FIRST HEALTH SYSTEMS

SPEECH THERAPY REVISIT NOTE

DATE OF SERVICE ___/___/___

TIME IN _____ OUT _____

HOMEBOUND REASON: ❑ Needs assistance for all activities ❑ Residual weakness
❑ Requires assistance to ambulate ❑ Confusion, unable to go out of home alone
❑ Unable to safely leave home unassisted ❑ Severe SOB, SOB upon exertion
❑ Dependent upon adaptive device(s) ❑ Medical restrictions
❑ Other (specify) _____

TYPE OF VISIT:
❑ Revisit
❑ Revisit and Supervisory Visit
❑ Other (specify) _____
SOC DATE ___/___/___

TREATMENT DIAGNOSIS/PROBLEM _____

EXPECTED TREATMENT OUTCOME(S) _____

SPEECH THERAPY INTERVENTIONS/INSTRUCTIONS (Mark all applicable with an "X")

Evaluation (C1)	Aural rehabilitation (C6)	Pain Management
Establish rehab. program	Non-oral communication (C8)	Speech dysphagia instruction program
Establish home maintenance program	Alaryngeal speech skills	Care of voice prosthesis including
❑ Copy given to patient/client	Language processing	removal, cleaning, site maintenance
❑ Copy attached to chart	Food texture recommendations	Teach/Develop communication system
Patient/Client/Family education	Safe swallowing evaluation	Trach. instruction and care
Voice disorders (C2)	Therapy to increase articulation,	Other:
Speech articulation disorders (C3)	proficiency, verbal expression	
Dysphagia treatments (C4)	Lip, tongue, facial exercises to	
Language disorders (C5)	improve swallowing/vocal skills	

OBSERVATIONS, INSTRUCTIONS AND MEASURABLE OUTCOMES _____

EVALUATION AND PATIENT/CLIENT/CAREGIVER RESPONSE _____

CARE PLAN: ❑ Reviewed/Revised with patient/client involvement.
If revised, specify _____

❑ Outcome/Instruction achieved (describe) _____

❑ PRN order obtained
APPROXIMATE NEXT VISIT DATE: ___/___/___
PLAN FOR NEXT VISIT _____

DISCHARGE DISCUSSED WITH: ❑ Patient/Client/Family
❑ Care Manager ❑ Physician ❑ Other (specify) _____
BILLABLE SUPPLIES RECORDED? ❑ N/A ❑ Yes (specify) _____

CARE COORDINATION: ❑ Physician ❑ PT ❑ OT ❑ ST ❑ SS
❑ SN ❑ Other (specify) _____

SUPERVISORY VISIT (Complete if applicable)

❑ ST Assistant ❑ Aide / ❑ Present ❑ Not present
SUPERVISORY VISIT: ❑ Scheduled ❑ Unscheduled
OBSERVATION OF _____

TEACHING/TRAINING OF _____

PATIENT/CLIENT/FAMILY FEEDBACK ON SERVICES/CARE (specify) _____

NEXT SCHEDULED SUPERVISORY VISIT ___/___/___
CARE PLAN UPDATED? ❑ No ❑ Yes (specify) _____

If ST assistant/aide **not present**, specify date he/she was contacted regarding updated care plan: ___/___/___

SIGNATURES/DATES

X _____ ___/___/___
Patient/Client/Caregiver (if applicable) *Date*

Complete **TIME OUT** (above) prior to signing below.
_____ ___/___/___
Therapist (signature/title) *Date*

PART 1 – Clinical Record **PART 2 – Therapist** **PART 3 – Care Coordination**

PATIENT/CLIENT NAME – Last, First, Middle Initial | ID#