

# SENSORY & COMMUNICATION

Items below in **orange** are from **MnCHOICES**. Items below in **blue** are from **CARE**.

## Vision

### Ability to see in adequate light (with glasses or other visual appliances)

- Adequate: Sees fine detail, including regular print in newspapers/books
- Mildly to Moderately Impaired: Can identify objects; may see extra large print
- Severely impaired: No vision or object identification questionable
- Unable to assess
- Unknown

*If 'Mildly to Moderately Impaired or Severely Impaired' 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)

## Assessment Domains

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- 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 participant 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

## Assessment Domains

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- 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 participant 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

## Assessment Domains

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

- No

**Explain:** \_\_\_\_\_ *(Displays when this option is checked)*

- Yes
- Chose not to answer

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

- No

**Explain:** \_\_\_\_\_ *(Displays when this option is checked)*

- Yes
- Chose not to answer

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

- No

**Explain:** \_\_\_\_\_ *(Displays when this option is checked)*

- Yes
- Chose not to answer

**Can the participant find their way in unfamiliar environments independently?**

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

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

## Assessment Domains

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### Is the participant currently receiving any training?

- No
- Yes

**Explain:** \_\_\_\_\_ *(Displays when this option is checked)*

- Chose not to answer

### Would they like to receive orientation or mobility training?

*(Displays when 'No' is checked to previous question)*

- No

**Explain:** \_\_\_\_\_ *(Displays when this option is checked)*

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

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

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

**Notes/Comments:** \_\_\_\_\_

### Hearing

#### Ability to hear (with hearing aid or hearing appliance, if normally used)

- Adequate- Hears normal conversation and TV without difficulty
- Mildly to moderately impaired- Difficulty hearing in some environments or speaker may need to increase volume or speak distinctly
- Severely impaired- Absence of useful hearing
- Unable to assess
- Unknown

*If 'Mildly to Moderately Impaired or Severely Impaired' 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 participant 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

## Assessment Domains

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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)
- 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

## Assessment Domains

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### How often does the participant 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 participant use their assistive device(s) as prescribed/recommended?

- No

**Explain:** \_\_\_\_\_ *(Displays when this option is checked)*

- Yes
- Chose not to answer

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

- No

**Explain:** \_\_\_\_\_ *(Displays when this option is checked)*

- Yes
- Chose not to answer

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

- No

**Explain:** \_\_\_\_\_ *(Displays when this option is checked)*

- Yes
- Chose not to answer

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

- No



## Assessment Domains

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- 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: \_\_\_\_\_

### Functional Communication

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

- Expresses complex message without difficulty and with speech that is clear and easy to understand
- Exhibits some difficulty with expressing needs and ideas (e.g. some words or finishing thoughts) or speech is not clear
- Frequently exhibits difficulty with expressing needs and ideas
- Rarely/never expresses self or speech is very difficult to understand
- Unable to assess
- Unknown

*If 'Some difficulty, frequently or rarely/never expresses self' 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)

## Assessment Domains

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### 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

### Understanding Verbal Content (excluding language barriers):

- Understands: Clear comprehension without cues or repetitions
- Usually understands: Understands most conversations, but misses some part/intent of message. Requires cues at times to understand
- Sometimes understands: Understands only basic conversations or simple, direct phrases. Frequently requires cues to understand
- Rarely/Never understands
- Unable to answer
- Unknown

Comments: \_\_\_\_\_

## Assessment Domains

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### Does the participant currently receive speech and language therapy?

- No
- Yes

**Explain:** \_\_\_\_\_ *(Displays when this option is checked)*

- Chose not to answer

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

- No

**Explain:** \_\_\_\_\_ *(Displays when this option is checked)*

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

### Does the participant use some form of sign language to communicate?

- No
- Yes
- 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 participant use visual language, other than sign language to communicate?

- No

## Assessment Domains

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- 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 participant use facilitated communication?**

- No
- Yes
- Chose not to answer

**Does the participant 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

## Assessment Domains

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- 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 participant 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)

## Assessment Domains

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### Does the assistive device meet the participant'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 participant'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:** \_\_\_\_\_

### Sensory Integration

Does the participant have a Sensory Integration Disorder Diagnosis?

- No
- Yes

**Explain:** \_\_\_\_\_ *(Displays when this option is checked)*

- Unsure
- Chose not to answer

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

- No
- Yes

**Explain:** \_\_\_\_\_ *(Displays when 'Yes' is checked)*

- Unsure
- Chose not to answer

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

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

- No
- Yes
- Unsure
- 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

## Assessment Domains

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- 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 participant 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:

### 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 participant? For example, do they need signaling devices?

- No
- Yes

Explain: \_\_\_\_\_ (Displays when 'Yes' is checked)

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

Explain: \_\_\_\_\_ (Displays when 'Yes' is checked)

- Chose not to answer
- Under what circumstances does the participant need to have an interpreter or translator present?

Describe: \_\_\_\_\_

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

- No
- Yes

Explain: \_\_\_\_\_ (Displays when 'Yes' is checked)

- Chose not to answer

Notes/Comments: \_\_\_\_\_

## Referrals (Sensory & Communication)

What is important to the individual?

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### 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

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