Print Form

Physical Therapy Speech Therapy Occupational Therapy
Independent Living Inc.
Providing Home Based Therapy for Infants, Children and Adults

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Speech-Language Therapy Re- Evaluation

Evaluation Period: _____ to _____

ADDITIONAL SERVICES RECOMMENDED BY THERAPIST COMPLETING EVALUATION:
☐ Occupational Therapy
☐ Physical Therapy

Patient: _____
DOB: _____ CA_____ AA_____
Parents: _____
Phone: _____
Diagnosis: _____ ICD#_____
Date of Eval: _____
Therapist: _____

PCP: _____
_____
_____
Phone: _____
Fax: _____
CC: _____
Mdcd #: _____

Background Information/ History

☐ NO CHANGE FROM PREVIOUS EVALUATION DATED: _____

Medical Diagnosis (s): _____
Prenatal/ Birth History: _____
_____ Birth Weight:____lbs ____ oz
Medical History: _____
_____
Developmental Milestones (approx age): sitting _____standing _____walking _____first word (s) _____
Hearing: _____ Vision: _____ F/ UP: _____
Previous Therapy History: _____
Current Additional Services: _____
Current Educational Placement: _____
Current Equipment Use: _____
Current Medications: _____
Allergies: _____
Referral Source: _____
Reason for Referral: _____
Accompanied by:_____
Parent Concerns: _____
Additional Comments: _____
_____

Name _____

Assessment Information

Evaluation Methods Implemented to Assess Communication/ Feeding Skills:

☐ Informal Measures ☐ Formal Measures ☐ Other: _____

Formal Measures Used :_____

Informal Measures Used: ☐ Caregiver Report ☐ Clinical Observation ☐ Other:_____

If formal measure not administered, indicate why: _____

Language (s) tests administered in: ☐ English ☐ Spanish ☐ Other: _____

Modifications to testing procedures: _____

Behavioral Observations: _____

_____

_____

Language Development

Areas assessed include auditory comprehension (understanding of language) and oral expression (use of language), pragmatic, social and play skills. Results of formal assessment are as follows:

Test Name: _____	Raw Score	Standard Score	Percentile	Age Equiv.	Severity Ranking
Auditory Comprehension					
Oral Expression					
Other:_____					
Other: _____					

Test Name: _____	Raw Score	Standard Score	Percentile	Age Equiv.	Severity Ranking
Auditory Comprehension					
Oral Expression					
Other:_____					
Other: _____					

Auditory Comprehension (Receptive Language)

Strengths: _____

_____

_____

Areas for Further Development: _____

_____

_____

Oral Expression (Expressive Language)

Strengths: _____

_____

_____

Areas for Further Development: _____

_____

_____

Additional Assessment Information (if applicable): _____

_____

_____

Name: _____

Oral Motor Function/ Structure

☐ A cursory oral peripheral examination was unremarkable. All oral structures and musculature appear intact f for speech and feeding.
☐ Unable to assess due to: ☐ fatigue ☐ compliance ☐ other: _____
☐ A cursory oral peripheral examination revealed: _____
_____
_____
_____ _____ _____ _____
Skills affected: ☐ Articulation/Speech ☐ Feeding/Swallowing ☐ Other: _____

Articulation

☐ Within Normal Limits for age
☐ Unable to assess due to: ☐ limited expressive language ☐ fatigue/ compliance ☐ time constraints
☐ other:_____
Formal Measure Used: _____ Informal Measure Used: _____
Scores:

Raw Score	Std Score	% ile	AE	Severity Rating

Conversational Intelligibility (connected speech): _____
Phonemic Inventory (if appropriate): _____
_____
Phonological Processes (if appropriate): _____
_____
_____
Misarticulations/ Distortions:
Initial Position: _____
Medial Position: _____
Final Position: _____

Voice

☐ No concerns noted at this time
☐ Unable to assess due to: ☐ limited expressive language ☐ fatigue/ compliance ☐ time constraints
☐ other:_____
Indicate and Describe areas of concern:
☐ Vocal Quality: ☐ breathy ☐ shrill ☐ hoarse ☐ harsh ☐ weak ☐ glottal fry ☐ no voice ☐ other _____
☐ Pitch: ☐ too high ☐ too low ☐ monotone ☐ other _____
☐ Resonance: ☐ hypernasal ☐ hyponasal ☐ nasal emission ☐ other: _____
☐ Intensity: ☐ too loud ☐ too soft/ quiet ☐ monoloudness ☐ other: _____
☐ Other: _____

Fluency

☐ No concerns noted at this time
☐ Unable to assess due to: ☐ limited expressive language ☐ fatigue/ compliance ☐ time constraints
☐ other:_____
Indicate and Describe areas of concern:
☐ Rate of Speech: ☐ too fast ☐ too slow ☐ other: _____
☐ Description of Dysfluencies: _____
_____
Secondary Behaviors: _____
Percentage of speech affected: _____ Severity: _____
Other:_____

Name:_____

FEEDING/ SWALLOWING ASSESSMENT

☐ Within Normal Limits ☐ Within Functional Limits

☐ History of Feeding and/ or Swallowing Difficulties If so, describe:_____

_____

☐ See Comprehensive Feeding/ Swallowing Evaluation Addendum (attached– page 8)

Means of Intake/ Current Diet (indicate all that apply):

____ Bottle Fed ____ Open Cup ____ Puree Food (Stage 1) ____ Semi Solids

____ Breast Fed ____ Sipper Cup ____ Junior Foods (Stage 2/3) ____ Utensils _____

____ Tube Fed ____ Straw ____ Table Foods/ Solids ____ Other: _____

Limitations and/or Adaptations to feeding/diet: _____

_____

Reported/ Observed concerns: _____

Previous Long/ Short Term Goals and Progress: the patient will be able to:

(If goal ~~partially met - progress achieved toward goal is documented~~)

LTG 1: _____

STG 1: _____

_____ ☐Goal Met ☐ Partially Met _____ ☐ Con't Goal

☐ Not addressed ☐ Discontinue

STG 2: _____

_____ ☐Goal Met ☐Partially Met _____ ☐ Con't Goal

☐ Not addressed ☐ Discontinue

STG 3: _____

_____ ☐Goal Met ☐ Partially Met _____ ☐ Con't Goal

☐ Not addressed ☐ Discontinue

LTG 2: _____

STG 4: _____

_____ ☐Goal Met ☐ Partially Met _____ ☐ Con't Goal

☐ Not addressed ☐ Discontinue

STG 5: _____

_____ ☐ Goal Met ☐ Partially Met ____ ☐ Con't Goal

☐ Not addressed ☐ Discontinue

STG 6: _____

_____ ☐Goal Met ☐Partially Met _____ ☐Con't Goal

☐Not addressed ☐Discontinue

LTG 3: _____

STG 7: _____

_____ ☐ Goal Met ☐Partially Met _____ ☐Con't Goal

☐ Not addressed ☐ Discontinue

STG 8: _____

_____ ☐ Goal Met ☐ Partially Met ____ ☐ Con't Goal

☐ Not addressed ☐ Discontinue

STG 9: _____

_____ ☐Goal Met ☐ Partially Met ____ ☐ Con't Goal

☐ Not addressed ☐ Discontinue

Name: _____

Previous Long/ Short Term Goals Progress Con't:

LTG 4: _____

STG 10: _____

_____ ☐Goal Met ☐ Partially Met _____ ☐ Con't Goal
☐ Not addressed ☐ Discontinue

STG 11: _____

_____ ☐Goal Met ☐ Partially Met _____ ☐ Con't Goal
☐ Not addressed ☐ Discontinue

STG 12: _____

_____ ☐Goal Met ☐ Partially Met_____ ☐Con't Goal
☐ Not addressed ☐ Discontinue

LTG 5: _____

STG 13: _____

_____ ☐Goal Met ☐ Partially Met ____ ☐ Con't Goal
☐ Not addressed ☐ Discontinue

STG 14: _____

_____ ☐ Goal Met ☐ Partially Met ____ ☐Con't Goal
☐ Not addressed ☐ Discontinue

STG 15: _____

_____ ☐Goal Met ☐ Partially Met ____ ☐ Con't Goal
☐ Not addressed ☐ Discontinue

Attendance/ Participation

Attendance and participation in Speech/Language/Feeding Therapy during previous authorization period was:

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Unable to document/ data not available

Explain_____

ASSESSMENT

Name: _____

RECOMMENDATIONS

It is recommended that the above stated patient receive speech therapy:

- ☐ Duration: 6 months (unless otherwise stated) Other:_____
- ☐ Frequency: _____ times per week Other: _____
- ☐ Treatment Sessions up to 30 minutes
- ☐ Treatment Sessions 30 - 60 minutes are medically necessary due to:
  _____
- ☐ Therapy is not recommended due to: _____
- ☐ Therapy not indicated at this time, a Re-Evaluation recommended in _____
- ☐ Refer to Physician for Modified Barium Swallow Study due to:
  _____
- ☐ Other: _____

Plan of Care

- ☐ Oral Stimulation and/or Exercises
- ☐ Articulation/ Speech Therapy
- ☐ Expressive and/or Receptive Language Therapy
- ☐ Auditory Discrimination Training
- ☐ Feeding and/or Swallowing Therapy
- ☐ Other: _____
- ☐ Behavior Modification
- ☐ Fluency Training
- ☐ Parent/ Caregiver Training
- ☐ Voice Therapy and/or Vocal Care Program
- ☐ Aural Rehabilitation
- ☐ Alternative/Augmentative Communication

Caregiver Training Plan:

- ☐ Verbal/ Written Home Exercise Plan
- ☐ Provided treatment strategies/ patient progress following session
- ☐ Active participant in treatment session
- ☐ Other: _____

Updated Long/ Short Term Goals: the patient will be able to:

☐ See Previous Long/ Short Term Goals for Continued Goals

LTG 1: _____

_____

STG 1: _____

_____

STG 2: _____

_____

STG 3: _____

_____

LTG 2: _____

_____

STG 4: _____

_____

STG 5: _____

_____

Name: _____

Updated Long/ Short Term Goals Con't:

STG 6: _____

_____

LTG 3: _____

_____

STG 7: _____

_____

STG 8: _____

_____

STG 9: _____

_____

LTG 4: _____

_____

STG 10: _____

_____

STG 11: _____

_____

STG 12: _____

_____

_____ _____

Therapist Signature Date

_____ _____

CFY Supervisor Signature (if applicable) Date

Dear Physician,

If you agree with the treatment plan above, please sign and date the report and mail/ fax to Independent Living, Inc– Pediatrics Your signature will convert this report into a prescription.

_____ _____

Physician's Signature Date

_____

Medipass Authorization Number (if applicable)

Name: _____

Comprehensive Feeding Evaluation Addendum

History

Summary of Concern: _____

_____

Related Medical History (describe):

☐ Reflux _____ ☐ Tube Fed _____ ☐ Aspiration _____

☐ Allergies _____ ☐ Constipation _____ ☐ Age of Onset _____

☐ Vomiting _____ ☐ Spitting up _____ ☐ Other: _____

Most Recent MBS completed on:_____ Location: _____ By: _____

Summary of Results: _____

_____

_____

Specialists: _____

Procedures: _____

Other: _____

Present Diet

Intake Method (s): _____ Amount: _____

Primary Feeder: _____ Position fed: _____

Length of Feeds: _____ Consistencies: _____

Reported behavior at home: _____

_____

Foods Preferred: _____

Foods Refused: _____

Food Allergies: _____

Direct Feeding Observation

Clearance for feeding trial: ☐ Yes ☐ No (If no, do not proceed)

Fed by: _____ Position: _____

Foods attempted: _____

_____

Observations (sensory/structural/behavioral/respiratory): _____

_____

_____

_____

Interventions attempted: _____

_____

Intervention results: _____

_____

Summary of Results

_____

_____

_____

_____