ULTRA Health Care Inc.

SPEECH THERAPY EVALUATION

☐ EVALUATION ☐ RE-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 ☐ Interim ☐ Final
SOC DATE ___/___/___
(If Initial Evaluation, complete Speech Therapy Care Plan)

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

PERTINENT BACKGROUND INFORMATION

TREATMENT DIAGNOSIS/ PROBLEM _____

ONSET ___/___/___

MEDICAL PRECAUTIONS:

MEDICAL HISTORY

☐ Hypertension ☐ Fractures
☐ Cardiac ☐ Cancer
☐ Diabetes ☐ Infection
☐ Respiratory ☐ Immunosuppressed
☐ Osteoporosis ☐ Open wound
☐ Other (specify) _____

Assistive Device:
Needs: _____
_____
Has:
_____
_____

LIVING SITUATION

☐ Capable ☐ Able ☐ Willing caregiver available
☐ Limited caregiver support (ability/willingness)
☐ No caregiver available

HOME SAFETY BARRIERS:
☐ Clutter ☐ Throw rugs
☐ **Needs** grab bars ☐ Needs railings
☐ Steps (number/condition) _____
☐ Other (specify) _____

BEHAVIOR/MENTAL STATUS

☐ Alert ☐ Oriented ☐ Cooperative
☐ Conf used ☐ Memory deficits ☐ Impaired Judgement
☐ Other (specify) _____

PAIN

INTENSITY: 0 1 2 3 4 5 6 7 8 9 10
LOCATION: _____
AGGRAVATING /RELIEVING FACTORS: _____
PAIN TYPE (dull, aching, etc):
PATTERN (Irradiation):

PRIOR/CURRENT LEVEL OF FUNCTION

Prior level of function Specify Problematic Areas

Current level of function Specify Problematic Areas

PERTINENT MEDICAL/SOCIAL HISTORY AND/OR PREVIOUS THERAPY RECEIVED AND OUTCOMES

SAFE SWALLOWING EVALUATION: ☐ No ☐ Yes, specify date and M.D. _____

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

CURRENT DIET TEXTURE: _____

LIQUIDS: ☐ Thin ☐ Thickened (Specify): _____ Other (Specify): _____

THERAPIST SIGNATURE/TITLE _____ DATE ___/___/___

PATIENT NAME - Last, First, Middle Initial	ID#

SPEECH THERAPY EVALUATION

☐ EVALUATION ☐ RE-EVALUATION

DATE OF SERVICE ___/___/___
TIME IN _____ OUT _____

COGNITIVE STATUS/COMPREHENSION SPEECH/LANGUAGE EVALUATION SENSORY/PERCEPTUAL

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		
	Paragraph		
WRITING	Letters/Numbers		
	Words		
	Sentences		
	Spelling		
	Formulation		
	Simple addition/subtraction		

REFERRAL FOR: ☐ Vision ☐ Hearing ☐ Swallowing ☐ Other (Specify) _____

CLINICAL FINDING

ORAL PERIPHERAL EXAM	ORAL MOTOR EXAM
UPS	UPS ABDUCTED ADDUCTED
MANDIBLE	TONGUE ELEVATION PROTRUSION
MAXILLA	TONGUE RETRACTION LATERALIZATION
TEETH	VELUM ELEVATION
OCCLUSION	P-T-K FORWARD BACKWARD
PALATE	PHONEME CONTROL
UVULA	Do sensory/perceptual affect safety? ☐Yes ☐ No If yes, recommendations:
PHARYNX	COMMENTS:

COMMUNICATION DEVICES

VISUAL TRACKING:

R/L DISCRIMINATION:

MOTOR PLANNING PRAXIS:

FOR RE-EVALUATION USE ONLY: IF A PREVIOUS PLAN OF CARE WAS ESTABLISHED, THEM IT WILL: ☐ CHANGE ☐ NOT CHANGE

TEST	SCORE	COMMENTS	TEST	SCORE	COMMENTS

PATIENT'S NAME: _____ MED. RECORD #: _____

THERAPIST'S SIGNATURE/TITLE _____ DATE ___/___/___

PHYSICIAN'S SIGNATURE _____ DATE ___/___/___

** If no changes made to Initial Plan of care, MD signature no required.*