Therapy Station
Progressing towards Independence

SPEECH THERAPY RE-EVALUATION

AUTHORIZATION PERIOD: _____TO_____

Patient: _____ Examiner: _____
DOB: _____ DOE: _____
CA: ___Years_____Month Diagnosis: _____
Parents: _____ Physician: _____

Medical/Background History: _____
_____
_____
_____

Previous Goals and Status:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Assessment: _____
_____
_____
_____
_____
_____
_____

New Goals: The patient will be able to**:**
1._____
_____
2._____
_____
3._____
_____
4._____
_____

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Patient Name:_____

PATIENT PLAN OF CARE

Recommended Modalities:

__ Oral Motor	__ Sensory Integration	__ Language Training
__ Articulation Drill	__ Perceptual Skills	__ Therapeutic Exercise
__ Home Program	__ Auditory Training	__ Care giver training

Recommended Treatment sessions:

It is recommended that the above-mentioned patient receive _____ speech therapy treatment sessions, up to _____minutes with in _____ months to maximize functional abilities.

Justification for longer or no treatment session recommended: *(please write reason if patient require more than 30 minutes per treatment session)*

_____
_____
_____

_____SLP/L _____
Speech Therapist Date

Dear Physician:
Thank you for the referral. Please sign and return the treatment plan to Therapy Station. Your signature will convert this report into a prescription.

I certify that the above treatment plan is medically necessary and valid.

_____ _____
Physician's Signature Date

_____
Medipass Auth. Number (if applicable)