

[Name of HH Agency]

Phone:

Fax:

SPEECH THERAPY EVALUATION

EPISODE: 09/19/14 - 11/17/14

10/10/14 1:00PM - 2:00PM 60 MIN

PHYSICIAN:

PHONE:

FAX:

PATIENT:

DOB:

Reason for Evaluation Initial

Patient had concussion from bathroom fall recently.

Homebound Status

- needs assistance for all activities
- needs assistance to ambulate
- leaves home with taxing effort
- leaves for med appointments only
- dependent on assistive device
- medical restrictions

Patient wheel-chair bound.

Rehabilitation Potential

- good

Visitation Frequency

1WK1, 2WK2, 1WK1

Pertinent Diagnoses

- Patient has had recurrence of stroke-like symptoms

Medical/Surgical History/Previous Speech Therapy Treatment

Patient admitted to hospital for concussion.

Prior Functional Status

Before stroke patient had been WNL

Vital Signs

- Not measured at this time

Physical Status

Patient wheel-chair bound.

Pain

- No pain at present

Support System

Caregiver there most days.

Cognitive Status

- confused
- memory deficit
- Oriented to Person
- Oriented to Place
- Oriented to Time
- Oriented to Reason for treatment

Diet

- No dietary restrictions

Speech/Voice

Articulation Moderately impaired

Patient omits the /s/ or substitutes a /t/ for /s/ in consonant blends.

Speech intelligibility Moderately impaired

Reading Comprehension

Letters/numbers	Severely impaired
Words	Severely impaired
Simple sentences	Severely impaired
Complex sentences	Severely impaired
Paragraphs	Severely impaired

Speech Therapy Care Plan: New Interventions

1 Patient will improve articulation of speech and improve auditory comprehension.

Speech Therapy Care Plan: New Goals

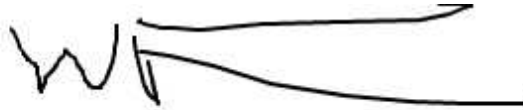
- 1 Patient will demonstrate improved articulatory precision, demonstrated by the production of functional intelligible speech within 4 weeks
- 2 Patient will answer functional questions with ___70% accuracy within _4_ weeks
- 3 Patient will use external memory aids and compensatory strategies to recall routine, personal information and recent events to improve orientation to time & recall daily events with ___70% accuracy and __2_cues within __4_ weeks.

Discharge Plan

when goals met

SIGNATURES:

CARE PLAN DISCUSSED WITH PATIENT/CAREGIVER AND AGREED UPON
COMPLETED AND ELECTRONICALLY SIGNED BY _____, SLP



PATIENT'S SIGNATURE:

PHYSICIAN'S SIGNATURE: _____ DATE: _____

[Name of HH Agency]
[Address]

SPEECH THERAPY CARE PLAN

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COMPLETED AND ELECTRONICALLY SIGNED BY _____, SLP

PHYSICIAN'S SIGNATURE: _____ DATE: _____