Becoming a member of the Research Involvement Network means we will occasionally send you information about opportunities to become involved in AAC research projects.

***Please note the declaration at the foot of this sheet must be signed by the applicant or their appointed representative.***

**Title**: (e.g. Mr/Mrs/Ms)

**Name**:

**Address**:

**Postcode**:       **Contact phone number**:

**Email address**:

***Please tick the boxes that apply to you:***

**[ ]** I use Augmentative & Alternative Communication *(please fill in page 2)*

**[ ]** I am a family member or carer (paid or voluntary) of an individual who uses AAC *(please
fill in page 3)*

**[ ]** In my job I work with people who use AAC *(please fill in page 4)*

***I am interested in taking part in the following activities*** *(tick all that apply):*

**[ ]** Taking part in research (e.g. by completing a survey about my experiences)

**[ ]** Helping to develop or run research (e.g. by being a member of an advisory panel for a research project)

***How we will use your information***

*The information you have supplied will be stored electronically by Communication Matters. We will use your information to contact you with information about the Research Involvement Network and opportunities to become involved in research projects. We may contact you from time to time with information about other aspects of our work. Communication Matters will store your information securely and confidentially and will not pass your details to any other organisation.*

*If you decide to leave the Research Involvement Network you can advise us at any time by contacting the Research Manager. Once you have notified us that you wish to leave the network we will remove all data that could be used to identify you. We may keep other data for the purposes of statistical analysis.*

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| **I agree Communication Matters may keep the information I have supplied and use it to contact me** |
| **Signed**:       | **Date**:       |
| **Relationship to applicant (if signed on behalf of applicant):**       |
| **If applicant is under 18 years old, this form must be countersigned by a parent or legal guardian:** |
| **Signed**:       | **Date**:       |
| **Relationship to applicant (if signed on behalf of applicant):**       |

**I use Augmentative & Alternative Communication**

If you are willing to give us a bit more information about yourself this will help us to contact you with opportunities that are relevant to you.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date of birth**:       | **Gender**: | **[ ]**  |  MALE | **[ ]**  |  FEMALE |

1. *Please indicate as much as possible what methods of communication you use or have used:*

|  |  |  |
| --- | --- | --- |
| **Method** | **Use now** | **Used in the past** |
| Gesture or pointing , without use of specialised books, cards etc | **[ ]**  | **[ ]**  |
| Signing (using any recognised or self made signing system) | **[ ]**  | **[ ]**  |
| Communication book(s), charts, card(s) or boards etc | **[ ]**  | **[ ]**  |
| Low Tech manual systems e.g. PECS, E-Tran frames etc | **[ ]**  | **[ ]**  |
| Low Tech electronic systems e.g. single message VOCAs/ those that use overlays | **[ ]**  | **[ ]**  |
| High Tech systems e.g. Touch screen dynamic devices etc | **[ ]**  | **[ ]**  |
| Computer (laptop or desk top) with AAC software | **[ ]**  | **[ ]**  |
| iPad or equivalent | **[ ]**  | **[ ]**  |
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| --- |
| Other (*please describe*)       |

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1. *If you have used electronic systems please indicate types of access you use or have used:*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Method** | **Use now** | **Used in the past** | **Method** | **Use now** | **Used in the past** |
| Touch Screen  | **[ ]**  | **[ ]**  | Touch Screen & keyguard | **[ ]**  | **[ ]**  |
| Single switch scanning | **[ ]**  | **[ ]**  | Two switch scanning | **[ ]**  | **[ ]**  |
| Head pointer or head mouse | **[ ]**  | **[ ]**  | Eyegaze | **[ ]**  | **[ ]**  |
| Typing (on keyboard)  | **[ ]**  | **[ ]**  | Facilitated communication | **[ ]**  | **[ ]**  |
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| --- |
| Other (*please describe*)       |

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1. *Please give details of any condition(s) or diagnosis that has led to your use of AAC:*

**[ ]** Cerebral palsy **[ ]** Stroke

**[ ]** Motor Neurone Disease **[ ]** Down’s syndrome

**[ ]** Traumatic brain injury **[ ]** Multiple Sclerosis

**[ ]** Parkinson’s **[ ]** Learning difficulties

**[ ]** Head, neck or oral cancer **[ ]** Autism/Autistic Spectrum Disorder

**[ ]** Muscular dystrophy **[ ]** Specific Language Impairment

**[ ]** Profound & multiple learning difficulties **[ ]** Other (d*escribe*)

**I am a family member or carer of an individual who uses AAC**

If you are willing to give us a bit more information about yourself this will help us to contact you with opportunities that are relevant to you.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date of birth**:       | **Gender**: | **[ ]**  |  MALE | **[ ]**  |  FEMALE |

1. *Please tell us your relationship to the person you support e.g. mother, partner, neighbour etc*

|  |  |  |
| --- | --- | --- |
| **Name of person using AAC:**  | **I am their:** | **Their date of birth:** |
|       |       |       |

1. *Please indicate as much as possible what methods of communication they use or have used:*

|  |  |  |
| --- | --- | --- |
| **Method** | **Use now** | **Used in the past** |
| Gesture or pointing , without use of specialised books, cards etc | **[ ]**  | **[ ]**  |
| Signing (using any recognised or self made signing system) | **[ ]**  | **[ ]**  |
| Communication book(s), charts, card(s) or boards etc | **[ ]**  | **[ ]**  |
| Low Tech manual systems e.g. PECS, E-Tran frames etc | **[ ]**  | **[ ]**  |
| Low Tech electronic systems e.g. single message VOCAs/ those that use overlays | **[ ]**  | **[ ]**  |
| High Tech systems e.g. Touch screen dynamic devices etc | **[ ]**  | **[ ]**  |
| Computer (laptop or desk top) with AAC software | **[ ]**  | **[ ]**  |
| iPad or equivalent | **[ ]**  | **[ ]**  |
|

|  |
| --- |
| Other (*please describe*)       |

 |

1. *If they have used electronic systems please indicate types of access they use or have used:*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Method** | **Use now** | **Used in the past** | **Method** | **Use now** | **Used in the past** |
| Touch Screen  | **[ ]**  | **[ ]**  | Touch Screen & keyguard | **[ ]**  | **[ ]**  |
| Single switch scanning | **[ ]**  | **[ ]**  | Two switch scanning | **[ ]**  | **[ ]**  |
| Head pointer or head mouse | **[ ]**  | **[ ]**  | Eyegaze | **[ ]**  | **[ ]**  |
| Typing (on keyboard)  | **[ ]**  | **[ ]**  | Facilitated communication | **[ ]**  | **[ ]**  |
|

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| --- |
| Other (*please describe*)       |

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1. *Please give details of any condition(s) or diagnosis that has led to their use of AAC:*

**[ ]** Cerebral palsy **[ ]** Stroke

**[ ]** Motor Neurone Disease **[ ]** Down’s syndrome

**[ ]** Traumatic brain injury **[ ]** Multiple Sclerosis

**[ ]** Parkinson’s **[ ]** Learning difficulties

**[ ]** Head, neck or oral cancer **[ ]** Autism/Autistic Spectrum Disorder

**[ ]** Muscular dystrophy **[ ]** Specific Language Impairment

**[ ]** Profound & multiple learning difficulties **[ ]** Other (d*escribe*)

*If you support more than one person who uses AAC feel free to photocopy this page or ask us for an extra sheet for their details.*

**In my job I work with people who use AAC**

**Job title**:

**Employer**:

 *(If you have more than one employer please give main one. Your employer will NOT be contacted.)*

1. *Professional role:*

**[ ]** Speech & Language Therapist **[ ]** Speech & Language Therapy assistant

**[ ]** Occupational Therapist **[ ]** Technical/AT/ICT specialist

**[ ]** Head teacher **[ ]** Mainstream teacher

**[ ]** SEN teacher **[ ]** SEN Co-ordinator (SENCO)

**[ ]** Teaching or classroom assistant **[ ]** Medical practitioner

**[ ]** Psychologist/Child Psychologist **[ ]** Physiotherapist

**[ ]** Social Worker **[ ]** Administrator/fundraiser/supporter

**[ ]** Other (*please describe*)

1. *Please give details of the client group(s) you work with (tick all that apply):*

**[ ]** Children **[ ]** Adults

1. *Please give details of the condition group(s) you work with (tick all that apply):*

**[ ]** Cerebral palsy **[ ]** Stroke

**[ ]** Motor Neurone Disease **[ ]** Down’s syndrome

**[ ]** Traumatic brain injury **[ ]** Multiple Sclerosis

**[ ]** Parkinson’s **[ ]** Learning difficulties

**[ ]** Head, neck or oral cancer **[ ]** Autism/Autistic Spectrum Disorder

**[ ]** Muscular dystrophy **[ ]** Specific Language Impairment

**[ ]** Profound & multiple learning difficulties **[ ]** Other (d*escribe*)

**I would like to take part in research myself [ ]** YES **[ ]** NO

**I can help to find participants from my client group(s)**  **[ ]** YES **[ ]** NO

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| **If you have questions** please contact us at rin@communicationmatters.org.uk  |
| **Please return this form to: Communication Matters, 3rd Floor, University House, University of Leeds, Leeds, LS2 9JT or email to: admin@communicationmatters.org.uk** (or email us to send you a stamped reply envelope). |