0005902

SPEECH THERAPY EVALUATION

❑ Initial Assessment
❑ Resumption of Care

Patient's Name	SOC Date	Certification Period From: To:	Medical Record Number
Address City State Zip			Phone Number
Allergies	Date of Birth	Sex	
Nutritional Requirement	Precautions		

Home bound: ❑ Yes ❑ No
Reasons:
❑ Needs assistance for all activities _____
❑ Residual weakness _____
❑ Requires Maximum assistance _____
❑ Taxing effort to leave home _____
❑ Confusion _____
❑ Unsafe to go out of home unassisted _____
❑ Severe SOB. SOB upon exertion _____
❑ Other _____

ICD-9-CM Principal Diagnosis Date

Rehab Diagnosis Date

ICD-9-CM Surgical Procedures Date

Prior Level of Function:

Past Medical History

DME and Supplies

Activities Permitted
❑ Complete bedrest ❑ Wheelchair
❑ Up as tolerated ❑ Walker
❑ Crutches ❑ No restriction
❑ Cane ❑ Other: _____
❑ Splints/Braces/Prosthesis

Current Living Environment/Caregiver Support:

Cognition
❑ Short-term memory _____ ❑ Insight/judgement _____ ❑ Forgetful
❑ Long-term memory _____ ❑ Sequencing _____ ❑ Agitated
❑ Follows _____ step commands ❑ Disoriented to _____
❑ Safety awareness _____ ❑ Other: _____

VITAL SIGNS: ☐ Rest ☐ with activity ☐ post activity

Temperature: _____ Pulse: _____ Respirations: _____ BP: _____/_____

Pulse oximetry _____ with alternate vitals being taken

Environmental Barriers/Risks:

ROM/STRENGTH:
Upper Extremities:

Lower Extremities:

PAIN:
Location: _____ Intensity: _____ Duration: _____
Onset: _____ Current pain regime: _____
Is pain regime effective: ☐ Yes ☐ No (If no, describe interventions)
Description of pain/comments: _____

Coordination:

Fine:

Gross:

Sensation:

Auditory/Visual Function:

Neuromuscular/Tone:

Posture:

Integumentary:

Edema:

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SPEECH THERAPY EVALUATION

Patient's Name	Medical Record Number

Expressive Language:	Current Diet:
	Dentation:
Reading:	Secretion Management:
	Labial ROM/Strength/Coordination:
Writing:	Lingual ROM/Strength/Coordination:
	Vellum:
Receptive Language:	Reflexes:
	Dry Swallow:
Motor Speech Production:	Vocal Quality:
	Labial Seal:
Alternative Communication Devices:	Mastication:
	Bolus:
Other:	A/P Transfer:
	Oral Clearance:
	Onset of Swallow:
	Laryngeal Excursion:

SKILLED NEED/REASON FOR INTERVENTION

EDUCATION

PATIENT/CAREGIVER EDUCATION COMPLETED:	PATIENT/CAREGIVER RESPONSE:

TIME IN	TIME OUT
❑ AM ❑ PM	❑ AM ❑ PM

SIGNATURE/CREDENTIALS AND DATE