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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
	☐ Other (Please specify):		
Is Client Enrolled in a Hospice:	☐ Yes ☐ No		

Current Communication Impairment: Type of communication impairment

Physical status:
Examples of medical need for device

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Daily communication needs:
Describe the daily functional use of the SGD

Brief description of need for repair:

Is this repair due to abuse or neglect: ☐ Yes ☐ No

*If yes, please explain:

Plan to safeguard device:

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

**PRC-Saltillo to complete:
Original purchase date of the SGD