ST

SPEECH THERAPY EVALUATION AND CARE PLAN

Patients Name:	Date:
Address:	Diagnosis:
Time In:_____ Time Out:_____	Frequency:
Cert Period:	Initial Eval: □ Re-cert □ 13th visit □ 19th visit□
Pertinent Medical HX:	Pertinent Social History:

HOMEBOUND REASON

□ Needs assistance for all activities □Confusion unable to go out alone □Dependent upon adaptive device

□Residual weakness □unable to safely leave home unassisted □ Medical restrictions

□Sever SOB Upon exertion □Other: Specify_____

Medical Precautions: □None □Other_____

Grade 5=WFL=within functional limits 4=WFL with cues 3=Mild impairment 2=Moderate Impairment 1=Severe impairment 0=Unable or Not tested

	PRIOR LEVEL	CURRENT LEVEL
Attention Span		
Short-Term Memory		
Long-term Memory		
Judgment		
Problem Solving		
Organization		
Other		
Other Facial exam		
Articulation		
Prosody		
Voice/Respiration		
Speech Intelligibility		
Other		
Chewing Ability		
Oral Stage Management		
Pharyngeal Stage mgmnt		
Reflex Time		
Other		

Comments:

	PRIOR LEVEL	CURRENT LEVEL
Verbal Expression		
Auditory Complications		
Commands		
Non-Verbal Communications		
Syntax		
Length of utterance		
Alaryngeal Speech		
Other		
Reading accuracy		
Writing accuracy		
Writing Comprehension		
Other		
Auditory/Speech discrimination		
Speech Reading		
Hearing Tests		
Vision		
Other		

Patient Signature: _____ Physician Signature: _____

SP Signature: _____