RHC™
Recovery Home Care

SPEECH THERAPY EVALUATION

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 EVALUATION:
- ☐ Initial (complete Care Plan)
- ☐ Interim
- ☐ Final

SOC DATE ____/____/____

ORDERS FOR EVALUATION ONLY? ☐ Yes ☐ No If no, orders are

PERTINENT BACKGROUND INFORMATION

MEDICAL DX/TREATMENT DX _____

ONSET ____/____/____

MEDICAL PRECAUTIONS _____

PRIOR LEVEL OF FUNCTION _____

LIVING SITUATION/SUPPORT SYSTEM _____

DESCRIBE PERTINENT MEDICAL/SOCIAL HISTORY AND/OR PREVIOUS THERAPY PROVIDED _____

PAIN (describe) Impact on therapy care plan? ☐ Yes ☐ No

SAFE SWALLOWING EVALUATION? ☐ No ☐ Yes; specify date, facility and M.D. _____

VIDEO FLUOROSCOPY? ☐ No ☐ Yes; specify date, facility and M.D. _____

CURRENT DIET TEXTURE _____

LIQUIDS: ☐ Thin ☐ Thickened (specify) ☐ Other (specify)

SPEECH/LANGUAGE EVALUATION

4 – WFL (within functional limits) 3 – Mild impairment 2 – Moderate impairment 1 – Severe impairment 0 – Unable to do/did not test

	FUNCTION EVALUATED	SCORE	COMMENTS
COGNITION	Orientation (Person/Place/Time)		
	Attention span		
	Short-term memory		
	Long-term memory		
	Judgment		
	Problem solving		
	Organization		
	Other:		
SPEECH/VOICE	Oral/facial exam		
	Articulation		
	Prosody		
	Voice/Respiration		
	Speech intelligibility		
	Other:		
SWALLOWING	Chewing ability		
	Oral stage management		
	Pharyngeal stage management		
	Reflex time:		
	Other:		

	FUNCTION EVALUATED	SCORE	COMMENTS
VERBAL EXPRESSION	Augmentative methods		
	Naming		
	Appropriate Yes / No		
	Complex sentences		
	Conversation		
AUDITORY COMPREHENSION	Word discrimination		
	1 step directions		
	2 step directions		
	Complex directions		
	Conversation		
	Speech reading		
READING	Letters/Numbers		
	Words		
	Simple sentences		
	Complex sentences		
	Paragraphs		
WRITING	Letters/Numbers		
	Words		
	Sentences		
	Spelling		
	Formulation		
	Simple addition/subtraction		

REFERRAL FOR: ☐ Vision ☐ Hearing ☐ Swallowing ☐ Other (specify)

Complete **TIME OUT** (above) prior to signing below.

DATE ____/____/____

THERAPIST SIGNATURE/TITLE

PATIENT INFORMATION

PATIENT/CLIENT NAME – Last, First, Middle Initial

ID#

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Recovery Home Care

SPEECH THERAPY CARE PLAN

SOC DATE ____/____/____

DIAGNOSIS _____ **ONSET** ____/____/____

ANALYSIS OF EVALUATION/TEST SCORES _____

PATIENT/CLIENT DESIRED OUTCOMES	SHORT TERM OUTCOMES Time Frame	LONG TERM OUTCOMES Time Frame

PLAN OF CARE (Mark all applicable with an "X".)

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

FREQUENCY _____ **REHAB POTENTIAL** ☐ Good ☐ Fair ☐ Poor

EQUIPMENT RECOMMENDATIONS _____

SAFETY ISSUES/INSTRUCTION/EDUCATION _____

COMMENTS/ADDITIONAL INFORMATION _____

PATIENT/CLIENT/CAREGIVER RESPONSE TO PLAN OF CARE _____

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

PLAN FOR NEXT VISIT _____

PLAN DEVELOPED BY (signature/title/date) _____ ____/____/____

CARE PLAN REVIEW

DATE	REVIEWED/REVISED BY (signature title)	COMMENTS

PART 1 – Clinical Record **PART 2 – Patient's Residence**

PATIENT/CLIENT NAME – Last, First, Middle Initial	ID#