RecoverHealth
We bring health care home

SPEECH THERAPY EVALUATION

CLIENT NAME	SERVICE DATE	BRANCH	TIME IN: TIME OUT:

☐ INITIAL EVALUATION ☐ RE-EVALUATION CERT / RE-CERT PERIOD:________________ to ________________
☐ MEDICATIONS REVIEWED ☐ MEDICATION PROFILE UPDATED

I. HOMEBOUND REASON: ☐ Needs assistance with ADL ☐ Residual weakness ☐ Medical restrictions ☐ Severe pain
☐ Requires assistance to ambulate ☐Severe SOB with ________________ ☐ Dependent on adaptive device(s)
☐ Unable to leave home safely due to ________________ ☐ Other (specify)________________

II. PERTINENT BACKGROUND INFORMATION

REASON FOR REFERRAL:

MEDICAL DIAGNOSIS & PROBLEM(S):________________ **Onset:**________
TREATMENT DIAGNOSIS & PROBLEM(S):________________ **Onset:**________
MEDICAL PRECAUTIONS: ________________
PERTINENT MEDICAL HISTORY:

GENERAL PRIOR LEVEL OF FUNCTION:
(See below for details)
LIVING SITUATION / SUPPORT SYSTEM:________________
HAVE INSTRUMENTAL TESTS BEEN COMPLETED (VF, MBS, FEES)**?** ☐ Yes ☐ No *If yes, provide date & results:* Date:________
Results:________________
DIET: Prior ________Current________ **LIQUIDS:** Prior ________Current________
MODE OF COMMUNICATION: Prior: ☐ Verbal ☐ Non-Verbal ☐ Augmentative **Current:** ☐ Verbal ☐ Non-Verbal ☐ Augmentative
CURRENT HEARING STATUS: ☐ WFL ☐ Impaired → ☐ Amplifiers used in ☐ Left ☐ Right

III. VITAL SIGNS

RADIAL PULSE	BP SITTING	BP STANDING	BP SUPINE	RESPIRATION	PAIN
R IR	L R	L R	L R	R IR	☐ With movement____; ☐Sitting ____; ☐Standing;____; ☐ Lying____ Does pain interfere w/activities? ☐ Yes ☐ No

0 NO HURT | 2 HURTS LITTLE BIT | 4 HURTS LITTLE MORE | 6 HURTS EVEN MORE | 8 HURTS WHOLE LOT | 10 HURTS WORST

Is pain management program effective? ☐ Yes ☐ No
Location of pain:________________
Describe pain:

KEY: 0=Profound (0-9%); 0.5=Severe (10-24%); 1.0=Mod/Sev (25-49%); 1.5=Mod (50-74%); 2= Mild/Mod (75-89%); 2.5=Mild (90-99%); 3=Ind (100%); U=Untested/Unable; NA = Not applicable

Function	Components	PLOF	CLOF	Comments
IV. COGNITION **Overall score_____**	Orientation (circle)	Person/ Place/ Time	Person /Place/ Time	
	Attention span	Sec.	Sec.	
	Short-term memory			
	Long – term memory			
	Judgment/ Problem solving			
	Organization			
	Other:________			
V. SPEECH / VOICE **Overall score_____**	Oral / Facial Function			
	Articulation			
	Breath support for Voice Production			
	Speech Intelligibility			
	Other:			
VI. VERBAL EXPRESSION **Overall score_____**	Word			
	Phrase / Sentence			
	Conversation			
	Other:			

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Function	Components	PLOF	CLOF	Comments
VII. AUDITORY COMPREHENSION for HOME SAFETY	Appropriate Yes/No			
	1 step directions			
	2 step directions			
Overall score_____	Conversation			
VII. READING COMPREHENSION for HOME SAFETY	Letters/Numbers			
	Words			
	Simple sentences			
	Complex sentences			
Overall score_____	Paragraph			
IX. WRITING ABILITY RELATED TO ROUTINE DAILY ACTIVITY	Letters/Numbers			
	Words			
Overall score_____	Simple sentences			
X. SWALLOWING	**Oral Stage Mngmt**			
	OralStrength / ROM / Coordi			
	Bolus Formation / Manip			
	Lip Closure/Seal			
	Ant-Post Propulsion			
	Pocketing			
Overall score_____	**Pharyngeal Stage Mngmt**			
	Reflex time			
	Coughing / Gurgly Voice			
	Laryngeal Elevation			
	Other:			

ADDITIONAL NOTES

Patient Signature:	Date:	Therapist Signature & Professional Designation:	Date:

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SPEECH THERAPY CARE PLAN

CLIENT NAME	BRANCH	EVALUATION DATE	PHYSICIAN NAME

☐ **INITIAL EVALUATION** ☐ **RE-EVALUATION** **CERT / RE-CERT PERIOD:_______________ to _______________**

Treatment Diagnosis & Reason for ST:____**Onset:**_______________

Frequency & Duration of ST POC:_______________________________ **effective week of:**_____________________________

SPEECH THERAPY INTERVENTIONS

	Evaluation of speech & language		Treatment of speech disorders		Establish home exercise program ☐ Copy given to patient ☐ Copy attached to chart
	Treatment of auditory processing disorder		Treatment of communication disorder Aural rehabilitation		
	Treatment of voice disorders		Evaluation of dysphagia		Patient / Family education
	Treatment of language disorders		Treatment of dysphagia		Teach / Develop communication syst

ANALYSIS / CARE PLANNING / TREATMENT

☐ ST Evaluation only. No further indications for service

Instruction provided this date: ☐ Safety training ☐ Exercise
☐ Other:____
☐ Equipment Needs: ______________________________________

☐ Client appropriate for additional services; Need verbal orders
☐ Refer to ______________________________ for evaluation.

DISCHARGE DISCUSSED WITH:
☐ Patient ☐ Family ☐ Physician ☐ Care Manager
☐ Other (specify):

CARE COORDINATION: ☐ Physician ☐ SN ☐ PT ☐ OT ☐ ST
☐ MSS ☐ HHAide ☐ALF staff ☐Other (specify) _______________

APPROXIMATE NEXT VISIT DATE: ______/______/______

GOALS FOR SPEECH THERAPY

CLIENT/CAREGIVER'S DESIRED OUTCOMES FROM S.T.: ____

STG LTG

Goals should include the functional deficit, be objective & measurable

☐ ☐ ☐ Resident will participate in OMEs x ______ each to increase lingual ROM from ____________ to_______________ for increased oral phase safety

☐ ☐ ☐ Resident will increase anterior to posterior propulsion from ____________ to______________ for increased oral phase safety

☐ ☐ ☐ Improve safe swallowing skills with ____diet using compensatory strategies, diet modifications, caregiver/family education with _____________% assist.

☐ ☐ ☐ Client will demonstrate compensatory technique of ____
_________________________ with ____ cues to decrease s/s of aspiration.

☐ ☐ ☐Language goal(s):
(specify)

☐ ☐ ☐ Resident will identify key words in phrases with ____% accuracy to improve understanding of spoken language

☐ ☐ ☐ Cognitive goal(s):
(specify)

☐ ☐ ☐Client / Caregiver will be independent in a HEP of
in order that

☐ ☐ ☐ ____

☐ ☐ ☐ ____

Short-term goals achieved in ____________________ weeks

Long term goals achieved in _________________ weeks.

REHAB POTENTIAL: ☐ Fair due to ______________________
☐ Good due to ____
☐Excellent due to_______________________________________

DISCHARGE PLAN: Discontinue Speech Therapy when client meets goals or reaches maximum rehab potential.

Client / Caregiver aware of POC & agreeable to POC: ☐ Yes ☐ No (explain)

Plan developed by: ____**Date:**_______________
Professional signature/title

SPEECH THERAPY CARE PLAN & PHYSICIAN'S ORDERS

Verbal Orders received from _______________________**by:** __________________________________ **Date:**_______________

MD Phone Number:_____________________________ *Professional signature/title* ☐ Orders read back & verified

Physician Signature: ____ **Date:**_______________
Please sign & return promptly