Quality Care
Home Health Agency, Inc.

☐ INITIAL
☐ UPDATED

SPEECH THERAPY CARE PLAN

SOC DATE ____/____/____

TREATMENT DIAGNOSIS/PROBLEM _____

ONSET: ____/____/____

ANALYSIS OF EVALUATION/TEST SCORES _____

PLAN OF CARE SPEECH THERAPY: INTERVENTIONS/INSTRUCTIONS (Mark all applicable with an "X".)

	Evaluation (C1)		Aural rehabilitation (C6)		Pain Management
	Establish rehab. program		Non-oral communication (C8)		Speech dysphagia instruction program
	Establish home maintenance program		Alaryngeal speech skills		Care of voice prosthesis including
X	❑ Copy given to patient		Language processing	X	removal, cleaning, site maintenance
X	❑ Copy attached to chart		Food texture recommendations		Teach/Develop communication system
	Patient/Family education		Safe swallowing evaluation		Trach. instruction and care
	Voice disorders (C2)		Therapy to increase articulation,		Retraining of cognitive, feeding, and perceptual skills
	Speech articulation disorders (C3)	X	proficiency, verbal expression		Teach safe/effective use of communication
	Dysphagia treatments (C4)		Lip, tongue, facial exercises to	X	device (specify): device
	Language disorders (C5)	X	improve swallowing/vocal skills		Other:

Note Each **Modality**, specify frequency, duration, amount: _____

OBSERVATIONS, INSTRUCTIONS AND MEASURABLE OUTCOMES: _____

EVALUATION AND PATIENT/CAREGIVER RESPONSE: _____

ADDITIONAL SPECIFIC SPEECH THERAPY GOALS (Note: Each Modality, specify frequency, duration, amount) Locator # 22

PATIENT EXPECTATION	SHORT TERM Time Frame	LONG TERM Time Frame
❑ Patient will demonstrate improved reading/writing, use of gesture/numbers within _____ weeks.	❑ Patient will eating and drinking and taking all medications by mouth within ____ wks	❑ Patient will demonstrate functional communications, exhibit maximum verbal and sentence formulation and comprehension within disease limits w/ _____ weeks.
❑ Patient will demonstrate improved swallowing/chewing/oral/motor control within _____ weeks.	❑ Patient will increase accuracy of yes-no responses to greater than 80% accuracy within ____ wks.	❑ Patient will demonstrate appropriate use of functional VERBAL/NON-VERBAL communications system within _____ weeks.
❑ _____	_____	❑ _____

FREQUENCY AND DURATION _____ REHAB POTENTIAL ❑ Good ❑ Fair ❑ Poor

EQUIPMENT RECOMMENDATIONS _____

SAFETY ISSUES/INSTRUCTION/EDUCATION _____

PATIENT/CAREGIVER RESPONSE TO PLAN OF CARE _____

DISCHARGE DISCUSSED WITH: ❑ Patient/Family ❑ Care Manager ❑ Physician ❑ Other (specify) _____

CARE COORDINATION: ❑ Physician ❑ PT ❑ OT ❑ STA ❑ SS ❑ SN ❑ Other (specify) _____

APPROXIMATE NEXT VISIT DATE ____/____/____

PLAN FOR NEXT VISIT _____

DISCHARGE PLAN: ❑ When goals met ❑ Other (specify): _____

PLAN DEVELOPED BY: _____ _____ ____/____/____

Therapist Name | Signature & Title | Date

CARE PLAN REVIEW

DATE	REVIEWED/REVISED BY (signature/title)	COMMENTS

PART 1 - Clinical Record **PART 2 - Patient's Home Folder**

PATIENT NAME - Last, First, Middle Initial	ID#

Sanz Health Services

SPEECH THERAPY EVALUATION

☐ EVALUATION ☐ RE-EVALUATION

DATE OF SERVICE ___/___/___

TIME IN _____ OUT _____

HOMEBOUND REASON: ☐ Needs assistance for all activities ☐ Residual weakness
☐ Requires assistance to ambulate ☐ Confusion, unable to go out of home alone
☐ Unable to safely leave home unassisted ☐ Severe SOB, SOB upon exertion
☐ Dependent upon adaptive device(s) ☐ Medical restrictions
☐ Other (specify) _____

TYPE OF EVALUATION
☐ Initial ☐ Interim ☐ Final
SOC DATE ___/___/___
(If Initial Evaluation, complete Speech Therapy Care Plan)

ORDERS FOR EVALUATION ONLY? ☐ Yes ☐ No If no, orders are _____

PERTINENT BACKGROUND INFORMATION

TREATMENT DIAGNOSIS/ PROBLEM _____

ONSET ___/___/___

MEDICAL PRECAUTIONS:

MEDICAL HISTORY

☐ Hypertension ☐ Fractures
☐ Cardiac ☐ Cancer
☐ Diabetes ☐ Infection
☐ Respiratory ☐ Immunosuppressed
☐ Osteoporosis ☐ Open wound
☐ Other (specify) _____

Assistive Device:
Needs: _____
_____
Has: _____
_____

LIVING SITUATION

☐ Capable ☐ Able ☐ Willing caregiver available
☐ Limited caregiver support (ability/willingness)
☐ No caregiver available

HOME SAFETY BARRIERS:
☐ Clutter ☐ Throw rugs
☐ **Needs** grab bars ☐ Needs railings
☐ Steps (number/condition) _____
☐ Other (specify) _____

BEHAVIOR/MENTAL STATUS

☐ Alert ☐ Oriented ☐ Cooperative
☐ Conf used ☐ Memory deficits ☐ Impaired Judgement
☐ Other (specify) _____

PAIN

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

LOCATION: _____

AGGRAVATING /RELIEVING FACTORS: _____

PAIN TYPE (dull, aching, etc):

PATTERN (Irradiation):

PRIOR/CURRENT LEVEL OF FUNCTION

Prior level of function Specify Problematic Areas

Current level of function Specify Problematic Areas

PERTINENT MEDICAL/SOCIAL HISTORY AND/OR PREVIOUS THERAPY RECEIVED AND OUTCOMES

SAFE SWALLOWING EVALUATION: ☐ No ☐ Yes, specify date and M.D. _____

VIDEO FLUOROSCOPY?: ☐ No ☐ Yes, specify date and M.D. _____

CURRENT DIET TEXTURE: _____

LIQUIDS: ☐ Thin ☐ Thickened (Specify): _____ Other (Specify): _____

THERAPIST SIGNATURE/TITLE _____ DATE ___/___/___

PART 1 - Clinical Record **PART 2 - Therapist**

PATIENT NAME - Last, First, Middle Initial

ID#

Sanz Health Services

SPEECH THERAPY EVALUATION

☐ EVALUATION ☐ RE-EVALUATION

DATE OF SERVICE ____/____/____

TIME IN _____ OUT _____

COGNITIVE STATUS/COMPREHENSION SPEECH/LANGUAGE EVALUATION SENSORY/PERCEPTUAL

4- WFL (within functional limits) 3 - Mild impairment 2 - Moderate impairment 1 - Severe impairment 0- Unable to do/did not test

	FUNCTION EVALUATED	SCORE	COMMENTS
COGNITION	Orientation (Person/Place/Time)		
	Attention span		
	Short-term memory		
	Long-term memory		
	Judgment		
	Problem solving		
	Organization		
	Other:		
SPEECH/VOICE	Oral/facial exam		
	Articulation		
	Prosody		
	Voice/Respiration		
	Speech intelligibility		
	Other:		
SWALLOWING	Chewing ability		
	Oral stage management		
	Pharyngeal stage management		
	Reflex time		
	Other:		

	FUNCTION EVALUATED	SCORE	COMMENTS
VERBAL EXPRESSION	Augmentative methods		
	Naming		
	Appropriate Yes / No		
	Complex sentences		
	Conversation		
AUDITORY COMPREHENSION	Word discrimination		
	1 step directions		
	2 step directions		
	Complex directions		
	Conversation		
	Speech reading		
READING	Letters/Numbers		
	Words		
	Simple sentences		
	Complex sentences		
	Paragraph		
WRITING	Letters/Numbers		
	Words		
	Sentences		
	Spelling		
	Formulation		
	Simple addition/subtraction		

REFERRAL FOR: ☐ Vision ☐ Hearing ☐ Swallowing ☐ Other (Specify) _____

CLINICAL FINDING

ORAL PERIPHERAL EXAM	ORAL MOTOR EXAM	
UPS	UPS ABDUCTED	ADDUCTED
MANDIBLE	TONGUE ELEVATION	PROTRUSION
MAXILLA	TONGUE RETRACTION	LATERALIZATION
TEETH	VELUM ELEVATION	
OCCLUSION	P-T-K FORWARD	BACKWARD
PALATE	PHONEME CONTROL	
UVULA	Do sensory/perceptual affect safety? ☐Yes ☐ No If yes, recommendations:	
PHARYNX	COMMENTS:	

COMMUNICATION DEVICES

VISUAL TRACKING:

R/L DISCRIMINATION:

MOTOR PLANNING PRAXIS:

FOR RE-EVALUATION USE ONLY: IF A PREVIOUS PLAN OF CARE WAS ESTABLISHED, THEM IT WILL: ☐ CHANGE ☐ NOT CHANGE

TEST	SCORE	COMMENTS	TEST	SCORE	COMMENTS

PATIENT'S NAME: _____ MED. RECORD #: _____

THERAPIST'S SIGNATURE/TITLE _____ DATE ____/____/____

PHYSICIAN'S SIGNATURE _____ DATE ____/____/____

** If no changes made to Initial Plan of care, MD signature no required.*

SPEECH THERAPY REVISIT NOTE

DATE OF SERVICE ____/____
TIME IN _____ OUT _____

HOMEBOUND REASON: ❑ Needs assistance for all activities ❑ Residual weakness
❑ Requires assistance to ambulate ❑ Confusion, unable to go out of home alone
❑ Unable to safely leave home unassisted ❑ Severe SOB, SOB upon exertion
❑ Dependent upon adaptive device(s) ☐ Medical restrictions
❑ Other (specify) _____

TYPE OF VISIT
❑ Revisit
❑ Revisit and Supervisory Visit
❑ Other (specify) _____
SOC DATE ____/____/____

TREATMENT DIAGNOSIS/PROBLEM _____

EXPECTED TREATMENT OUTCOME(S) _____

SPEECH THERAPY INTERVENTIONS/INSTRUCTIONS (Mark all applicable with an "X")

	Evaluation (C1)		Aural rehabilitation (C6)		Pain Management
	Establish rehab. program		Non-oral communication (C8)		Speech dysphagia instruction program
	Establish home maintenance program		Alaryngeal speech skills		Care of voice prosthesis including
X	❑ Copy given to patient		Language processing	X	removal, cleaning, site maintenance
X	❑ Copy attached to chart		Food texture recommendations		Teach/Develop communication system
	Patient/Family education		Safe swallowing evaluation		Trach. instruction and care
	Voice disorders (C2)		Therapy to increase articulation,		Retraining of cognitive, feeding, and perceptual skills
	Speech articulation disorders (C3)	X	proficiency, verbal expression		Teach safe/effective use of communication
	Dysphagia treatments (C4)		Lip, tongue, facial exercises to	X	device (specify): device
	Language disorders (C5)	X	improve swallowing/vocal skills		Other:

Note Each Modality, specify frequency, duration, amount: _____

OBSERVATIONS, INSTRUCTIONS AND MEASURABLE OUTCOMES: _____

EVALUATION AND PATIENT/CAREGIVER RESPONSE: _____

CARE PLAN: ❑ Reviewed/Revised with patient involvement.
If revised, specify _____

❑ Outcome/instruction achieved (describe) _____

❑ PRN order obtained
APPROXIMATE NEXT VISIT DATE: ____/____/____
PLAN FOR NEXT VISIT _____

DISCHARGE DISCUSSED WITH: ❑ Patient/Family
❑ Care Manager ❑ Physician ❑ Other (specify)_____
BILLABLE SUPPLIES RECORDED? ❑ N/A ❑ Yes (specify)_____

CARE COORDINATION: ❑ Physician ❑ PT ❑ OT ❑ ST ❑ SS
❑ SN ❑ Other (specify) _____

TEACHING, TRAINING, RESPONSE TO INSTRUCTIONS:

❑ To Patient ❑ To CG ❑ To Family ❑ Other: _____
INSTRUCTION ABOUT: ❑ Treatment, Equipment ❑ Other: _____
TEACHING/TRAINING OF _____

PATIENT/FAMILY RESPONSE TO INSTRUCTIONS:
(specify) _____

CARE PLAN UPDATED? ❑ No ❑ Yes (specify, complete Modify Order)_____

If ST assistant/aide not present, specify date he/she was contacted regarding updated care plan: ____/____/____

SIGNATURES/DATES

X ____/____/____
Patient/Caregiver (if applicable) *Date*

Complete TIME OUT (above) prior to signing below.
____/____/____
Therapist (signatureltitle) *Date*

PART 1 - Clinical Record **PART 2 - Therapist**

PATIENT NAME - Last, First, Middle Initial	ID#

SPEECH THERAPY DEPTH ASSESSMENT

Patient Name: _____ Evaluation Date: _____

Principle Diagnosis: _____ Certification Period: _____ to _____

Pertinent Diagnosis: _____

Reason for PT Referral: _____

History of Present Illness: _____

_____

Prior Functional Status: _____

_____

Mental Status: ☐ Alert ☐ Oriented ☐ Forgetful ☐ Disoriented ☐ Lethargic ☐ Depressed
Safety Assessment: ☐ No problems ☐ Problems-specify _____

Speech and Language Evaluation

I. LANGUAGE/COMMUNICATION SKILLS:

Primary Mode of Communication: Verbal Sign Language Augmentative Device
Gestures/Vocalizations Other_____

RECEPTIVE LANGUAGE SKILLS:

☐ WNL ☐ Delayed Severity Level_____

Skills Areas:

Need Areas:

Expressive Language Skills:

☐ WNL ☐ Delayed Severity Level_____

Skills Areas:

Need Areas:

PRAGMATICS:

☐ WNL ☐ Delayed

Areas of need: turn taking eye contact proxemics topic maintenance affect

Other_____

II. SPEECH-ARTICULATION:

Intelligibility in connected speech: poor fair good excellent

Error types and sounds noted:

Comments:

III. ORAL PERIPHERAL/ORAL MOTOR SKILLS:

WNL Other

Structures:

Palate:_____

Tongue:_____

Dentition:_____

Other structures:_____

Tone:_____

Coordination:_____

Symmetry:_____

Diadokokinesis:_____

Aprasia:_____ Dysarthria:_____

IV. FEEDING/SWALLOWING

☐ WNL ☐ Swallowing difficulties

Current Diet: _____
Concerns/Difficulties: _____
Bedside Completed: _____
History of dysphagia or aspiration: _____
Any prior swallowing evals: _____
Comments:

V. HEARING

☐ WNL ☐Hearing Loss_____

Date of last audiological exam: _____

Aids Left Right Bilateral None

History of hearing difficulties: _____
History of ear infections:_____
Structural abnormalities: _____
Excessive cerument (ear wax): _____
Other: _____

VI. VOICE/FLUENCY

☐ WNL ☐ Abnormal

Volume: _____
Pitch: _____
Quality:_____
Nasality: _____
Rate: _____
Rhythm _____Stuttered wpm: _____
Secondary characteristics: _____
Breathing: _____Abdominal: _____Thoracic: _____WNL:_____
Comments:

SCREENING/TEST RESULTS:

Recommendations:

Speech-language pathologist

SPEECH THERAPY ASSESSMENT

Patient's Name: _____Eval. Date: _____

Goals: _____

_____

_____

_____

_____

Plan for Next Visit: _____

_____

_____

Homebound Status: ☐ Bed bound ☐ W/C Bound ☐ Chair Bound ☐Non-ambulatory

☐ Unstable Gait/requires assistance to ambulate ☐ NWB ☐PWB ☐ Assistive device_____
☐ Unable to negotiate stairs ☐ SOB when ambulating _____ft.
☐ Other: _____

Coordination of Care/Discharge Planning: _____

_____

_____

_____

Therapist Signature: _____

Date: _____

Speech/Language Pathology

EVALUATION OF SWALLOWING FUNCTION

Name:_____ D.O.B. _____ Age:_____ Date of Eval:_____
Diagnosis: _____
Vidwofluroscopy: ☐ Yes ☐ No If yes, date and place:_____
Current Method of Nurtition: ☐ PO ☐ NPO ☐ PEG Tube Current Diet:_____
Patient Complaint:_____

ORAL PERIPHERAL EXAMINATION

	Lip	Tongue	Buccal	Soft Plate	Jaw
Structure					
Symmetry					
Tone					
Gross Sensation					
Rate of Movement					
Range of Movement					

Drooling:
☐ Yes ☐ No

Dentures:
Upper
_____
Lower
_____

Tracheotomy:
☐ Yes ☐ No

PROTECTIVE REFLEXES

	Present	Absent
Swallow		
Cough		
Gag		

VOLITIONAL PROTECTIVE ABILITIES

	Adequate	Weak	Absent
Swallow			
Cough			
Clear Throat			
Phonate			

TRAIL FEEDING

Key: WNL= normal WFL = Within Functional Limits + = Present - = Absent

Consistencies of food used				
Oral Stage				
Lip Seal				
Chewing				
Bolus Controlled				
Tongue Pumping				
Oral Transit Time				
Oral Clearance				
Pocketing				
Pharyngeal Stage				
Observable Swallow Response				
Laryngeal Excursion				
Coughing and/or Throat Clearing				
Post Swallow Vocal Quality				
Cervical Auscultation				
Other				

Swallowing Treatment Indicated: ☐ Yes ☐ No Comments:_____
Recommended Diet: _____
Swallowing Program. Strategies Instructed: ☐ Yes ☐ No **See written swallowing program for details** ☐

_____
Speech/Language Pathology Signature

PATIENT TEACHING GUIDE
SWALLOWING PROGRAM FOR SAFETY

Patient Name_____

DIET

SOLIDS:

- ☐ Puree
- ☐ Ground
- ☐ Chopped
- ☐ Soft
- ☐ Foods should be moist
- ☐ Regular
- ☐ Avoid mixed textures
- ☐ Other_____

LIQUIDS:

- ☐ Nectar thick liquids
- ☐ Honey thick liquids
- ☐ May have all liquids
- ☐ Other_____

IF CHANGE OCCURS IN THE FREQUENCY OR QUALITY OF THE COUGH, OR IF A FEVER IS NOTED, CONTACT YOUR DOCTOR.

POSITIONING

- ☐ Sit up in chair with back support
- ☐ Chin down ("look in lap" – lean over")
- ☐ Turn/tilt head RIGHT/LEFT
- ☐ Remain upright for _____hour(s) after eating (**DO NOT LIE DOWN)**
- ☐ Other _____

REMINDERS TO

- ☐ Wear dentures
- ☐ Decrease distractions (e.g. TV, radio)
- ☐ Take small bites/sips
- ☐ One sip at a time
- ☐ Place food on RIGHT/LEFT side of mouth
- ☐ Swallow_____ times per bite/sip
- ☐ Sweep tongue around to check mouth for pocketing of food
- ☐ Be sure mouth is clear of food before taking another bite
- ☐ Other_____
- ☐ Every 2 to 3 bites wash down with liquid
- ☐ Pause between bites/sips
- ☐ Eat and drink slowly
- ☐ Refrain from talking while chewing/Swallowing
- ☐ Clear throat or cough following swallows (voice should be clear after the swallow)
- ☐ Mouth care after each meal or snack

ADDITIONAL STRATEGIES

- ☐ Thermal stimulation
- ☐ Supraglottic swallow
- ☐ Other _____
- ☐ Effortful swallow
- ☐ Practice oral exercises as instructed

SUPERVISION

- ☐ 100% supervision
- ☐ Review strategies before eating
- ☐ Reminders during meal
- ☐ Review strategies before independent time

_____

Speech/Language Pathologist (Signature) **Date**

Sanz Health Services

SPEECH THERAPY
WEEKLY SUMMARY REPORT

ACTIVITIES PERMITTED: ☐ Complete Bedrest ☐ Bedrest/BRP ☐ Transfer Bed/ Chair ☐ Up as Tolerated
☐ Full Weightbearing ☐ Partial Weightbearing ☐ No Weightbearing ☐ Independent at Home ☐ No Restrictions
☐ Wheel Chair ☐ Walker ☐ Cane ☐ Crutches ☐ Hoyer Lift ☐ Stair Climbing
☐ Other _____

MENTAL STATUS: ☐ Oriented ☐ Forgetful ☐ Disoriented ☐ Agitated ☐ Comatose ☐ Depressed ☐ Lethargic
☐ Other _____

HOMEBOUND STATUS DUE TO:
☐ Bed bound ☐ Severe SOB ☐ Ambulates with Assist ☐ Uses W/C, Walker, Cane
☐ Up in Chair with max assist ☐ Severe Weakness ☐ Paralysis ☐ Unable to walk
☐ Balance/Gait - Unsteady ☐ Other _____

Subjective Comments: _____

Specific Safety Issues Addressed: _____

TREATMENT RENDERED (If Pt/CG. instructed. see response below)	INSTRUCTED: Pt.	C.G.
☐ Assessment	☐	☐
☐ Therapy to increase articulation, proficiency, verbal expression	☐	☐
☐ Lip, tongue, facial exercises to improve swallowing/vocal skills	☐	☐
☐ Care of voice prosthesis including removal, cleaning, site maintenance	☐	☐
☐ Cognitive-Perceptual Re-Training	☐	☐
☐ Teach/Develop communication system	☐	☐
☐ Safe swallowing evaluation	☐	☐
☐ Speech dysphagia instruction program	☐	☐
☐ Aural rehabilitation/Language processing	☐	☐
☐ Other	☐	☐

PLAN OF CARE: PROBLEM - ACTION/PROGRESS TOWARD GOALS - PT'S/CG's RESPONSE TO TREATMENT/INSTRUCTION

☐ Interdisciplinary Communication: ☐ R.N. ☐ P.T./P.T.A. ☐ O.T./OTA ☐ ST Assistant ☐ M.S.W. ☐ H.H.A. ☐ M.D.

Date/Describe: _____

Next Scheduled Visit Date: _____ Plan for Next Visit: _____

Additions to Plan of Care _____

Patient Name _____

Therapist Name/Signature/Title _____ Date: _____

ALC HOME HEALTH
AMERICA-LOVING CARE HOME HEALTH INC.

FIELD SUPERVISORY REPORT
ST/STA

CLIENT'S NAME:_____ MR#:_____

EMPLOYEE'S NAME:_____ DATE:_____

	Please respond with Yes, No or NA to the following questions	Yes	No	NA
1	Did the ST/STA identify herself/himself and explain her/his duties at the first visit with you?			
2	Did the ST/STA explain the care provided according to the plan of care?			
3	Did the ST/STA provide care according to the scope of practice & in response to meet your needs?			
4	Did you feel the ST/STA was concerned with your health?			
5	Were you able to express your feelings and opinions without reservation to the ST/STA?			
6	Were you able to participate in the care planning process and in your care?			
7	Was the ST/STA following dress code? Using ID badge			
8	Was the ST/STA prepared with appropriate supplies and equipment as needed?			
9	Was the ST/STA on time for the visit or did he/she contact the client to change time?			
10	Did the ST/STA follow universal precaution and safety precaution?			
11	Did the ST/STA document care provided in the client's home chart?			
12	Did the ST/STA maintain confidentiality while providing care to you in your home.			
	Clinical Record Supervision	Yes	No	NA
1	Did the ST/STA adequately document assessment, teaching and treatment performed in the home record? Are changes in treatments orders reported to the Agency?			
2	Did the ST/STA notify the MD, DON or Case Manager when abnormal signs and symptoms were present and was this noted in the home record?			
3	Is the ST/STA carrying out the established Plan of Care? If No, use the comment section to identify areas not addressed and the reason?			
4	Does the ST/STA report every 14 days or less the client's condition to the MD as per agency policy? (Physician status report)			
5	Does the ST/STA report to the Case Manager, DON any new or changed medication orders or modification to the plan or care regarding treatment orders and are theses changes documented in the home record and medication sheet?			

COMMENTS:_____

_____

Client information packet is present in the home? _____Yes _____No
Client understands rights? _____Yes _____No

CLIENT COMMENTS:_____

SUPERVISOR'S SIGNATURE:_____ DATE:_____

SPEECH/LANGUAGE PATHOLOGY VISIT REPORT/DISCHARGE SUMMARY

PATIENT NAME _____ **DOB**_____ **Date Of Visit**_____

THE PLAN OF CARE **SKILLED INTERVENTION CODES: I – INSTRUCTION T – TREATMENT**

EVALUATION:

Receptive language/Auditory:	**Expressive language/Verbal:**	**Speech:**	**Swallowing / feeding:**
single words	automatic speech	gross oral movements imitation	postures / positioning
pictures / objects	imitation	speech movements	food placement / post
directions/commands	labeling	intelligibility/articulation	safety/restrictions
questions	sentence completion	oral facial exercises	airway protection/
cause – effect	word finding/recall	rate increase/decrease	supraglottic swallow
preposition identification	sentence production	breath control/volume	foods/textures
pronoun identification	expression of ideas		diet upgrade
verbal identification	vocal responses		liquids
Receptive language/visual:	preposition identification	**Cognition:**	compensatory strategies
matching skills	pronoun identification	eye contact	rate of p.o. intake
motoric imitation	verb identification	attention/concentration	amount of p.o. intake
Reading: yes/no		reasoning skills	multiple sequential dry
phrase	**Expressive language/Gestural:**	high level language skills	swallows
sentence	use of gestures, sign language,	organization of functional information	signs/symptoms complications
	augmentative	divergent/convergent thinking	nutrition consult
		organization of functional information	thermal stimulation
Voice:	**Expressive language/writing:**	short term/long term memory	video fluoroscopy
therapy	automatic	sequencing skills	
a laryngeal instruction	copying	association/categorization skills	NO clearance/follow-up
	dictation		

Summary of Therapeutic Program/Goals Achieved/Condition at Discharge:

NOTIFICATION OF CHANGE	☐ SN ☐ Nutrition ☐ PT ☐ Supervisor ☐ OT ☐ Other_____	MD: _____ Date:_____ ABN needed: ☐ Yes ☐ No ☐ N/A
SERVICES PROVIDED	☐ SN ☐ PT ☐ Other _____ ☐ HHA ☐ OT Services to Continue_____	
REASON FOR DISCHARGE	☐ Goal(s) achieved ☐ Patient has achieved maximum benefit from therapy ☐ Refused service ☐ Other_____	
RECOMMEND-ATIONS/ REFERRALS		
SIGNATURE/ TITLE		**PATIENT/CAREGIVER SIGNATURE**

Sanz Health Services

THERAPY DISCHARGE SUMMARY

PATIENT LAST NAME | FIRST NAME | PATIENT #

TYPE OF DISCHARGE: ☐ COMPLETE ☐ PARTIAL - STILL RECEIVING SERVICES OF: ☐ PT ☐ ST ☐ OT ☐ HHA ☐ SN

ADM DATE _____ **DISCH DATE** _____ DR _____

DIAGNOSIS (PRIMARY) _____ ADDRESS _____

_____ CITY, ST _____ ZIP _____

VISITS RENDERED BY: _____ RN _____ HHA _____ PT _____ OT _____ ST _____ MSW

REASON FOR DISCHARGE:
☐ GOALS MET ☐ MOVED OUT OF AREA ☐ OTHER
☐ HOSPITALIZATION ☐ PATIENT EXPIRED
☐ SKILLED NURSING FACILITY ☐ CARE REFUSED
☐ TRANSFER TO ANOTHER AGENCY ☐ SKILLED CARE NO LONGER NEEDED

DISPOSITION	☐ SELF CARE	☐ NH	☐ ACLF	☐ FAMILY CARE	☐ OTHER	
CONDITION	☐ IMPROVED	☐ STABLE	☐ UNSTABLE	☐ DECEASED	☐ REGRESSED	
DEPENDENCY	☐ DEPENDENT	☐ INDEPENDENT	☐ REQUIRES SUPERVISION/ASSIST			
EXERCISES	☐ PASSIVE	☐ ACTIVE	☐ ACTIVE ASSISTIVE	☐ RESISTIVE		
PERFORMED WITH:	☐ R.U.E.	☐ R.L.E.	☐ L.U.E.	☐ L.L.E.	☐ TRUNK	☐ NECK
TRANSFER	☐ HOYER LIFT	☐ CRUTCHES	☐ WALKER			
ACTIVITIES:	☐ W/C	☐ CANE	☐ QUAD CANE	☐ OTHER _____		
GAIT TRAINING:	☐ N.W.B.	☐ P.W.B.	☐ F.W.B.			
	☐ EVEN SURFACES	☐ STAIRS	☐ UNEVEN SURFACES			
ASSISTANCE REQUIRED:	☐ MAXIMUM	☐ MINIMUM	☐ MODERATE	☐ GUARDING	☐ OTHER _____	
DISTANCE AMBULATED:	☐ 20 ft.	☐ 40 ft.	☐ 60 ft.	☐ 80 ft.	☐ 100 ft.	☐ 120 ft.
INSTRUCTED ON HOME PROGRAM:	☐ PATIENT	☐ SIGNIFICANT OTHER	☐ FAMILY			

NARRATIVE: _____

SUMMATION OF SERVICES RENDERED AND GOALS ACHIEVED

Physical Therapy

_____ PATIENT HAS ACHIEVED ANTICIPATED GOALS
_____ PATIENT IS SAFELY INDEPENDENT WITHIN DISEASE LIMITATIONS
_____ ABSENCE OF PAIN
_____ FREE OF CONTRACTURES
_____ RANGE OF MOTION OF ALL JOINTS IS WITHIN NORMAL RANGE
_____ DEMONSTRATES RANGE OF MOTION EXERCISES
_____ DEMONSTRATES MUSCLE STRENGTHENING EXERCISES
_____ DEMONSTRATES TURNING AND POSITIONING SCHEDULE
_____ AMBULATES SAFELY WITH ASSISTIVE DEVICE
_____ AMBULATES SAFELY WITHOUT ASSISTIVE DEVICE

Speech Therapy

_____ PATIENT HAS REACHED ALL REALISTIC ACHIEVABLE GOALS
_____ PATIENT HAS ATTAINED MAXIMUM BENEFIT FROM THERAPEUTIC PROGRAM
_____ VERBAL AND SENTENCE FORMULATION AND COMPREHENSION IMPROVED TO MAXIMUM ATTAINMENT WITHIN DISEASE LIMITATIONS

_____ DEMONSTRATES TRANSFER TECHNIQUE AND USE OF SPECIAL DEVICES
_____ DEMONSTRATES ABILITY TO DO SPECIAL TREATMENTS
_____ HEALED INCISION
_____ DEMONSTRATES STUMP WRAPPING AND HYGIENE
_____ DEMONSTRATES TECHNIQUE TO CARE FOR AND PROTECT FUNCTIONING EXTREMITY
_____ DESCRIBES PHANTOM LIMB SENSATION
_____ PATIENT DEMONSTRATES STABILIZATION OF AMBULATION

Occupational Therapy

_____ PATIENT HAS REACHED ALL REALISTIC ACHIEVABLE GOALS
_____ DEMONSTRATES KNOWLEDGE OF OPERATION & CARE OF ADAPTIVE EQUIPMENT
_____ DEMONSTRATES ENERGY CONSERVATION/WORK SIMPLIFICATION TECHNIQUES
_____ DEMONSTRATIONS COMPENSATORY & SAFETY TECHNIQUES

PATIENT/S.O. RESPONSE AND ADHERENCE TO TEACHING: ☐ GOOD ☐ FAIR ☐ POOR

THERAPY GOALS MET: ☐ YES ☐ NO ☐ IF NO, EXPLAIN _____

PATIENT/S.O.GOALS MET: ☐ YES ☐ NO ☐ IF NO, EXPLAIN _____

COMMENTS: _____

☐ PATIENTS/So. INSTRUCTED ON IMPORTANCE OF ADHERENCE OF EXERCISE PROGRAM, M.D. FOLLOW-UP AND NOTIFY M.D. IF COMPLICATIONS OCCUR. ☐ M.D. NOTIFIED OF DISCHARGE

THERAPIST SIGNATURE _____ DATE _____

White: Medical Records Yellow: Physician

Quality Care
Home Health Agency, Inc.

SPEECH THERAPY
DISCHARGE SUMMARY ADDENDUM

SPEECH THERAPY GOALS REACHED

POC (485) GOALS REACHED:

- ❑ PROVIDED ORAL MOTOR EXERCISES INVOLVING LINGUAL AND LABIAL EXERCISES. IMPROVED SPEECH, FACIAL SYMMETRY AND MUSCULATION, IMPROVED DYSPHAGIA.
- ❑ VOICE DISORDER TREATED, SPEECH ARTICULATION DISORDER TREATED, LANGUAGE DISORDER TREATED, AURAL REHABILITATION COMPLETED, NON-ORAL COMMUNICATION TREATED.
- ❑ PATIENT DEMONSTRATED FUNCTIONAL COMMUNICATIONS, EXHIBIT MAXIMUM VERBAL AND SENTENCE FORMULATION AND COMPREHENSION WITHIN DISEASE LIMITS.
- ❑ PATIENT DEMONSTRATED APPROPRIATE USE OF FUNCTIONAL VERBAL/NON-VERBAL COMMUNICATIONS SYSTEMS.
- ❑ PATIENT DEMONSTRATED IMPROVED SWALLOWING/CHEWING/ORAL/MOTOR CONTROL.

OTHER:

_____

_____

CARE OF PLAN SHORT/LONG TERM GOALS REACHED:

- ❑ Patient will eating and drinking and taking all medications by mouth within ____ wks
- ❑ Patient will increase accuracy of yes-no responses to greater than 80% accuracy within ____ wks.

OTHER:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

OTHER:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

ADDITIONAL SPECIFIC OT GOALS REACHED

Patient Expectation	SHORT TERM	LONG TERM

DISCHARGE INSTRUCTIONS DISCUSSED WITH: ❑ Patient/Family ❑ Care Manager ❑ Physician ❑ Other (specify) _____

CARE WAS COORDINATED: ❑ Physician ❑ PT ❑ SN ❑ ST ❑ MSW ❑ Aide ❑ OTA ❑ Other (specify) _____

- ❑ DISCHARGED: PATIENT AND/OR CAREGIVER IS/ARE ABLE TO DEMONSTRATE KNOWLEDGE OF DISEASE MANAGEMENT, S/S COMPLICATIONS. PATIENT IS ABLE TO FUNCTION INDEPENDENTLY WITHIN HIS/HER CURRENT LIMITATION AT HOME.
- ❑ RETURNED TO INDEPENDENT LEVEL OF SELF CARE.
- ❑ ABLE TO REMAIN SAFELY IN RESIDENCE WITH ASSISTANT OF _____

REHAB STATUS: ❑ Poor ❑ Fair ❑ Good ❑ Excellent

- ❑ DISCHARGED: MAXIMUM FUNCTIONAL POTENTIAL REACHED
- ❑ ABLE TO UNDERSTAND MEDICATION REGIME AND CARE RELATED TO DISEASE
- ❑ ABLE TO REMAIN IN HOME/RESIDENCE/ALF WITH ASSISTANCE OF PRIMARY CAEGIVER/SUPPORT AT HOME ABLE TO UNDERSTAND MEDICATION REGIMEN, AND CARE RELATED TO HIS/HER DISEASE. DISCHARGED: MAXIMUM FUNCTIONAL POTENTIAL REACHED.

Goals documented by: _____ Date _____

Therapist Name/Signature/title

PATIENT NAME - Last, First, Middle Initial	ID#