies, sign language, etc.)		
Low Tech Tools: (i.e., visual supports, schedules, communication board/book, picture exchange, etc.)		
High Tech Tools: (i.e., speech-generating devices, computer equipment, switches, special mouse, etc.)		

NEXT STEPS

1. Are there **communication goals** for the child?

YES

I DON'T KNOW

NO

If Yes, list the child's communication goals:

- 1.
- 2.
- 3.

2. How are goals being worked on?

Please rate:

Not at all

1

2

3

4

5

Completely

Comments:

3. What **supports** have been accessed for the child? [please list]

<u>People:</u> (i.e., daily communication partners, school/Board support staff, ASD Consultants, specialists, medical teams, Early Interventionists, etc.)
<u>Training:</u> (i.e., Hanen, sign language, computer software, trainings, workshops, individual coaching, etc.)
<u>Materials/Resources:</u> (i.e. websites, books, articles, etc.)

4. What are the next steps for the child?

5. Do the Daily Communication Partners have the skills and knowledge to proceed?

<input type="checkbox"/> YES	<input type="checkbox"/> NO
If No, what are the gaps/needs?	

6. If further consultation is needed, what do you hope will be achieved from a referral to the ACS Clinic?

<input type="checkbox"/> Strategies to improve child's expressive communication (i.e., needs/ideas, vocabulary)	<input type="checkbox"/> Strategies to help clarify a child's speech that is not understood by most partners.
<input type="checkbox"/> Strategies to assist child in communicating more with peers, school staff, and others.	<input type="checkbox"/> Help identify vocabulary needs for communication book/display.
<input type="checkbox"/> Assistance with assessment and goal setting.	<input type="checkbox"/> Help design a communication book/ display.
Other/Comments:	