RecoverHealth
We bring health care home

CLEAR FORM

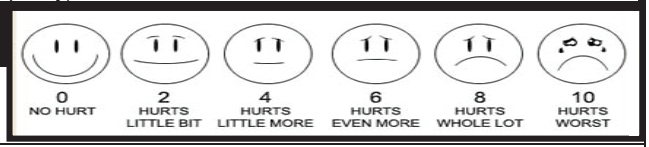
SPEECH THERAPY VISIT &TREATMENT NOTE

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

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S.T. FUNCTIONAL REASSESSMENT REPORT

☐**G0153: ST services: 15 min/ea** ☐**G0161: ST for maint prgrm: 15 mi/ea** **Date:_____**

CLIENT NAME	MR NUMBER	ST POC written for: visits

PROGRESS TOWARD GOALS: Provide objective measures of impairment;
Provide objective measures of improvement &/or functional progress toward goals

GOAL	STATUS at LAST REPORT	STATUS THIS DATE
☐ Short Term ☐ Long Term		◯Goal Met ◯Cont with Goal ◯Goal Revised
☐ Short Term ☐ Long Term		◯Goal Met ◯Cont with Goal ◯Goal Revised
☐ Short Term ☐ Long Term		◯Goal Met ◯Cont with Goal ◯Goal Revised
☐ Short Term ☐ Long Term		◯Goal Met ◯Cont with Goal ◯Goal Revised
☐ Short Term ☐ Long Term		◯Goal Met ◯Cont with Goal ◯Goal Revised
☐ Short Term ☐ Long Term		◯Goal Met ◯Cont with Goal ◯Goal Revised

FUNCTIONAL MEASUREMENT TOOLS USED:			
	Attention Span:		
	Verbal Expression score:		
	Auditory Compre score:		
	Other Test:		
	ROM* Area & Score:		

Provide justification as to <u>why</u> the client will <u>continue to require skilled therapy services</u>. Use statements that will objectively assess client's response to therapy. Provide information to explain what treatment is no longer needed & what adjustments will be made in treatment next period. Relate the results to functional outcomes, problems remaining

***ST should continue due to:* ☐Pt potential to improve materially in a reasonable & generally predictable period of time based on the POC
☐A ST's skills/ knowledge are needed to design/establish a safe maint. program ☐A ST's skills/ knowledge are needed to perform a safe maint. program

Supervisory Visit for ☐HHA Is He/She Present? ◯Yes ◯No ☐Plan of Care Reviewed/Revised with Client/Caregiver involvement

Client / Caregiver Satisfied with Service? ◯Yes ◯No Following Care Plan? ◯Yes ◯No

Therapist Signature & Prof Designation: DATE: