

AAC Pre-Assessment Form

Caregiver & School Team Information (updated Jan 2026)

Personal Information

Name of Student:		Date of Meeting(s):
School:	Grade:	Parent/guardian(s): Primary Medical Diagnosis:
Teacher:	Class Rm#:	Language(s):
Student Services Teacher:		Spoken:
Alternative spaces required:		Understood:

COMMUNICATION AND INTERACTION SKILLS

1. Have any recent speech-language assessments been completed with the student yes | no

2. What specific **communication** questions and concerns do you want addressed during this assessment?

Family: _____

School Team: _____

3. How is the student currently communicating? *(check all that apply)*

___ Verbal: ___ one word, ___ two words ___ three words, ___ sentences

If using verbal speech, how intelligible is the student?

➔ Familiar person with context: ___ % Unfamiliar person without context: ___ %

___ Vocalizations

___ Body Positioning

___ Signs/ASL

___ Bring desired item to person/person to item

___ Pointing/Reaching

___ Core Vocabulary Board

___ Eye Gaze

___ AAC Device: _____

___ Gestures

___ Echolalia (delayed / immediate)
Common Scripts

___ Facial Expressions

4. Does the student initiate communication:

___ Independently (with who?): _____

___ With prompt (with who?): _____

5. Does the student communicate for purposes of (check all that apply):

___ Requesting

___ Share Information

___ Commenting

___ Protesting

___ Questioning

___ Telling a story

___ Interaction/greeting

6. Describe how the student tells you when they

are feeling happy or sad?
are hungry or thirsty?
need help with something?
want something to stop?
want more of something?
want a specific toy/game/person?
have a question?
need the bathroom?

7. What, if any, everyday technology or devices does the student use (or try to use)? Examples: TV, YouTube, Netflix, iPad or tablet, video game, electronic toys.

8. What long-term communication goals do you have for the student?

SUPPORTS, MOTOR SKILLS AND SENSORY PREFERENCES

1. Does the student currently receive/have:

speech therapy (school-based and/or private)	yes no
occupational therapy	yes no
physiotherapy	yes no
vision supports	yes no
hearing supports	yes no
other:	yes no

a wheelchair (manual/power)	yes no
laptray on wheelchair	yes no
braces (hands/feet/body)	yes no
glasses	yes no
hearing aid(s)	yes no
walker	yes no
stander	yes no
bike	yes no

2. Please list current medications and their purpose.

Medication	Purpose

3. Circle which parts of their body the student can **voluntarily control**, if student has motor difficulties (indicate if left or right side is preferred).

head arm fingers elbow foot toe fist eye other:

4. If the student would use a device, what way of operating the device do you think they might use?

point with a finger/thumb

point with fist

use a light on head

look at the desired word/symbol

use a switch to scan to the words

point with a head stick

6. If the student is currently using a switch, what kind of switch is it and where is it placed?
7. If the student is in a wheelchair, do you feel they are well positioned and comfortable in the chair?
yes | no Describe.
8. Are there toileting needs?
9. Does the student require support for eating/have a modified diet? If so, describe.
10. Does the student demonstrate sensory preferences (likes and dislikes)?
11. Describe any calming or regulating strategies that are beneficial to the student.
12. Describe any specific interests/motivators.

AUGMENTATIVE & ALTERNATIVE COMMUNICATION:

1. Does the student already use an **AAC device**? yes | no If YES, please name the device/app/software and indicate how long the student has been using this device.
2. Does the student have a **paper-based communication board, pictures or eye pointing**? yes | no
If YES, describe below:

3. Have any other AAC device(s) been tried or suggested? yes | no If YES, please describe them.

Name of the device/app/software	
How did the student operate it?	
What grid size or how many buttons?	
Where was it used? (school/home)	
How long was it used?	

4. If the student is in a wheelchair and had an AAC device in the past, how was the device transported with the student? (circle)

on the laptray | with a mounting system | carried by someone | other

5. If the student had a mounting system for an AAC device,

- Is it in working order? yes | no
- Does that mounting system fit his/her current wheelchair? yes | no

6. Does the student use any type of switches to operate things? yes | no If YES, describe:

- What part of the body does the student use to activate the switch?
- How are the switches mounted or stabilized?
- What kind of things does the student control with a switch? How good is the student controlling his/her timing in hitting the switch at the right time?

SCHOOL CONSIDERATIONS:

1. Is there an IEP in place if previously attended school? Communication goals?
2. Is there a visual schedule in place? Timers? Explain transitions.
3. Describe interest in and exposure to literacy at school/home.

Current literacy abilities:

Is the student able to identify all uppercase letters?

Is the student able to identify all lowercase letters?

Is the student able to identify all consonant sounds?

Is the student able to identify all vowel sounds?

Can they order all the letters of the alphabet?

Have they shown knowledge of sight words?

Does the student access a writing tool and/or keyboard to type/explore typing?

Has an LRSD literacy screener or adapted assessment been completed with this student?

NEXT STEPS:

TO DO:

- ☐ Communication Dictionary
- ☐ TASP
- ☐ TACL
- ☐ Evaluation Genie
- ☐ DAGG-3
- ☐ AAC-P
- ☐ Communication Matrix
- ☐ Methods of Communication Chart
- ☐ Red/Yellow/Green task analysis
- ☐ Vocabulary personalization/Interest Inventory