ASSISTIVE TECHNOLOGY INVENTORY LIST

Individual: Jade Johnson

Date AT Inventory was Initiated: 10/14/2013

Assistive Technology	**Location AT is Used (indicate the locations AT is used in the shaded boxes below. Indicate with a check mark if AT listed in the 1st column is used in this location)**			**Contact Person (refer to contact code at the bottom of the page)**
	home	*job*	*Volun-teer*	
Communication System (Device, Mount, Switch) **1. Step-by-Step VOCA** **2. 24-hour tangible symbol communication system** **3. Work Visual Schedule** **4. Volunteer Visual Schedule**	**1. X** **2. X**	**1. X** **2. X** **3. X**	**1. X** **2. X** **4. X**	**#1** **#1** **#1** **#1**
Environmental Control **1. Jelly bean switch** **2. Control Unit** **3. Wireless TV remote control**	**1. X** **2. X** **3. X**	**1. X** **2. X**		**#1** **#1** **#2**
Mobility (wheelchair-describe removable parts. Walker, cane, gait belts, transfer equipment, etc.) **1. Invacare manual tilt-in-space wheelchair with custom molded seating system** **2. Wheelchair lap tray** **3. Walker**	**1. X** **2. X** **3. X**	**1. X** **2. X**	**1. X** **2. X**	**#3** **#3** **#3**

To make changes to the list, the contact person should cross out item(s) that are no longer recommended or write in new items. Initial and date the change. Describe the reason for the change if necessary.

Contact Person Code: (if you are the contact person for any AT on this list, write your name and phone # next to a number below then enter that number in the contact code column of the form)

1.____Sara Smith, SLP 332-9755____________ 2.______Beth Beach, OTR 765-5099__________

3.____Tom Terry, PT 564-0088_____________ 4.______Dora Davis, RN 332-6745_____________

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Alternative Positioning 1. Zero gravity chair	1. X			#3
Mealtime 1. Built-up handle Good Grip Spoon 2. High sided plate	1. X 2. X	1. X 2. X	1. X 2. X	#2 #2
ADL (bathing, dressing, oral hygiene, etc.) 1. Shower Chair	1. X			#2

Other: No medical technology (i.e. enteral feeding equipment, mattress, bed, bedrails) and No home modifications (i.e. ramps, grab bars, items affixed to the home)

Items	**yes**	**no**	*home*	*job*	*Volun-teer*	**Contact Person**
Dentures/Partials						
1. Glasses	X		1. X	1. X	1. X	#4
Hearing Aids						
Splints/Orthotics (if yes describe below) 2. Bilateral AFOs	X		2. X	2. X	2. X	#3
Other (list below)						

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