SPEECH THERAPY REVISIT NOTE

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 VISIT:
☐ Revisit
☐ Revisit and Supervisory Visit
☐ Other (specify) _____
SOC DATE ___/___/___

TREATMENT DIAGNOSIS/PROBLEM _____

EXPECTED TREATMENT OUTCOME(S) _____

SPEECH THERAPY INTERVENTIONS/INSTRUCTIONS (Mark all applicable with an "X")

☐ Evaluation (C1)	☐ Aural rehabilitation (C6)	☐ Pain Management
☐ Establish rehab. program	☐ Non-oral communication (C8)	☐ Speech dysphagia instruction program
☐ Establish home maintenance program	☐ Alaryngeal speech skills	☐ Care of voice prosthesis including
☐ Copy given to patient	☐ Language processing	☐ removal, cleaning, site maintenance
☐ Copy attached to chart	☐ Food texture recommendations	☐ Teach/Develop communication system
☐ Patient/Family education	☐ Safe swallowing evaluation	☐ Trach. Instruction and care
☐ Voice disorders (C2)	☐ Therapy to increase articulation,	☐ Other:
☐ Speech articulation disorders (C3)	☐ proficiency, verbal expression	☐
☐ Dysphagia treatments (C4)	☐ Lip, tongue, facial exercises to	☐
☐ Language disorders (C5)	☐ improve swallowing/vocal skills	☐

OBSERVATIONS, INSTRUCTIONS AND MEASURABLE OUTCOMES _____

EVALUATION AND PATIENT/CAREGIVER RESPONSE _____

CARE PLAN: ☐ Reviewed/Revised with patient involvement.
If revised, specify _____

☐ Outcome/Instruction achieved (describe) _____

☐ PRN order obtained
APPROXIMATE NEXT VISIT DATE: ___/___/___
PLAN FOR NEXT VISIT _____

DISCHARGE DISCUSSED WITH: ☐ Patient/Family
☐ Care Manager ☐ Physician ☐ Other (specify) _____
BILLABLE SUPPLIES RECORDED? ☐ N/A ☐ Yes (specify) _____

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

SUPERVISORY VISIT (Complete if applicable)

☐ ST Assistant ☐ Aide / ☐ Present ☐ Not present
SUPERVISORY VISIT: ☐ Scheduled ☐ Unscheduled
OBSERVATION OF _____

TEACHING/TRAINING OF _____

PATIENT/FAMILY FEEDBACK ON SERVICES/CARE
(specify) _____

NEXT SCHEDULED SUPERVISORY VISIT ___/___/___
CARE PLAN UPDATED? ☐ No ☐ Yes (specify) _____

If ST assistant/aide **not present**, specify date he/she was contacted regarding updated care plan: ___/___/___

SIGNATURES/DATES

X _____ ___/___/___
Patient/Caregiver (if applicable) *Date*

Complete **TIME OUT** (above) prior to signing below.
_____ ___/___/___
Therapist (signature/title) *Date*

PATIENT NAME – Last, First, Middle Initial | ID#

PRIMA HOME HEALTH