ST

Speech Therapy Visit Note

Patients Name_____ Date_____ Time In: _____ Time Out: _____

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 □Severe SOB upon exertion

□Other(specify)_____

TX Diagnosis:_____

Expected Outcome of visit:_____

Pain Locations_____

Pain Scale: 0 1 2 3 4 5 6 7 8 9 10

INTERVENTIONS

Evaluation____	Teach Develop Communication System___	Patient/Caregiver/Family Education_____
Voice Disorders____	Safe Swallowing Eval_____	Speech Dysphagia Program_____
Speech Articulation disorder_____	Food Texture Recommendations_____	Therapy to increase articulation_____
Dysphagia Treatments__	A laryngeal Speech Skills____	Lip, tongue, facial exercises to improve swallowing/vocal skills_____
Language Disorders____	Written Instructions Provided___	Other:_____
Aural Rehab_____	Establish/Upgrade HEP_____	
Non-Oral Communication_____		

Treatment Provided:

Continue with POC: **5 day D/C Notice given □Yes □No (family, PT, caregiver)**

ST Signature: _____ Patient Signature: _____