RecoverHealth
We bring health care home

CLEAR FORM

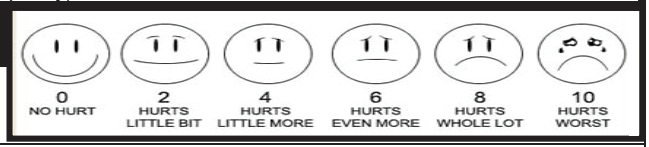
SPEECH THERAPY VISIT &TREATMENT NOTE

CLIENT NAME	SERVICE DATE	EMPLOYEE NAME	BRANCH
CLIENT SIGNATURE		**EMPLOYEE SIGNATURE**	**TIME IN:** **TIME OUT:**

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

VITAL SIGNS

RADIAL PULSE	BP SITTING	BP STANDING	BP SUPINE	RESPIRATION
☐ R ☐ IR	☐ L ☐ R	☐ L ☐ R	☐ L ☐ R	☐ R ☐ IR



MEDICATIONS REVIEWED? ☐ Yes ☐ No;
ANY NEW/CHANGED MEDICATIONS? ☐Yes ☐No
FOUND IN HOME RX#_____
COMPLIANT WITH MED REGIME? ☐ Yes ☐ No
☐ **MED PROFILE UPDATED**

☐ With movement____; ☐Sitting ____; ☐Standing;____; ☐ Lying____
Does pain interfere w/activities? ☐ Yes ☐ No
Is pain management program effective? ☐ Yes ☐ No
Location of pain:_____
Describe pain: _____

TREATMENT THIS DATE:

KEY: CUES: MC = Manual Cues, VC = Verbal Cues, VSC = Visual Cues

SUBJECTIVE:

SLP TREATMENT of speech, language, voice, communication &/or auditory processing disorder • List purpose of exercise(s) • Describe type/amount/ purpose of Cues provided for exercise • List ex: include # sets, # reps • List any stimulus devices • List any equipment used or recommended	
TREATMENT of swallowing dysfunction and/or oral function for feeding • List purpose of exercise(s) • Describe type/amount/ purpose of Cues provided • List ex: include # sets, # reps • Describe diet texture modifications • List any stimulus devices • List any equipment used or recommended	
OTHER *specify:* _____ • List technique • Describe the treatment • Describe type/amount/ purpose of cues provided for treatment	
STANDARDIZED ASSESSMENTS & OTHER TEST SCORES PERFORMED • Provide interpretation of results	
SAFETY TRAINING & PATIENT/CAREGIVER EDUCATION	

SAFETY ISSUES: ☐ Impulsiveness ☐ Poor understanding of deficits ☐ Verbal Cues req'd ☐ Poor positioning at meals ☐ Equipment in poor condition

CARE COORDINATION: ☐ Physician ☐ SN ☐ PT ☐ PTA ☐OT ☐ OTA ☐ST ☐ MSS ☐Aide ☐ALF staff ☐Other (specify) _____

Response to Tx: ☐ Tolerated well ☐ Fair tolerance ☐ Poor tolerance ☐ No complaints

Plan: ☐ Cont per POC ☐ Begin DC planning ☐ Reassess by MD

Analyze client's response to treatment & describe functional gains made thus far, & plans for next treatment:

Supervisory Visit for ☐HHA

Is He/She Present? ☐ Yes ☐ No

☐Plan of Care Reviewed/Revised with Client/Caregiver Involvement

Following Care Plan? ☐ Yes ☐ No
Client Caregiver Satisfied with Service? ☐ Yes ☐ No