ULTRA Health Care Inc.

# 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*

**PART 1 - Clinical Record** **PART 2 - Therapist**

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