BRIGGS, Des Moines, IA 50306 (800) 247-2343
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FIRST HEALTH SYSTEMS

SPEECH THERAPY EVALUATION

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 EVALUATION ❑ Initial ❑ Interim ❑ Final
SOC DATE ___/___/___
(If Initial Evaluation, complete Speech Therapy Care Plan, for 3580/2P)

ORDERS FOR EVALUATION ONLY? ❑ Yes ❑ No If no, orders are _____

PERTINENT BACKGROUND INFORMATION

MEDICAL DX/TREATMENT DX _____ ONSET ___/___/___
MEDICAL PRECAUTIONS _____
PRIOR LEVEL OF FUNCTION _____
LIVING SITUATION/SUPPORT SYSTEM _____
DESCRIBE PERTINENT MEDICAL/SOCIAL HISTORY AND/OR PREVIOUS THERAPY PROVIDED _____
PAIN (describe) _____ Impact on therapy care plan? ❑ Yes ❑ No

SAFE SWALLOWING EVALUATION? ❑ No ❑ Yes; specify date, facility and M.D. _____
VIDEO FLUOROSCOPY? ❑ No ❑ Yes; specify date, facility and M.D. _____
CURRENT DIET TEXTURE _____
LIQUIDS: ❑ Thin ❑ Thickened (Specify) _____ ❑ Other (Specify) _____

SPEECH/LANGUAGE EVALUATION

4 – WFL (within functional limits) 3 – Mild impairment 2 – Moderate impairment 1 – Severe impairment 0 – Unable to do/did not test

	FUNCTION EVALUATED	SCORE	COMMENTS
COGNITION	Orientation (Person/Place/Time)		
	Attention span		
	Short-term memory		
	Long-term memory		
	Judgment		
	Problem solving		
	Organization		
	Other:		
SPEECH/VOICE	Oral/facial exam		
	Articulation		
	Prosody		
	Voice/Respiration		
	Speech intelligibility		
	Other:		
SWALLOWING	Chewing ability		
	Oral stage management		
	Pharyngeal stage management		
	Reflex time		
	Other:		

	FUNCTION EVALUATED	SCORE	COMMENTS
VERBAL EXPRESSION	Augmentative methods		
	Naming		
	Appropriate Yes / No		
	Complex sentences		
	Conversation		
AUDITORY COMPREHENSION	Word discrimination		
	1 step directions		
	2 step directions		
	Complex directions		
	Conversation		
	Speech reading		
READING	Letters/Numbers		
	Words		
	Simple sentences		
	Complex sentences		
	Paragraph		
WRITING	Letters/Numbers		
	Words		
	Sentences		
	Spelling		
	Formulation		
	Simple addition/subtraction		

REFERRAL FOR: ❑ Vision ❑ Hearing ❑ Swallowing ❑ Other (Specify) _____

Complete **TIME OUT** (above) prior to signing below.

THERAPIST SIGNATURE/TITLE _____ DATE ___/___/___

PART 1 – Clinical Record **PART 2 – Therapist**

PATIENT NAME – Last, First, Middle Initial	ID#

SPEECH THERAPY

SPEECH THERAPY CARE PLAN

SOC DATE ___/___/___

DIAGNOSIS _____ **ONSET** ___/___/___

ANALYSIS OF EVALUATION/TEST SCORES _____

PATIENT/CLIENT DESIRED OUTCOMES	SHORT TERM OUTCOMES Time Frame	LONG TERM OUTCOMES Time Frame

PLAN OF CARE (Mark all applicable with an "X")

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

FREQUENCY _____ **REHAB POTENTIAL** ☐ Good ☐ Fair ☐ Poor

EQUIPMENT RECOMMENDATIONS _____

SAFETY ISSUES/INSTRUCTION/EDUCATION _____

COMMENTS/ADDITIONAL INFORMATION _____

PATIENT/CLIENT/CAREGIVER RESPONSE TO PLAN OF CARE _____

CARE COORDINATION: ☐ Physician ☐ SN ☐ PT ☐ OT ☐ ST ☐ SW ☐ Other (specify) _____

PLAN FOR NEXT VISIT _____

PLAN DEVELOPED BY (signature/title/date) _____ ___/___/___

CARE PLAN REVIEW

DATE	REVIEWED/REVISED BY (signature title)	COMMENTS

PART 1 – Clinical Record **PART 2 – Patient's Residence**

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