



H & M HEALTH SERVICES INC.

Home Health Care

(Certified Medicare Agency)

4125 Hollywood Boulevard

Hollywood, Florida 33021

(954) 985-0770 / (800) 281-5268 / Fax (954) 985-0734

SPEECH THERAPY EVALUTION

PATIENT NAME _____ MR# _____
ADDRESS _____ BIRTHDATE ____/____/____
PHONE _____ AGE _____ SEX M F
FAMILY CONTACT _____

PRINCIPAL DIAGNOSIS _____

PERTINENT OR CONTRIBUTING DIAGNOSIS _____

NAME OF PHYSICIAN _____ PHONE _____

SPECIFIC TREATMENT ORDERS (including frequency)

Table with 3 columns: PRESENT LEVEL, PRIOR LEVEL, EVALUATIONS. Rows include VOICE DISORDERS, SPEECH ATRICIATION, DYSPHAGIA, LANGUAGE DISORDERS, AURAL REHABILITATION, NONORAL COMMUNICATION, OTHERS.

SIGNIFICANT CLINICAL FINDINGS _____

GOALS/REHABILITATION POTENTIAL _____

SPEECH THERAPTIST SIGNATURE _____

PATIENT SIGNATURE _____

