Equipment Demo Request

SLP Contact Information:

Name:_____ Phone:_____ Ext: _____

Facility: _____ Fax: _____

Address:_____ County: _____

City: _____ State:_____ Zip: _____

Email: _____

Preferred method of contact: ☐ Phone ☐ Email

Client Contact Information:

Name:_____ DOB: _____

Address: _____ Phone: _____

City:_____ State:_____ Zip:_____

County: _____

Notes:

Best days and times for an appointment:

☐ **Monday**	☐ **AM**	☐ **PM**
☐ **Tuesday**	☐ **AM**	☐ **PM**
☐ **Wednesday**	☐ **AM**	☐ **PM**
☐ **Thursday**	☐ **AM**	☐ **PM**
☐ **Friday**	☐ **AM**	☐ **PM**

Location of Assessment: _____

_____

Products of interest:

- ☐ **ProSlate 8™**
- ☐ **ProSlate 10™**
- ☐ **ProSlate 13™**
- ☐ **WinSlate 12™**
- ☐ **WinSlate 12 Enable Eyes™**

Other:

Diagnosis:

- ☐ Cerebral Palsy
- ☐ Head Injury
- ☐ MS
- ☐ ALS
- ☐ MR/DD
- ☐ Spinal Cord Injury
- ☐ Muscular Distrophy
- ☐ Paraplegic
- ☐ Quadriplegic
- ☐ Stroke
- ☐ Autism
- ☐ Other_____

Client Skills:

- ☐ Speller (*circle one*)
  Good Poor Beginner
- ☐ Slight Words Only
- ☐ Future Speller
- ☐ Non-Speller

Rev 07/20/2017

Access Method:

- ☐ Touch
  Approx. Target Size
- ☐ Scanning
  - ☐ Visual
  - ☐ Auditory
- ☐ Eye Tracking

Vision:

- ☐ Normal
- ☐ Normal w/lenses
- ☐ Req. Enlargement
- ☐ Very Limited
- ☐ Legally Blind

Speech:

- ☐ Totally Non-Verbal
- ☐ Limited Intelligibility
- ☐ Dysarthric
- ☐ Aphasic
- ☐ Other _____

Ambulation Method:

- ☐ Walks (*circle one*)
  Normal Involved
- ☐ Manual W.C.
- ☐ Power W.C.
- ☐ Walker
- ☐ Scooter
- ☐ Bed
- ☐ Other _____

Payment Method:

(*check all that apply*)

- ☐ Medicaid
- ☐ Home Care Waiver
- ☐ Private Insurance
- ☐ BVR/ Voc Rehab
- ☐ Medicare (Part B)
- ☐ Medicare HMO
- ☐ Self-Pay
- ☐ School System
- ☐ Other _____

Client Resides:

- ☐ Private Residence
- ☐ Group Home
- ☐ Nursing Facility
  - ☐ Skilled
  - ☐ Assisted Living
  - ☐ MR/DD
  - ☐ ICF/MR
- ☐ Receives Hospice Care

Is Infectious Disease Present?

☐Bloodborne ☐Airborne

Previous Device(s):

(*provide all requested info*)

Device _____

Date Obtained_____

Funding Source_____

Reason(s) for wanting to change device(s)

_____

Forbes AAC
181 Illinois Ave. South
Mansfield, OH 44905

phone 419.589.7688
fax 419.589.5146

FORBES AAC

forbesaac.com