

## Switch Access Screening Form

Please complete this form with consultation from an OT or PT.

Completed by:

Position:  OT  PT

Date:

### Student's previous experience with Switch Access:

- None (has never used switches)
- Limited (some attempts made but use is not consistent or established)
- Experienced (prior use or uses switches consistently and effectively)

If the student has previous experience using switches, please describe:

### Functional Abilities Relevant to Switch Access Goals:

#### Physical Function

- Demonstrates at least one repeatable movement with potential for switch activation

Location of repeatable movement:

Location	Left	Right
Hand		
Head		
Mouth		
Foot		
Other Upper Extremity		
Other Lower Extremity		
Other:		

Please describe observed movement(s):

**Cognition/Sensory**

Has a reliable way to communicate yes/no with unfamiliar communication partners.

Please describe:

Follows verbal commands:       single step     multi-step

Vision – Describe:

Hearing – Describe:

**Sensory Considerations:**

Tactile (e.g. likes/dislikes certain textures) – Describe:

Auditory (e.g. likes/dislikes loud noises) – Describe:

Visual (e.g. likes/dislikes bright lights) – Describe:

Comments:

**Social/Emotional**

- Demonstrates interest in switch access practice
- Has motivators related to switch access (e.g. music, videos, jokes, games, sensory stimulation toys). Describe:

- Adult support is available for daily switch access practice

**Positioning/Mobility Equipment:**

<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Walker	<input type="checkbox"/> Half Tray
<input type="checkbox"/> Standing Frame	<input type="checkbox"/> Tray	<input type="checkbox"/> Other:

Comments:

**Environment:**

Switch Access Environments (check all that apply):

- School
- Community
- Home

Comments:

**Other Relevant Information** (e.g., health status, physical function, communication, interests, goals):