SENSORY & COMMUNICATION

About this Domain (Sensory & Communication)
To assess and collect information about the individual's:

- Vision and hearing
- Sensory functioning
- Ability to communicate
- To identify referrals for unmet needs

Vision

Does the person have any problems with their vision?

- o No
- o Yes
- o Chose not to answer

If 'Yes' was selected, the following questions will be displayed:

Check all that apply:

- ☐ Cataracts
- ☐ Decreased Side Vision - Left
- ☐ Decreased Side Vision - Right
- ☐ Diabetic retinopathy
- ☐ Farsighted
- ☐ Glaucoma
- ☐ Halos or rings around light, curtains over eyes, or flashes of lights
- ☐ Legally Blind (even with the use of glasses or contacts)
- ☐ Macular degeneration
- ☐ Nearsighted
- ☐ Night Blindness (unable to functionally see in dark environments)

- [ ] Problems with Depth Perception
- [ ] Retinitis Pigmentosa
- [ ] Tunnel Vision
- [ ] Other _____ *(Displays when 'Other' is checked)*
- [ ] Other _____ *(Displays when 'Other' is checked)*

Describe your vision WITHOUT the use of an assistive device:

- Can read regular print in books or newspapers (Adequate)
- Can read regular print but may have decreased peripheral vision; may not read regular print but can read headlines or large print (Minimally Limited)
- Must have large print to read; has difficulty identifying small objects; vision has limited usefulness for navigation (Moderately Limited)
- Sees primarily lights and shadows; has significantly restricted field of vision; or no useful vision (Severely Limited)
- Unknown

Does the person use any assistive devices to help with their vision?

- No
- Yes
- Chose not to answer

If 'Yes' was selected to the previous question, the following question will be displayed:

Check all that apply:

- [ ] Books on tape / CD
- [ ] CCTV (closed circuit TV for magnification of print materials)
- [ ] Cassette player
- [ ] Computer input devices (switches, buttons, adaptive key strokes)
- [ ] Computer output device (refreshable Braille display)
- [ ] Computer software (screen magnification i.e. Magic or screen reader i.e. JAWS)
- [ ] Contacts
- [ ] Distance magnifiers
- [ ] Glasses
- [ ] Hand reader or stand magnifier
- [ ] Large number phone
- [ ] Large Visual Display (LVD) for TTY

- ☐ Long or folding cane
- ☐ Medical phone alert system
- ☐ Projection devices
- ☐ Reading Rectangle
- ☐ Seeing eye dog/Guide dog
- ☐ Service animal
- ☐ Strong convex lenses
- ☐ Tactile or Braille markings for appliances / other IADL items
- ☐ Talking watch / clock
- ☐ Other _____ *(Displays when 'Other' is checked)*

Describe your vision WITH the use of your assistive device(s):

- ○ Adequate – can read regular print in books or newspapers
- ○ Minimally limited – can read regular print but may have decreased peripheral vision; may not read regular print but can read headlines or large print
- ○ Moderately limited – must have large print to read; has difficulty identifying small objects; vision has limited usefulness for navigation
- ○ Severely limited – sees primary lights and shadows; has significantly restricted field of vision; or no useful vision
- ○ Not determined

How often does the person use their assistive device(s)?

- ○ During all working hours
- ○ Only when prompted/supervised
- ○ As needed
- ○ Refuse to wear/use

Explain: _____ *(Displays when this option is checked)*

- ○ Chose not to answer

Does the person use their assistive device(s) as prescribed/recommended?

- o No

Explain: _____ *(Displays when this option is checked)*

- o Yes
- o Chose not to answer

Is the person able to maintain and/or use their assistive device(s) on their own?

- o No

Explain: _____ *(Displays when this option is checked)*

- o Yes
- o Chose not to answer

Do the assistive device(s) meet the person's vision needs?

- o No

Explain: _____ *(Displays when this option is checked)*

- o Yes
- o Chose not to answer

Can the person find their way in unfamiliar environments independently?

- o No
- o No, but not due to vision
- o Yes
- o Chose not to answer

(If 'No' was selected to previous question, the following question will be displayed)

Is the person currently receiving any training?

- O No
- O Yes

Explain: _____ *(Displays when this option is checked)*

- O Chose not to answer

Would they like to receive orientation or mobility training?
(Displays when 'No' is checked to previous question)

- O No

Explain: _____ *(Displays when this option is checked)*

- O Yes (make referral for appropriate training)
- O Chose not to answer

Has your vision become worse in the last 3 months, or since your last assessment?

- O No
- O Yes - consider a referral for further vision or medical assessment
- O N/A (blind)
- O Unsure - consider a referral for further vision or medical assessment
- O Chose not to answer

Notes/Comments: _____

Vision has been reviewed and updated? *(Displays for reassessment only)*

☐ Yes

Hearing

Does the person have any hearing loss?

- No
- Yes
- Chose not to answer

If 'Yes' was selected, the following questions will be displayed:

Describe your hearing WITHOUT the use of an assistive device:

- Normal
- Difficulty in 1:1 conversations with some people and/or in noisy environments (Minimally Impaired)
- Some useful hearing; uses own speech to make needs and wants known (Moderately Impaired)
- May hear loud sounds; identifying source and location of sound may be difficult; relies on visual means for understanding others (sign language, written language, speech reading, captioning on television) (Highly Impaired)
- No useful hearing (Severely Impaired)
- Unknown

Does the person use any assistive devices to help with their hearing?

- No
- No – uses interpreter
- Yes – has device but chooses not to use it

Explain: _____ *(Displays when this option is checked)*

- Yes
- Chose not to answer

If 'Yes' was selected, the following questions will be displayed:

What type of device(s)? (check all that apply):

- ☐ Alerting devices (for phone, doorbell, smoke detectors, etc.)
- ☐ Assistive listening device
- ☐ Audio loop system
- ☐ Captel telephone
- ☐ Closed captioning
- ☐ Cochlear implant(s)
- ☐ FM sound system
- ☐ Hearing aid - right
- ☐ Hearing aid - left
- ☐ Infra-red sound system
- ☐ Service animal
- ☐ TTY telephone
- ☐ Other _____ *(Displays when 'Other' is checked)*

Describe your hearing WITH the use of your assistive device(s):

- ○ Normal
- ○ Minimally Impaired – difficulty in 1:1 conversations with some people and/or in noisy environments
- ○ Moderately Impaired – overall useful hearing; uses own speech to make needs and wants known
- ○ Highly Impaired – may hear loud sounds; identifying source and location of sound may be difficult; relies on visual means for understanding others (sign language, written language, speech reading, captioning on television)
- ○ Severely Impaired – no useful hearing
- ○ Unknown

How often does the person use their assistive device(s)?

- O During all working hours
- O Only when prompted/supervised
- O As needed
- O Refuse to wear/use

Explain: _____ *(Displays when this option is checked)*

- O Chose not to answer

Does the person use their assistive device(s) as prescribed/recommended?

- O No

Explain: _____ *(Displays when this option is checked)*

- O Yes
- O Chose not to answer

Is the person able to maintain their assistive device(s) on their own?

- O No

Explain: _____ *(Displays when this option is checked)*

- O Yes
- O Chose not to answer

Do the assistive device(s) meet the person's hearing needs?

- O No

Explain: _____ *(Displays when this option is checked)*

- O Yes
- O Chose not to answer

Has the person's hearing become worse in the last 3 months, or since their last assessment?

- ○ No
- ○ Yes - consider a referral for further hearing or medical assessment
- ○ Unsure - consider a referral for further hearing or medical assessment
- ○ Chose not to answer

Notes/Comments: _____

Hearing has been reviewed and updated? *(Displays for reassessment only)*

☐ Yes

Functional Communication

Does the person have difficulty communicating with and/or making their wants and needs known to others?

- ○ No
- ○ Yes
- ○ Chose not to answer

If 'Yes' was selected, the following 2 questions will be displayed:

Describe the nature of the difficulty (check all that apply):

- ☐ Delayed expressive language
- ☐ No functional communication
- ☐ No functional expressive language
- ☐ Non-verbal
- ☐ Receptive language impairment (inability to comprehend spoken language)
- ☐ Speech impairment (articulation)
- ☐ Speech impairment (functional expressive language)

What is the primary cause of the difficulties you identified?

- Cognitive issues (delayed/ disordered development)
- Deaf
- Motor issues (cerebral palsy, etc.)
- Neurological issues (e.g., seizures, aphasia, apraxia)
- Physical / medical issues (e.g., after a laryngectomy)
- Other

Explain: _____ *(Displays when this option is checked)*

Expressive Communication Skills:

- No impairment
- Speech intelligible to familiar listeners
- Speech difficult to understand
- Combines signs and/or gestures to communicate
- Uses single signs or gestures to express wants and needs
- Uses augmentative communication aid
- Does not have functional expressive language

Receptive Communication Skills:

- Comprehends conversational speech
- Comprehends phrases with gestural cues/modeling prompts
- Limited comprehension – one to two words
- Comprehends signs/ gestures/modeling prompts
- Does not comprehend verbal, visual or gestural communication
- Unknown (specify in comments)

Comments: _____

Does the person currently receive speech and language therapy?

- O No
- O Yes

Explain: _____ *(Displays when this option is checked)*

- O Chose not to answer

Does the person need or would they like to receive speech and language therapy services?
(Displays when 'No' is checked)

- O No

Explain: _____ *(Displays when this option is checked)*

- O Yes – (make referral)
- O Chose not to answer

Does the person use some form of sign language to communicate?

- O No
- O Yes
- O Chose not to answer

What type of sign language do you use? ***(Displays when 'Yes' is checked)***

- ☐ American Sign Language
- ☐ Baby Sign
- ☐ Emoticon + Bodicon (facial expression + body language)
- ☐ Home Signs, Gestures
- ☐ International Sign Language
- ☐ Limited or Close Vision Signing
- ☐ Manual alphabet (finger spelling)
- ☐ Signed English
- ☐ Tactile (hand in hand) Signing
- ☐ Other

Explain: _____ *(Displays when 'Other' is checked)*

Does the person use visual language, other than sign language to communicate?

- ○ No
- ○ Yes
- ○ Chose not to answer

What type? *(Displays when 'Yes' is checked)*

- ☐ Cued speech
- ☐ Speech reading
- ☐ Writing or typing
- ☐ Other

Explain: _____ *(Displays when 'Other' is checked)*

Does the person use facilitated communication?

- ○ No
- ○ Yes
- ○ Chose not to answer

Does the person use any type of augmentative communication device?

- ○ No
- ○ No, but would like to (make referral)
- ○ Yes
- ○ Chose not to answer

If 'Yes' was selected, the following questions will be displayed:

What type of device(s)?

- ☐ Alpha Smart
- ☐ Alpha Talker
- ☐ Artificial Larynx
- ☐ Big Mac Switch
- ☐ Braille Screen Communicator
- ☐ Cheap Talk
- ☐ Dynamite
- ☐ Dynavox
- ☐ Electric Output Device
- ☐ Link Assistive Device
- ☐ Mini Message Mate
- ☐ PECS
- ☐ Pocket Talker
- ☐ Speak Easy
- ☐ TTY
- ☐ Voice Photo Album
- ☐ Voice Recognition Software
- ☐ Other Personal Listening Device _____ (Displays when 'Other' is checked)
- ☐ Other Picture Systems _____ (Displays when 'Other' is checked)
- ☐ Other _____ (Displays when 'Other' is checked)

Does the person need any of the following to use the device?

- ☐ Back up device when primary device is in for repair/maintenance
- ☐ Training
- ☐ Support or assistance

Explain: _____ *(Displays when this option is checked)*

- ☐ Other

Explain: _____ *(Displays when this option is checked)*

Does the assistive device meet the person's communication needs?

- ○ No

Explain: _____ *(Displays 'No' is checked)*

- ○ Yes
- ○ Chose not to answer

Do the device(s) currently need any of the following?

- ☐ Periodic repair
- ☐ Programming
- ☐ Replacement
- ☐ Upgrades or enhancements
- ☐ Other

Explain: _____ *(Displays when this option is checked)*

Has the person's ability to make their wants and needs known or to understand what others are saying to them become worse in the last 3 months?

- ○ No
- ○ Yes - make a referral for further medical or communication assessment
- ○ Unsure - make a referral for further medical or communication assessment
- ○ Chose not to answer

Notes/Comments: _____

Functional Communication has been reviewed and updated? *(Displays for reassessment only)*

- ☐ Yes

Sensory Integration

Does the person have a Sensory Integration Disorder Diagnosis?

- o No
- o Yes

Explain: _____ *(Displays when this option is checked)*

- o Unsure
- o Chose not to answer

Does the person have a Hypersensitivity Diagnosis - are they overly sensitive to sensory stimulation (touch, taste, smell, movement, hearing, vision)?

- o No
- o Yes

Explain: _____ *(Displays when 'Yes' is checked)*

- o Unsure
- o Chose not to answer

(If 'Yes' was selected to either question above, the following questions will be displayed)

Does the person use assistive devices or other interventions to help with sensory integration?

- o No
- o Yes
- o Unsure
- o Chose not to answer

If 'Yes' was selected to previous question, the following question will be displayed

Check all that apply:

- ☐ Noise canceling headphones
- ☐ Occupational therapy
- ☐ Safety ear plugs
- ☐ Sensory diet / menu for gaining behavioral control
- ☐ Other device

Explain: _____ *(Displays when this option is checked)*

- ☐ Other intervention

Explain: _____ *(Displays when this option is checked)*

Does the person experience any of the following issues related to sensory input?

- ☐ Appear to hear adequately, but have a delayed response to sounds / speech
- ☐ Avoid being touched
- ☐ Can't keep hands to self
- ☐ Difficulty keeping tongue in mouth, put hands / fingers in mouth frequently
- ☐ Difficulty making transitions from one situation to another
- ☐ Difficulty screening out sights and sounds (visual/auditory stimuli)
- ☐ Difficulty unwinding or calming self
- ☐ Engage in self-injury
- ☐ Engage in self-stimulation
- ☐ Fearful of activities moving through space, such as using an escalator, climbing stairs, etc.
- ☐ Fearful of new tasks and situations
- ☐ Grind, clench teeth
- ☐ Make repetitive vocal sounds – such as humming, throat-clearing, frequent coughing
- ☐ Misjudge force required to open and close doors, give hugs, etc.
- ☐ More clumsy or careless than peers
- ☐ Overly sensitive to touch, movement, sights, lights, or sounds
- ☐ Poor balance
- ☐ Prefer activities that involve swinging, spinning, rocking
- ☐ Reject textures of food, clothing
- ☐ Respond to loud or unexpected noise by becoming upset
- ☐ Rock self, to sleep, in frustration, in comfort, in excitement
- ☐ Smell objects

- [ ] Under-reactive to touch, movement, sights, or sounds
- [ ] Unusually high activity level
- [ ] Unusually low activity level
- [ ] Unusual reaction to pain – doesn't seem to notice
- [ ] Unusual reaction to pain – particularly noticeable reaction
- [ ] Walk on toes
- [ ] Other

Explain: _____ *(Displays when this option is checked)*

Notes/Comments:

Sensory Integration has been reviewed and updated? ***(Displays for reassessment only)***

- [ ] Yes

Supports Needed

Based on the results of the assessment, are there any health or safety issues that need to be considered in providing support to the person? For example, do they need signaling devices?

- o No
- o Yes

Explain: _____ *(Displays when 'Yes' is checked)*

- o Chose not to answer
- o Does the person need assistance to evacuate during emergencies, because of vision, hearing or other issues?
- o No
- o Yes

Explain: _____ *(Displays when 'Yes' is checked)*

- o Chose not to answer
- o Under what circumstances does the person need to have an interpreter or transliterator present?

Describe: _____

Does the person need any assistance in caring for their assistive device(s) or service animal?

- o No
- o Yes

Explain: _____ *(Displays when 'Yes' is checked)*

- o Chose not to answer

Notes/Comments: _____

Supports Needed has been reviewed and updated? ***(Displays for reassessment only)***

☐ Yes

Referrals (Sensory & Communication)

What is important to the individual?

_____

Referrals Needed:

- ☐ Assistive Technology _____ *(Displays if checked)*
- ☐ Deaf Blindness Services _____ *(Displays if checked)*
- ☐ Hearing Loss Resource Center _____ *(Displays if checked)*
- ☐ Hearing Specialist (audiologist, ENT) _____ *(Displays if checked)*
- ☐ Interpreter Services _____ *(Displays if checked)*
- ☐ Occupational Therapist _____ *(Displays if checked)*
- ☐ Ombudsman _____ *(Displays if checked)*
- ☐ Primary Health Care Provider _____ *(Displays if checked)*
- ☐ Speech/Language _____ *(Displays if checked)*
- ☐ Vision Loss Resource Center _____ *(Displays if checked)*
- ☐ Vision Specialist (optometrist, ophthalmologist, etc.) _____ *(Displays if checked)*
- ☐ Other **Specify:** _____ *(Displays when 'Other' is checked)*
- ☐ Other **Specify:** _____ *(Displays when 'Other' is checked)*

Assessed Needs and Support Plan Implications

_____

Referrals & Goals (Sensory & Communication) has been reviewed and updated?

(Displays for reassessment only)

- ☐ Yes