



EYEGAZE COMMUNICATION SYSTEM EVALUATION QUESTIONNAIRE

Please complete the following questions to aid us in assessing the client's potential successful use of the Eyegaze Communication System.

General Information

Name: _____ Sex: ___ Age: ___ Date of Birth: ___/___/___
Street Address: _____ Phone: _____
City, State, Zip: _____
Education Level: _____
Prior/Current Occupation: _____

Physical Status

Brief medical history/diagnosis: _____

Current physical condition including description of limitations: _____

Current medications (please include dose and times of day administered): _____

List any current physical discomforts: _____

Physical Status (continued)

List number of hours per day spent in chair: _____ wheelchair: _____ bed: _____

Does client wear contact lenses? Yes ___ No ___. If yes, hard ___ soft ___.

Does client wear glasses for reading? Yes ___ No ___. Bifocals ___.

Is client able to keep head steady for 5 seconds or longer? Yes ___ No ___.

Describe type and amount of head motion (e.g. spasticity, athetoid movements, no movement):_

Is client able to maintain eye contact with you for a second or more? Yes ___ No ___.

Describe client's eye control (e.g. steady gaze, drifting eye, nystagmus, etc.): _____

Can client direct his/her gaze in all directions? Yes ___ No ___. If no, explain. _____

Do client's eyes appear to track together? Yes ___ No ___. If no, explain. _____

Does client have a "dominant" eye? Yes ___ No ___. If yes, Left ___ or Right ___?

Does client have cataracts? Yes ___ No ___

Does client maintain normal eye moisture? Yes ___ No ___. Explain, if necessary: _____

Communication Skills

Is client able to read? Yes ___ No ___ Unknown at present ___.

Please describe how client currently communicates "yes" and "no." _____

How does client communicate other things? _____

Is client able to follow directions? Yes ___ No ___.

How does client usually respond to new people? _____

Communication Skills (continued)

Describe any speech capabilities: _____

Please list prior communication devices used and level of success/failure experienced: _____

Other information you think will be helpful. _____

Person Filling out Questionnaire:

Name: _____

Daytime Phone: _____

Relationship (Father, Mother, Spouse, Caregiver, etc.): _____

Full Address: _____

Please return to:

LC Technologies, Inc.
3919 Old Lee Highway
Suite 81B
Fairfax, VA 22030 USA

FAX: 703/385-7137

If you have questions, call:

Nancy R. Cleveland, R.N., B.S.N.

1/800/EYEGAZE [1/800/393-4293]
703/385-7133 *