

Therapy Station

Progressing towards Independence

SPEECH THERAPY EVALUATION

AUTHORIZATION PERIOD: _____ TO _____

Patient: _____

Examiner: _____

DOB: _____

DOE: _____

CA: ___ Years ___ Month

Diagnosis: _____

Parents: _____

Physician: _____

Medical/Background History: _____

Clinical Assessments:

Auditory Comprehension: (attention, identification, follows direction, concepts, negation, comparisons, time)

Verbal Expression: (non verbal, gestures, imitations, mean length utterance, use of grammar, responses to "Wh")

Patient Name: _____

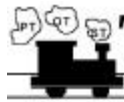
Articulation: (misarticulations, intelligibility)

Oral Motor: (cursory oral peripheral exam, means of intake, limitations)

Voice:(Vocal quality, pitch, intensity)

Fluency: (repetitions, characteristics, rate of speech)

Assessment: _____



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Patient Name: _____

PATIENT PLAN OF CARE

Recommended Modalities:

- | | | |
|---|--|---|
| <input type="checkbox"/> Oral Motor | <input type="checkbox"/> Sensory Integration | <input type="checkbox"/> Language Training |
| <input type="checkbox"/> Articulation Drill | <input type="checkbox"/> Perceptual Skills | <input type="checkbox"/> Therapeutic Exercise |
| <input type="checkbox"/> Home Program | <input type="checkbox"/> Auditory Training | <input type="checkbox"/> Care giver training |

Recommended Treatment sessions:

It is recommended that the above-mentioned patient receive _____ occupational 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)*

Goals: The patient will be able to:

1. _____

2. _____

3. _____

4. _____

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)

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❖ Physical Therapy

❖ Occupational Therapy

❖ Speech Therapy