MATRIX HOME CARE **SPEECH LANGUAGE PATHOLOGY VISIT NOTE/PROGRESS REPORT**

PATIENT/CLIENT NAME: ______________________ **DATE:** __________

Reevaluation: ______________________
Voice Disorder Treatments: ______________________
Speech Articulation Disorder Treatment: ______________________
Dysphagia Treatments: ______________________
Language Disorder Treatments: ______________________
Aural Rehabilitation ______________________
(Reserved): ______________________
Establish and/or design non-oral communication system: ______________________
Other: ______________________
Treatment Done: ______________________
Instructions/Teaching: ______________________
Narrative: ______________________
Plan/Goal: ______________________

Time In: __________ **Time Out:** __________

Patient/Designee: I certify that the Matrix Home Care Employee listed on this time slip worked the times indicated and the work was performed in a satisfactory manner. I agree to the times regarding this time slip.

Team Conference: ______________________ **Physician Contact:** ❑ Yes ❑ No

Patient/Client Signature: ______________________

SLP Name (Print): ______________________ **SLP Signature:** ______________________