Repair Speech/Language Evaluation

IMPORTANT: This document is intended for use for the repair of a Speech Generating Device (SGD).

Client's name:	
Address:	
Date of birth:	
Check all that apply:	☐ Insurance Client ID Number: _____ ☐ Medicare Client ID Number: _____ ☐ Medicaid Client ID Number: _____

Medical Diagnosis/Speech Diagnosis:

Place of residence:	☐ Home	☐ Skilled Nursing	☐ Nursing Facility
	☐ Custodial Living	☐ ICFMR	☐ Hospital
Is Client Enrolled in a Hospice?	☐ Yes ☐ No		

Current Communication Impairment: Type of communication impairment	
Physical status: Examples of medical need for device	
Daily communication needs: Describe the daily functional use of the SGD.	
Brief description of need for repair:	

SLP Signature:	**License Number:**
SLP Name (Print):	**Date:**