Illinois Dept. of Healthcare & Family Services AAC Device Trial Form

User's Name: _____ Trial dates: From _____ To _____
Communication device and accessories: _____

Support and Training
List names of people that put messages into the device: _____
_____
_____
Who will provide daily support and programming to the device once it is purchased?
_____
_____

People
The device helped me communicate with more people. YES NO
Who did you talk to using this device?

___family	___friends	___peers
___teacher	___supervisor/boss	___case manager
___coworkers	___staff	___aides/assistants
___therapists	___nurse	___doctor

Others (please list): _____
_____

Places/Situations
The device helped me communicate in more situations. YES NO
During this trial period, when and where did you use this device?

___in a group	___on the phone	___with new people
___at work	___at home	___at school

___in the community, i.e. _____
_____

Provide ten specific messages & situations in which the device was used during the trial.
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Types of Messages

The device helped me communicate more thoughts. YES NO

What kinds of things did you say with this device?

___greetings ___making requests
___feelings (anger, something hurts) ___needs (bathroom, drink, etc.)
___information about myself ___talks about past events
___talks about my favorite topic
___other things, i.e. _____
_____
_____

What are some features you like about this device?

_____
_____
_____
_____
_____

What are some features you didn't like about this device?

_____
_____
_____
_____
_____

Other comments: _____
_____
_____
_____
_____
_____
_____

List name/relationship of people completing this form:

_____ _____
_____ _____
_____ _____