



Eyegaze Communication System

EVALUATION QUESTIONNAIRE

If you are interested in being contacted by a registered nurse to discuss an evaluation with the Eyegaze System, please print and fill out the following questionnaire and mail or fax it to LC Technologies.

Please answer 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: ____/____/____ Phone: _____

Street Address: _____

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:

Number of hours per day that client spends in chair:_____ wheelchair:_____ bed:_____

Does client wear contact lenses? Yes_____ No_____ If yes, hard?_____ soft?_____

Does client wear glasses for reading? Yes_____ No_____ Bifocals? Yes_____ No_____

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 he/she direct his/her gaze in all directions? Yes_____ No_____ If no, explain:

Do his/her eyes appear to track together? Yes_____ No_____ If no, describe:

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 he/she communicate other things?

Is client able to follow directions? Yes_____ No_____

Does client seem motivated to be able to communicate more effectively? Yes_____ No_____

How does he/she usually respond to new people?

Describe any speech capabilities:

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

Other information that you think will be helpful:

Person Filling out Questionnaire:

Name:_____

Daytime Phone:_____

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

Full Address:_____

If you have questions, call:

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

(800) 393-4293 or (703) 385-7133

Contact Information:

LC Technologies, Inc
1483 Chain Bridge Road
Suite 104
McLean, Virginia 22101 U.S.A.

Voice: 703-385-7133 or
800-EYEGAZE (800-393-4293)

FAX: 703-288-3727

Email: requests@eyegaze.com

Web Service online since January 1996

This address is <http://www.eyegaze.com/2Products/Disability/questionnaire.html>

[LC Technologies Home Page](#)

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