Home Care Professionals

Evaluation/Reassessment Date:

SPEECH/LANGUAGE PATHOLOGY

Patient Name: | Record #:

☐ EVALUATION

Therapy Visit # _____ (optional per agency policy)

☐ FUNCTIONAL REASSESSMENT

Combined Therapy Visit # _____ (optional per agency policy)

☐ 11-13th - Visit ☐ 17-19th - Visit ☐ 30 - Day

Reason for SLP Referral:

Prior Functional Status:

Homebound ☐ Yes ☐ No If Yes, give reason:

ASSESSMENT

VITAL SIGNS (per agency policy)

PULSE: ☐ Apical _____ (Reg) (Irreg)
☐ Radial _____ (Reg) (Irreg)

TEMP.: _____ **RESP.:** _____ ☐ Actual ☐ Stated

Height _____
Weight _____

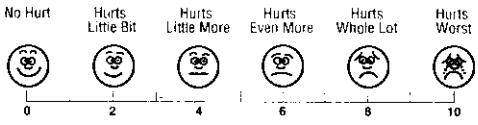
B/P Lying / Sitting / Standing
L _____ _____ _____
R _____ _____ _____

PAIN

Frequency of Pain interfering with patient's activity or movement:

☐ 0 - Patient has no pain
☐ 1 - Patient has pain that does not interfere with activity or movement
☐ 2 - Less often than daily
☐ 3 - Daily, but not constantly
☐ 4 - All the time

WONG-BAKER FACES[1] PAIN RATING SCALE



[1] *From Hockenberry MJ, Wilson D: Wong's essentials of pediatric nursing, ed. 8. St. Louis, 2009, Mosby. Used with permission. Copyright Mosby.*

■ See Additional Pain Assessment/Documentation (per agency policy)
Refer to:

PAIN PROFILE

Primary site: _____
Onset date: _____
Pain precipitated by: _____
Pain site assessment: _____
Current pain management & effectiveness: _____
Pain description: ☐ Dull ☐ Sharp ☐ Other: _____
☐ Pain management teaching to patient/family *(document below)*
Patient's pain goal: _____

Comments/Progress Towards Goals

PHYSICAL ☐ No deficit

☐ Mouth lesions/nodules ☐ Hard/soft palate abnormalities ☐ Inflamed mucosa ☐ Hard of hearing ☐ Ear infections ☐ Other: _____
☐ Abnormal tonsil appearance ☐ Tongue abnormalities ☐ Dyspnea ☐ Deaf ☐ Ear abnormalities

Comments

NUTRITION

Prescribed Diet: _____

Prescribed diet is a factor in the patient's plan and goal ☐ Yes ☐ No If Yes, explain: _____

FUNCTIONAL

KEY: A = Absent P = Present I = Independent MOD = Moderate Assist MAX = Maximum Assist Y = Yes N = No

	A	P	I	MOD	MA	I	Y	N
Answers simple questions								
Slurring								
Matches letter/pictures								
Uses sentences								
Voice								
Volume								
Quality								
Follows direction								
Recognizes letters								
Add/Subtract								

	A	P	I	MOD	MA	I	Y	N
Multiply/Divide								
Time								
Read								
Copy forms								
Signature								
Word finding								
Copy Words								
Money								
Reliable								
Pitch								

	A	P	I	MOD	MA	I	Y	N
Articulation								
Dysphagia								
Swallows liquids								
Swallows solids								
Chewing								
Choke								
Cough								
Pocketing/residual								
History of pneumonia								

Comments/Progress Towards Goals

SPEECH/LANGUAGE PATHOLOGY
EVALUATION/FUNCTIONAL REASSESSMENT

EVALUATION

ANY ADDITIONAL PROBLEMS IDENTIFIED

ADDITIONAL SERVICES INDICATED ☐ OT ☐ MSS ☐ AIDE ☐ SN ☐ HME ☐ PT

☐ OTHER

SLP ORDERS

Frequency/Duration of SLP Visit:

FOR: Assess/Perform/Instruct Pt/Cg:	A	P	I	Assess/Perform/Instruct Pt/Cg:	A	P	I
☐ Swallowing assessment & training	☐	☐	☐	☐ Exercises/Plan for strengthening oral-motor movements	☐	☐	☐
☐ Food texture education/recommendations and/or Home Plan established	☐	☐	☐	☐ Aphasia treatment plan	☐	☐	☐
☐ Develop/Establish alternate communication plan	☐	☐	☐	☐ Teaching language processing skills	☐	☐	☐
☐ Swallowing safety plan development	☐	☐	☐	☐ Aural rehab program	☐	☐	☐
☐ Dysphagia interventions/program	☐	☐	☐	☐ Other:	☐	☐	☐
☐ Aspiration precaution plan	☐	☐	☐	☐ Other:	☐	☐	☐

GOALS / REHABILITATION POTENTIAL / DISCHARGE PLAN

☐ Patient/Caregiver will verbalize understanding of home plan, as evidenced by _____ within _____ period of time.

☐ Patient safety will be maintained throughout plan, as evidenced by _____ within _____ period of time.

☐ Patient/Caregiver will verbalize/communicate understanding of prescribed diet plan as evidenced by compliance with diet plan within _____ period of time.

☐ Patient will reach maximum level of functioning, as evidenced by _____ within _____ period of time.

☐ Patient/Caregiver's Expectations: _____

☐ Other: _____

☐ Other: _____

☐ Rehabilitation Potential _____

SPECIFIC SLP GOALS

Measurable Short Term: _____

Measurable Long Term: _____

Skilled Services provided this visit and patient response: _____

SLP DISCHARGE PLANS

☐ Patient to be discharged when skilled care no longer needed ☐ Other (specify): _____

☐ Patient to be discharged to the care of: ☐ Self ☐ Caregiver ☐ Other: _____

REASSESSMENT

VARIABLE FACTORS/CONDITIONS AFFECTING PATIENT'S RESPONSE

☐ Unexpected Temporary Illness ☐ New Diagnosis

☐ Unexpected Family/Personal Event ☐ Other (specify) _____

EXPECTATIONS PATIENT'S CONDITION WILL IMPROVE

Is patient progressing towards goals? ☐ Yes ☐ No Is Goal attainable in a reasonable and generally predictable period of time? ☐ Yes ☐ No

Provide clinically supportable statement to explain. _____

Continue with current Plan of Care? ☐ Yes ☐ No If No, notify MD if update to POC is needed

Skilled Services provided this visit and patient response: _____

PATIENT NAME	**Patient Signature/Date (optional per agency policy):**	
SLP's Signature/Date:	**Time In** ☐ AM ☐ PM	**Physician's Signature/Date (optional per agency policy):**
	Time Out ☐ AM ☐ PM	

CHECK ONE: ☐ G0153-ST ☐ G0161-ST Maintenance