Sequal Assessment Form

When completing this form, please bear in mind that we are unable to meet the member in person and therefore require FULL COMPLETION OF ALL SECTIONS. ** Failure to do so could result in applications being returned. Thank you for your time.

Assessor's Information: **THIS FORM MUST BE FULLY COMPLETED AND SOLELY BY THE PROFESSIONAL ASSESSING BODY – EITHER A SPEECH AND LANGUAGE THERAPIST OR A SPECIAL NEEDS TUTOR.**

Assessment date		Assessor's contact address:
Assessor's name		
Assessor's contact number		
Assessor's professional capacity		Email
Assessor's relationship to member, if any.		

I confirm that I have completed this form giving details to the best of my knowledge

Assessor's signature . . . . . Date . . . . . .

PLEASE NOTE: **We would be grateful if you could approach the NHS hubs and other avenues of statutory funding before applying to Sequal, as our funds are limited. Please complete box below with their responses, together with details of applications made to any other organisation for funding, so that we are aware of any monies that may be forthcoming.**

Member's (Applicant's) Personal Details:

Member's name		D.O.B.	
Home address		Telephone number	

I confirm that this person is a British Citizen and I have seen evidence where applicable ☐ or documentation enclosed if born outside the U.K. ☐

Other contact details e.g. school or day centre or Residential Home

Does the member have a communication aid at the moment? If so, please provide details

PTO

Sequal's Assessment Continued (PLEASE ENCLOSE SEPARATE SHEET IF NECESSARY)

Disability Details:

Member's disability

How does this affect the member's communication and/or movement?

Is this disability likely to improve or deteriorate in the future?

What are the effects of the disability and how will the recommended equipment improve those e.g. long term medication, confidence, independence or education.

Please complete all boxes. **A = Very Good B = Good C = Fair D = Poor E = Nil**

Left Arm		Right Arm		Eyesight		Recall	
Left Hand		Right Hand		Speech		Humour	
Left Fingers		Right Fingers		Head/Neck		Motivation	
Left Foot		Right Foot		Breathing		Wheelchair Y/N	
Left Leg		Right Leg		Memory		Bedbound Y/N	

****PLEASE NOTE THAT EQUIPMENT TRIALS NEED TO BE ARRANGED TO ENSURE SUITABILITY BEFORE WE ARE ABLE TO ACCEPT A RECOMMENDATION. PLEASE ADVISE US IF ASSISTANCE IS REQUIRED IN THIS AREA.**

Equipment Required:

Tower/laptop/iPad

OR

AAC Type and Model : e.g Lightwriter SL40 Connect, Tobii I-12 etc.

Please note that an iPad can only be provided if communicational app required.

Software/app recommended:

****PRECISE TITLES PLEASE.**

Software required:

**I confirm that detailed trials have taken place for……weeks

Full details of any accessories/ access devices required : e.g. track or roller ball, touch screen, case etc Is training required?

Details of supplier conducting trials.

Make & Model of wheelchair and exact mount needed.

Where system to be delivered to when fund raising complete.