SOUTH EAST HOME CARE

SPEECH THERAPY EVALUATION

TIENT'S NAME:_____ ID#:_____ DATE: _____

AGNOSIS: _____ FUNCTIONAL LIMITATIONS: _____

DDRESS: _____ BIRTH DATE: ____/____/____

_____ AGE: _____ SEX: M F

HONE: _____ FAMILY CONTACT : _____

RINCIPAL DIAGNOSIS : _____

ERTINENT OR CONTRIBUTING DIAGNOSIS: _____

AST INPATIENT STAY: FROM: _____ TO: _____

AME OF FACILITY: _____

AME OF PHYSICIAN: _____ PHONE: _____ LAST M.D. SAW PT. _____

SPECIFIC TREATMENT ORDERS (INCLUDING FREQUENCY/ DURATION)	
	☐ C 1 EVALUATION
	☐ C 2 VOICE DISORDER TREATMENT
	☐ C 3 SPEECH ARTICULATION DISORDER TREATMENT
	☐ C 4 DYSPHASIA
	☐ C 5 LANGUAGE DISORDER TREATMENT
	☐ C 6 AURAL REHABILITATION
	☐ C 7 NON-ORAL COMMUNICATIONS
	☐ C 8 OTHER

NIFICANT CLINICAL FINDINGS _____

LS / REHABILITATION POTENTIAL: _____