Oklahoma State University
Department of Communication Sciences and Disorders

Speech-Language-Hearing
Clinic Manual
2024-2025

Table of Contents

SECTION 1 7
INTRODUCTION TO CLINIC: 7
DEVELOPMENT AND EVALUATION OF CLINICAL SKILLS 7
WELCOME NEW CLINICIANS 8
INTRODUCTION 8
CLIENTS 8
CLINIC PERSONNEL 10
Certification Standards in Speech-Language Pathology 11
RECORDING CLINICAL CLOCK HOURS 11
THE STUDENT CLINICIAN 12
EXPECTATIONS OF STUDENT CLINICIANS REGARDING CLINICAL PROCEDURES-Applies to all sites 12
DEVELOPMENT AND EVALUATION OF CLINICAL SKILLS 13
Clinical Observation Form 13
Weekly Supervisor / Clinician Meeting 14
Mid-semester and final evaluation of clinical skills 15
Student Self-Evaluation/ Supervisor's Evaluation of Clinical Skills 15
Competency Descriptors 15
EXAMPLE STUDENT'S SELF-EVALUATION OF CLINICAL SKILLS SUPERVISOR'S EVALUATION OF CLINICAL SKILLS (Grade Form) 17
AVERAGE LEVEL OF COMPETENCY: 20
PRACTICUM GRADE CALCULATIONS 20
CDIS DEPARTMENTAL ACADEMIC REQUIREMENTS FOR PARTICIPATION IN CLINICAL PRACTICUM 21
PROCEDURES FOR DEALING WITH INADEQUATE PERFORMANCE 21
OF VARIOUS CLINICAL PROCEDURES BY STUDENTS 21
Oklahoma State University 22
Communication Sciences and Disorders Department 22
Clinical Practicum Action Plan (Format) 22
Oklahoma State University 22
Communication Sciences and Disorders Department 22
Clinical Practicum Action Plan (Example) 22
SECTION 2 24

BEGINNING OF SEMESTER....24
CONFIDENTIALITY POLICY/HIPAA....25
BEGINNING OF SEMESTER PROCEDURES....27
NOTIFICATION OF CLINICAL ASSIGNMENTS....27
PREPARATION FOR INITIAL CONFERENCE....27
NOTIFY THE CLIENT....28
INITIATION OF TREATMENT CHECKLIST FOR CLINICIANS....30
CLINICIAN SCHEDULE....31
CLIENTS TO BE SCHEDULED (CTBS)....32
PERMISSION, RELEASE AND CONSENT FORMS POLICY....33
Authorization for Disclosure of Protected Health Information....33
Permission for Clinical Services....34
Permission to Leave Telephone Message and Electronically Transmit Information....34
Notice of Privacy Practices (NPP)....34
Informed Consent to Participate in Teletherapy Services (Select clients only)....34
Permission to Leave Telephone Messages and Electronically Transmit Information....35
Permission for Clinical Services....36
Client Confidentiality Agreement....37
Authorization for Disclosure of PHI....38
Informed Consent to Participate in Teletherapy Services....40
HIPPA Email Consent....41
Student Clinician / Staff Confidentiality Agreement....42
WRITING GUIDELINES FOR PROFESSIONAL REPORTS....43
PROCEDURES FOR SEMESTER TREATMENT PLANS....43
TIMELINE....43
COMPONENTS OF A TREATMENT PLAN....44
REASON FOR REFERRAL....44
RECOMMENDATIONS....45
OBJECTIVES / TREATMENT GOALS....45
LONG-TERM OBJECTIVES....46
SHORT TERM OBJECTIVES....46
ATTESTION / CERTIFICATION OF MEDICAL NECESSITY....48
Referring Physician, Additional Recipients....49

REPORT OPTIONS: 50
Semester Treatment Plan #2 EXAMPLE 51
TREATMENT PLAN CHECKLIST 53
WEEKLY THERAPY PLANS (WTP) 54
WTP Components 54
WTP EXAMPLE 55
SOAP NOTES 55
SOAP Note Template 56
Components of a SOAP note 56
Writing Guidelines for SOAP notes 59
SOAP NOTE EXAMPLE – Baseline data 60
SOAP NOTE EXAMPLE – after second treatment plan written 61
SECTION 3 63
GENERAL CLINIC PROCEDURES 63
CLINIC CANCELLATION PROCEDURES 64
LATE CLIENTS 64
CANCELLATION POLICY 64
Clinician Cancellation 64
Client Cancellation 64
EXCESSIVE CLIENT ABSENCES 65
CLINIC SECURITY 65
CLINIC FEES 66
GENERAL CLINIC OFFICE PROCEDURES 66
Office Conduct 66
Faculty and Clinician Mailboxes 67
Keys / Card Swipe 67
Unlocking/Locking Therapy Rooms 67
Supplies 67
Laminator Guidelines 68
Shredding 68
Mailing Reports 68
Clinic Forms Location 68
Clinic Equipment Check-Out 69

REQUESTING NEW IPAD APPS 69
COMPUTERS, PRINTING AND COPYING 70
Color Printing 70
RECORDING SESSIONS FOR MEDICAL RECORDS 70
Client Reinforcers 70
Feeding Supplies 70
Ordering Feeding Supplies 71
CLEANING CLINIC 71
Appropriate Clinic Dress 74
THERAPY MATERIALS ROOM PROCEDURES 75
DIAGNOSTIC TEST MANUALS & PROTOCOLS 75
Risk Management for Infectious and Chronic Communicable Diseases Policy and Procedures 76
SECTION 4 79
END OF SEMESTER INFORMATION 79
END OF SEMESTER PROCEDURES 80
Checklist for final Supervisor – Clinician Conference 81
DEADLINES FOR THE CLOSE OF THERAPY 82
End of semester client/family conference; SOAP procedure; Clock hours 83
SOAP Note 84
Scheduling and Clock Hours for Client Conferences 84
INTRODUCTION TO PROGRESS REPORT 85
Procedures for Writing Progress Reports 85
Writing Guidelines for Professional Reports 85
Components of Progress Report Sections 86
EXAMPLES of Reason for Referral: 87
RESULTS SEMESTER PROGRESS 88
Example #1 88
Example #2 89
Summary/Diagnosis 90
Recommendations: 90
Example: 90
Long Term Objectives 90
Examples: 91

Short Term Objectives......91
Example: 91
Prognosis......91
Example 1 92
Custom......92
Referring Physician......93
Additional Recipients......93
Report Attachments......93
Report Options......93
Patient Portal......93
Progress Report Checklist......94
Progress Report Example......97
SoonerCare Requirements – as of August 2021......100
Examples of Medical Necessity STO......102
COVER LETTERS......105
STUDENT EVALUATION OF SUPERVISOR......105
STUDENT SURVEY OF INSTRUCTION......106
SECTION 5......107
DIAGNOSTIC PROCEDURES......107
PROCEDURES FOR SPEECH-LANGUAGE DIAGNOSTICS......108
New Client Diagnostic Appointment Scheduling & Assignment......108
CLIENT INFORMATION FORM_FOR SPEECH-LANGUAGE EVALUATION......109
Pre-Authorization Requirements for Sooner Care Patients......110
Clinician Responsibilities Before The Diagnostic Appointment......111
DIAGNOSTIC ASSIGNMENT......113
DIAGNOSTIC PLANNING WORKSHEET......114
PURE-TONE / TYMP / OAE SCREENING FORM......115
MIDDLE EAR / HEARING SCREENING PROTOCOL......116
ORAL MECHANISM SCREENING......117
Day of Appointment......119
After the Appointment......120
ASHA Clock Hours and Grades......122
EVALUATION REPORT TEMPLATE......123

FORMAT AND PROCEDURES FOR EVALUATION REPORT 124
EVALUATION REPORT CHECKLIST 133
RE-EVALUATION GUIDELINES 135
SoonerCare Requirements for Evaluations and Re-Evaluations 137
RE-EVALUATION REPORT CHECKLIST 140
EVALUATION REPORT EXAMPLE – PRESCHOOL 143
RE-EVALUATION REPORT EXAMPLE–SOONERCARE 147

SECTION 1

INTRODUCTION TO CLINIC:

DEVELOPMENT AND EVALUATION OF CLINICAL SKILLS

WELCOME NEW CLINICIANS

Your enrollment in clinical practicum represents your initial contact with the type of work for which you are being educated. For many of you this will be the first time you will have a chance to apply the theories and methods of therapy covered in your courses. Your experience in clinical practicum should expose both strengths and weaknesses in your ability to apply this knowledge to the clinical situation. You are not expected to know everything, so questions are expected and welcomed, however you will be responsible for knowing the material in this Clinic Manual.

This manual has been designed to acquaint you with the facilities of the Oklahoma State University Speech-Language-Hearing Clinic and to provide a reference for the policies and procedures to be followed during your clinical practicum.

It is a unique and exciting adventure in learning that you are about to embark upon. It should provide a learning experience unlike any other. You will have an opportunity to learn about your chosen field and also about yourself.

INTRODUCTION

The OSU Speech-Language-Hearing (SLH) Clinic is an integral part of the educational program for speech-language pathologists within the Department of Communication Sciences and Disorders (CDIS) at Oklahoma State University. It is monitored by the Council of Academic Accreditation in Audiology and Speech-Language Pathology (CAA) of the American Speech Language-Hearing Association (ASHA). The procedures contained in this manual are designed to carry out the policies of the CAA and the Council for Clinical Certification (CFCC). These policies are the necessary standards for all training programs to assure quality control in the educational experiences involved in professional development of a speech-language pathologist. Since the Oklahoma State University Communication Sciences and Disorders Department's program is CAA accredited, students completing this program are eligible to apply for the ASHA Certification of Clinical Competence upon graduation and completion of your Clinical Fellowship experience.

CLIENTS

Our client base is composed of a variety of ages, natures of disorders and intellectual abilities. Clients are referred to the clinic by physicians, psychologists, educators, other service-oriented agencies, themselves, or parents. Often, parents will seek help when they suspect a problem even if they are not referred by an outside agency. New clients are added throughout the semester and will be assigned to current clinicians. The Clinic Coordinator will aim to give 5-7 days advanced notice for new evaluations.

Clients can be enrolled in the clinic for either individual or group therapy. The type and number of therapy sessions per week, as well as the length of the sessions, depends upon

the age of the client and the severity of the communication disorder. For the most part, therapy sessions are scheduled one or two times weekly for 30- or 50-minute sessions.

In addition to opportunities to work with clients within the clinic, there are several unique opportunities in the community for the first-year clinician.

The **L.I.F.E Center**, an adult day care facility in Stillwater, is an additional off-campus site. Its purpose is to help adults with special needs or limitations to maintain or improve their level of function in a protective group setting and provides respite for caregivers. Graduate students gain experience in speech, language, voice, AAC and cognitive assessment and treatment with older adults. Adults at the L.I.F.E. Center cannot be at home unattended during the day due to physical, cognitive, or emotional disabilities.

A collaboration between the Department of Human Development and Family Science and the Department of Communication Sciences and Disorders in Stillwater has allowed our clinicians to provide speech and language services to the special needs' population at the **Cleo L. Craig Child Development Laboratory** (short name is Child Development Laboratory/CDL).

OSU has contracted with Stillwater Public Schools to provide services in their elementary settings. CDIS graduate students under the supervision of an OSU Supervisor will provide group and individual services based upon the student's Individual Education Plan (IEP) objectives. Screenings, evaluations, documentation and attending IEP meetings will be some of the experiences graduate clinicians will participate in at these settings.

Another partnership between CDIS and **Oklahoma ABLE Tech** offers graduate students hands-on experience with AAC devices and experience conducting AAC evaluations and training.

The OSU Speech and Hearing Clinic offers SPEAK OUT!® and LOUD Crowd® programs to individuals with Parkinson disease (PD) based in and around Stillwater. These therapy programs are aimed to improve/maintain the voice and cognitive-communication skills of individuals with PD. All graduate students receive free training of the SPEAK OUT!® and LOUD Crowd® program (typically during their first year) as part of a grant offered yearly by the Parkinson Voice Project.

During the summer, there are opportunities to participate in intensive half-day or full-day sessions offered through specialty "camps" for children or adults including Aphasia Camp in Tulsa and Reading Readiness and Fluency Camps in Stillwater.

CLINIC PERSONNEL

CLINICAL COORDINATOR

The Clinical Coordinator is a certified and licensed Speech-Language Pathologist with experience in diagnostics, therapy, scheduling and record-keeping for a university speech-language and hearing clinic. Kristi Carpenter is the Clinical Coordinator for the Stillwater clinic and Megan Whitehead for 2nd year off-campus practicum placements. Mrs. Carpenter oversees clinic scheduling, maintaining clinic forms and the clinic calendar, coordinating clinic materials, kits, and equipment, and recording student clock hours. She coordinates assignment of clients and students to supervisor as well as diagnostic evaluations. Mrs. Whitehead works with the off-campus practicum sites to set up affiliation agreements, assign 2nd year clinicians to a variety of off-campus practicum sites, ensures that the student clinician has completed all the requirements for placement at different sites and monitors those placements during the 8 weeks the student is there.

CLINICAL / DIAGNOSTIC SUPERVISORS

Clinical supervisors are ASHA certified CCC-SLPs with experience in the treatment of clients *and* supervision of student clinicians. The clinical supervisor is directly responsible for the client, the student clinician, and for the educational program. The supervisors at OSU possess clinical competency and are familiar with communication problems which are common to the hospital, community, and educational settings. They are able to prepare the student clinician to meet the many demands that may be made of them professionally. A variety of different supervisors, whose experience varies, provide the broadest educational experience for the student clinician.

Your supervisor will observe a minimum of 50% of your treatment sessions and provide you with written feedback. If we are conducting teletherapy, 100% supervision is provided. If for some reason they are not available or on campus, a “supervisor of record” is assigned to whom you turn to for assistance if needed. Your supervisor may ask you to record your session so they can view it at a later time. They will also meet with you weekly to discuss their observations of your therapy sessions, answer questions and assist you in planning future therapy objectives. They edit and finalize all the paperwork that is required for each client and sign off on clinical clock hours needed for graduation and certification.

Various clinical faculty will be assigned to supervise diagnostics with student clinicians during the semester. When a student is assigned a diagnostic evaluation, the Diagnostic Supervisor will meet with you to discuss your proposed plan for the client. Your supervisor will observe a minimum of 50% of the diagnostic and interpretation conference with the client/family and edit your evaluation report. At the end of the semester, your diagnostic and clinical supervisors will meet with you individually and review your clinical performance, or evaluation and grade using the *Supervisor’s Evaluation of Clinical Practicum* form.

AUDIOLOGY SERVICES
The Diagnostics Coordinator for Audiology is a certified and licensed audiologist. Graduate student clinicians, who have completed the necessary coursework, may be assigned to audiological teams to assist in audiological diagnostics as a part of their clinical practicum. The clinician observes and assists the audiologist at specified times during the semester of the assignment.

Certification Standards in Speech-Language Pathology

Please access the following link to find current ASHA standards for required clock hours.
Certification Standards in Speech-Language Pathology

RECORDING CLINICAL CLOCK HOURS

Clinicians are required to enter all minutes into Typhon by the end of the working week your client was seen. **Typhon will lock at midnight each Friday and you can no longer enter hours for that week.** Once entered the supervisor will sign off on the hours in Typhon. The hours will be printed from Typhon and placed in your file at the end of your clinical experience.

- For purposes of tracking the diversity of experience OSU students obtain, the following communication disorder categories have been delineated for students to enter hours under and include:
- Speech - articulation, phonological processes, dysarthria, apraxia
- Fluency - stuttering, cluttering
- Voice and resonance, including respiration and phonation.
- Receptive and expressive language (phonology, morphology, syntax, semantics, and pragmatics) in speaking, listening, reading, writing, and manual modalities; auditory processing disorder.
- Aural Rehab- NOT auditory processing disorder
- Dysphagia (oral, pharyngeal, esophageal, and related functions, including oral function for feeding; orofacial myofunction)
- Cognitive - communication (attention, memory, sequencing, problem-solving, executive functions)
- Communication modalities (including PECS, sign language, non-speech and speech generating devices, and other assistive technologies).

Your clock hours are available to you at all times in Typhon. OSU pays for the subscription to Typhon until you graduate so make sure that you print your total hours after you have completed your last externship for your own records.

THE STUDENT CLINICIAN

Receiving your first client can be an exciting and rewarding experience, but along with this comes a realization of how much there is to learn. It is hoped that this manual will provide you with knowledge about clinic procedures; however, it becomes more meaningful as you perform the tasks. You have been prepared by observations and course work to begin your practicum experience. Keep your appointments with your supervisor and be prepared. Please complete the Beginning of Semester Information checklist to help you be prepared. Use this to help you get organized for the clinic. Please remember that you are expected to be available from 8:00AM to 5:30PM Monday through Friday.

EXPECTATIONS OF STUDENT CLINICIANS REGARDING CLINICAL PROCEDURES-Applies to all sites

1. The clinician will demonstrate knowledge of and regard for professional ethics, client confidentiality and HIPAA.

2. The clinician will demonstrate professional responsibility toward the client by maintaining confidentiality with all clinic paperwork, audio/video recordings and in all conversations regarding the client.

3. While representing the OSU SLH Clinic, the clinician will exhibit professionalism in their work habits (e.g., timeliness of paperwork, attendance in therapy/supervisor meeting), ethics, behaviors, and dress code.

4. The clinician will demonstrate the ability to accurately interpret evaluation and therapy data and write required documentation (e.g., treatment plans, weekly therapy plans, SOAPs and/or evaluation reports) that communicates this interpretation and sets appropriate objectives for the semester and for the weekly sessions.

5. The clinician will execute therapy sessions successfully addressing the client's objectives and behaviors.

6. The clinician will demonstrate the ability to effectively communicate critical information with clients, families, and/or supervisors.

7. All paperwork (e.g., treatment plan, SOAP, progress reports, evaluation reports) will be submitted following clinic timelines. Clinicians will be responsible at the end of semester to verify all paperwork has been entered and finalized in the Electronic Medical Records (EMR) system.

8. The clinician will make sure the authorization forms and other clinic documentation have been signed by the client/client's parent and verify that they have been scanned into EMR (Electronic Medical Records).

9. The clinician will demonstrate the ability to maintain clinical clock hours properly and have them verified by each supervisor on a regular basis (e.g., weekly/biweekly).

10. The clinician will demonstrate responsibility for clinic materials and equipment by checking them out according to the established procedure and returning them to the correct place, on time, in proper order.

11. The clinician will demonstrate his/her ability to provide complete information to the Clinic Coordinator for scheduling purposes (e.g., Clinician schedule, CTBS forms, and room/schedule changes).

12. The clinician will demonstrate knowledge of and regard for infectious diseases by exercising proper hand washing and necessary cleaning of tabletops and therapy materials (See section on Risk Management for Chronic Communicable Diseases).

13. The clinician will demonstrate knowledge of and compliance with the clinic guidelines regarding conduct in the front office and clinic and use of the office equipment.

14. The clinician will demonstrate responsibility toward clinical attendance and promptness by beginning and ending sessions on time, educating the client of how they cancel a session and by notifying the client, front office, and supervisor if they are not able to keep a clinical appointment.

DEVELOPMENT AND EVALUATION OF CLINICAL SKILLS

Students will be given frequent, targeted feedback in a number of different ways to help them develop their professional and clinical skills.

Clinical Observation Form

When supervisors observe daily therapy sessions, they complete a *Clinical Observation Form.* The form looks at Treatment Execution Skills including:

- Use of Instruction (i.e., teaching targeted skills, giving direction, demonstration, bombardment)
- Response to errors (i.e., use of feedback/correction) • Behavior management
- Pacing/rate/response time (i.e., flow of the session)

- Use of supports/strategies to facilitate successful practice/performance from client • Clinician manner (i.e., enthusiasm, encouragement, responsiveness to client) • Incorporate supervisory correction/suggestions.

The supervisor will rank these skills on a four-point scale: from 0 = No Opportunity to 3 = Satisfactory. If any score lower than a 3 is given, they write a comment related to that. They also comment on anything they want the clinician to try the next session or activities/techniques that worked well, and the clinician should continue. These observations will be incorporated into the supervisor/clinician weekly meeting.

Confirm with each supervisor the way they will share this form with you: email, paper form, or a shared document.

Oklahoma State University Speech-Language-Hearing Clinic
Clinical Observation Form

Supervisor: Ashley
Date:

Clinician:
Patient:

Treatment Execution – Skill (Header)	
Use of Instruction (i.e. teaching targeted skills, giving direction, demonstration, bombardment	
Response to errors (i.e. use of feedback/correction)	
Behavior Management	
Pacing/rate/response time (i.e. flow of the sessions)	
Use of supports/strategies to facilitate successful practice/performance from client	
Clinician Manner (i.e. enthusiasm, encouragement, responsiveness to client)	
Incorporate supervisory correction/suggestions	

KEY: 0=NO OPPORTUNITY; 1 = Not Evident, Less then acceptable; 2 = Some Problems; 3 = Satisfactory, expected
Must have comment for score lower than 3
COMMENTS:

Weekly Supervisor / Clinician Meeting

Student clinicians will meet weekly with their supervisors to plan therapy, discuss therapy activities, and receive feedback on past sessions and paperwork.

Students are expected to come to meetings on time and prepared to discuss their clients as well as their performance. This is the time to ask questions and request resources. This is your meeting not the supervisors, please make the most of it.

Mid-semester and final evaluation of clinical skills

Mid-semester and before the final supervisor meeting, the student clinician completes the "*Student's Self-Evaluation of Clinical Skills*" form in order to evaluate his/her own performance. The evaluation is discussed with the supervisor during the mid-semester and end of semester meeting along with performance on the *Critical Skills* and *Overall Weekly Reports* meeting. The student form and *Supervisor's Evaluation of Clinical Skills* have the same skills (see below). These evaluation forms are based on knowledge and skills determined by ASHA and the supervisors/faculty at OSU to be critical for demonstrating mastery in a graduate program.

At the end of semester *Supervisor's Evaluation of Clinical Skills* will go into the student's graduate student file kept by the Graduate Advisor. The student can also respond to comments written on their final *Supervisor's Evaluation of Clinical Skills* either on their copy or on a separate sheet of paper. The student should give these comments to the Graduate Coordinator for their student file.

Student Self-Evaluation/ Supervisor's Evaluation of Clinical Skills

Competency Descriptors

A clinician must demonstrate a certain level of independence in a variety of skills. Skills are divided into 4 primary areas: Evaluation, Intervention, Management/Organization and Interpersonal Skills. Competency Levels are based on a 5-point scale from 1 = Total Assistance to 5 = Consistent (0 is for No Opportunity).

COMPETENCY LEVEL	**DESCRIPTOR**
5 = Consistent	• Clinician requires a low need of supervisory input (< 10% of the time); • Independent 90% of the time and/or demonstrates a skill consistently 90% of time or greater; • Requires only guidance and consultation to formulate, implement, and demonstrate the skill; • Exceeds expectations; no significant problems; and • Clearly recognizes clinical strengths and weaknesses and usually can make online changes.

4 = Refining	• Clinician requires low to moderate need for supervisory input (11 to 25% of the time); • Independent 75-89% of the time and/or demonstrates skills 75 - 89% of the time; • Requires monitoring and collaboration with supervisor to formulate, implement, and demonstrate the skill; • Meets expectations; experiencing only minor problems; and • Able to recognize strengths and weaknesses during the session but cannot always make online changes.
3 = Developing	• Clinician requires moderate amount of supervisory input (26 - 50% of the time); • Independent 50-74% of the time and/or demonstrates a skill 50 – 74% of the time; • Requires frequent monitoring and feedback from supervisor to formulate, implement, and demonstrate the skill; • Usually meets expectations; • Able to recognize strength and weaknesses after a session and independently or with supervisor's help can generate some ideas for change.
2 = Emerging	• Clinician requires moderate to high need for supervisory input (51 to 75% of the time); • Independent 25 -49% of the time and/or demonstrates a skill only 25-49% of the time; • Requires support by supervisor to formulate, implement and demonstrate the skill; • Expectations are inconsistently being met; • Recognizes clinic strengths and weaknesses if pointed out by supervisor; • Action plan/intervention program is needed.
1 = Not Evident	• Clinician requires high need for supervisory input (>76% of the time) time; and/or • Independent less than 25% of the time and/or demonstrates a skill less than 25% of the time. • Requires constant modeling and directed input by supervisor to formulate, implement and demonstrate the skill; • Doesn't meet expectations; experiencing comprehensive problems. • Action plan/intervention program is needed.
0 = No Opportunity	• A student does not have the opportunity to demonstrate a particular ability or skill.

EXAMPLE STUDENT'S SELF-EVALUATION OF CLINICAL SKILLS
SUPERVISOR'S EVALUATION OF CLINICAL SKILLS (Grade Form)

OKLAHOMA STATE UNIVERSITY SPEECH-LANGUAGE-HEARING CLINIC
SUPERVISOR'S EVALUATION OF CLINICAL SKILLS

Clinician's Name	Patient's Day/Time	# ASHA Hours Earned
Student Level: Beginning Intermediate Advanced	Supervisor	Total Points /# of Skills: 0
Year: Semester:		Overall Competency Level Score: **0.00**
Competency Level 5 = Consistent 4 = Refining 3 = Developing 2 = Emerging 1 = Not Evident 0 = No Opportunity N/O See Manual for further information		Grade Based on Student Level:

Complete all sections — **Competency Level**

EVALUATION	
1 Collects/integrates case history information	0
2 Selects appropriate evaluation procedures	0
3 Administers appropriate evaluation procedures	0
4 Demonstrates appropriate preparation in execution of the evaluation	0
5 Adapts evaluation procedures or provides alternate diagnostic procedures	0
6 Accurately completes/scores test forms	0
7 Accurately interprets results and test observations including diagnostic statement	0
8 Effectively communicates findings to client/parents	0
9 Reports are accurate, well organized, and professional; correct grammar, spelling, formatted,– follows clinic manual guideline	0
10 Makes appropriate referrals/therapy recommendations including goals	0
EVALUATION TOTAL	0

INTERVENTION	
11 Integrates information from client records in EMR and family reports for therapy	0
12 Takes initiative to research client's diagnosis and appropriate treatment strategies	0
13 Establishes appropriate semester treatment plan	0
14 Sessions are effective/efficient and organized (including organization,use of materials, time management)	0
15 Develops and utilizes appropriate materials and activities for therapy	0
16 Makes online adjustments based on immediate need of client	0
17 Implements evidenced based teaching strategies/intervention techniques	0
18 Implements behavior management appropriate for age and diagnosis	0
19 Discriminates correctness of target response and provides feedback	0
20 Discusses relevant supports for in home practice	0
21 Effective/ efficient data collection during session – including baseline data and reports appropriately on O section of SOAP notes	0
22 Compares therapy performance and adjusts therapy process as needed	0

23	Correlates P section of SOAP to the next week's WTP	0
24	Accuracy of SOAP note including S & P sections of note	0
25	Consistently proofs and edits paperwork including grammar, typos, and PDF formatting	0
26	Consistently meets all deadlines for all paperwork (SOAP, WTP, progress report)	0
27	Writes accurate/complete progress report meeting insurance guidelines for content	0
28	On progress report, sets appropriate objectives for next semester	0
	INTERVENTION TOTAL	0

MANAGEMENT/ORGANIZATION		
29	Attends supervisor meetings consistently	0
30	Follows OSU Policies and Procedures	0
31	Follows HIPAA confidentiality requirements	0
	MANAGEMENT/ORGANIZATION TOTAL	0

INTERPERSONAL SKILLS		
32	Takes responsibility for appropriate communication and interaction with clinical supervisors	0
33	Incorporates supervisor input into clinical work in a timely manner- including paperwork	0
34	Engages in constructive self-examination and growth of clinical abilities	0
35	Collaborates with other professionals (including co-treating clinicians) in clinical work	0
36	Displays understanding of diverse individual and cultural issues in client & professional relationships	0
37	Demonstrates ability to make adjustments in communication styles based on client/family need including nonverbal, tone of voice, & body language	0
38	Displays strong work ethic and pays attention to detail	0
39	Responds well to constructive criticism and feedback	0
40	Assumes responsibility and knows own clinical limitations	0
	INTERPERSONAL TOTAL	0

EVAL EARNED (NO ZEROS COUNTED)	**0**	X by Weigh % 0/40/80=	0
EVAL POSSIBLE (NO ZEROS COUNTED)	**0**		
INTERV. EARNED (NO ZEROS COUNTED)	**0**	X by Weigh % 0/40/80=	0
INTERV. POSSIBLE (NO ZEROS COUNTED)	**0**		
M/ORG. EARNED (NO ZEROS COUNTED)	**0**	X by Weigh % 10=	10
M/ORG. POSSIBLE (NO ZEROS COUNTED)	**0**		
INTERPERSONAL EARNED (NO ZEROS)	**0**	X by Weigh % 10=	10
INTERPERSONAL POSSIBLE (NO ZEROS)	**0**		
OVERALL TOTAL	**0**		

EVAL: TOTAL WEIGHTED EARNED	0	EVAL: TOTAL WEIGHTED POSSIBLE	0
INTERV: TOTAL WEIGHTED EARNED	0	INTER: TOTAL WEIGHTED POSSIBLE	0
M/ORG: TOTAL WEIGHTED EARNED	0	M/ORG: TOTAL WEIGHTED POSSIBLE	10
INTERP. : TOTAL WEIGHTED EARNED	0	INTERP: TOTAL WEIGHTED POSSIBLE	10
SUM TOTAL OF ALL WEIGHTED EARNED	0	SUM TOTAL OF ALL WEIGHTED POSSIBLE	20

SUM TOTAL WEIGHTED EARNED divided by SUM TOTAL WEIGHTED POSSIBLE = A PERCENT GRADE 0.00%

PERCENT GRADE MULTIPLY BY 5 SHOULD EQUAL A 5 POINT SCALE GRADE 0.00

AVERAGE LEVEL OF COMPETENCY:

Supervisor comments: if more space is needed, add a separate sheet of paper. Please comment on areas of particular strength for this clinician.

Please comment on areas in need of further development for this clinician

Additional Comments (including comments of readiness for next level of training)
[type here]

This evaluation has been shared with me, and any comments that I may have related to this evaluation shall be found below or on an attached, separate sheet of paper.

Supervisor Signature Date

Clinician Signature Date

Clinician Comments:
[type here]

Thank you for returning original form to the Clinic Coordinator by the last day of final exams each semester.

Supervisor and Clinician should retain a copy.

REVISED: May 2024

AVERAGE LEVEL OF COMPETENCY:

On *Student's Self-Evaluation of Clinical Skills* Form, the student comments on areas of strengths and areas in need of further development.

On *Supervisor's Evaluation of Clinical Skills* Form Supervisor comments on areas of particular strength for clinician and areas in need of further development for clinician.

Additional Comments (including comments of readiness for next level of training)

Clinician Comments: Once the evaluation is shared with the clinician, there is the opportunity for the student to make additional comments related to this evaluation. They can also attach comments on a separate sheet of paper.

Signatures – supervisor and clinician. Both supervisor and clinician sign and date the grade form. The clinician is given an opportunity to copy the final signed grade form for their records. The supervisor gives the original signed form to the Clinic Coordinator by the last day of finals week each semester.

PRACTICUM GRADE CALCULATIONS

Grades are based upon adequate performance on the final "*Supervisor's Evaluation of Clinical Practicum*" forms. **Any student clinician who participated in a Clinical Action Plan will not receive a grade above a "B" for the semester's cumulative practicum grade.**

The *Supervisor's Evaluation of Clinical Practicum* grade for each client a student has is determined based on the level of clinician's experience (e.g., Beginning, Intermediate, Advanced) and average performance on all skills (e.g., total number of points divided by the number of skills scored.) The composite practicum grade is figured by averaging all client scores for the semester and weighted according to the amount of time the clinician spent on each clinical assignment. This letter grade is calculated according to the chart below. The composite practicum grade is turned into the Registrar's office by the Clinic Coordinator. 25% of your clinic practicum grade is based on your grade in the Professional Development Seminar class.

Beginning Clinician (Fall 1st year)	**Intermediate Clinicians (Spring 1st year)**
A = 4.0 to 5.0	A = 4.25 to 5.0
B = 3.65 to 3.99	B = 3.75 to 4.24
C = 0 to 3.64	C = 0 to 3.74
Advanced Clinicians (Summer 1st year)	**Jump Starter and Senior Clinician**
A = 4.5 to 5.0	A = 3.75 to 5.0
B = 4.0 to 4.49	B = 2.9 to 3.74
C = 3.9 and under	C = 0 to 2.89

CDIS DEPARTMENTAL ACADEMIC REQUIREMENTS FOR PARTICIPATION IN CLINICAL PRACTICUM

**Please refer to Graduate Manual for the most up to date and accurate information regarding academic requirements for participation in clinical practicum.

PROCEDURES FOR DEALING WITH INADEQUATE PERFORMANCE OF VARIOUS CLINICAL PROCEDURES BY STUDENTS

Occasionally, a student clinician has difficulty meeting the standards set for practicum. (See *OSU Supervisor's Evaluation of Clinical Skills* and *Competency Level Descriptors,* in this section for description of the skills required and rating scale). The result may be inadequate performance in one or more aspects of clinical activity. When this event occurs, the following policy and procedures will be followed.

Behaviors that need remediation or improvement could include but are not limited to tardy or poorly written documentation, confidentiality breaches and inadequate application of clinical methodologies. These problems should be addressed immediately in the Supervisor-Clinician weekly meeting and documented in the *Observation Form*. At midsemester, the *OSU Supervisor's Evaluation of Clinical Skills* will be completed by the Supervisor(s). If at that time, no to minimal progress had been made and the clinician is struggling in one or more skills, the Clinical Coordinator will be notified and a meeting will be held with the student and must include the Supervisor(s), Clinic Coordinator indicated by ratings of 2 or lower on the *OSU Supervisor's Evaluation of Clinical Skills* form) will be addressed. With the student clinician's participation, a written plan (e.g., Clinical Practicum Action Plan) to help achieve improvements in the areas identified will be formulated. Weekly meetings will be held with a designated Supervisor(s) to assess progress towards reaching the goals in the plan.

A Clinic Action Plan will be instituted when a grade of C or lower is received on a Mid-term, or Final. This plan will be followed and modified as needed the following semester.

1. If a Clinic Action Plan is implemented, the clinician will not receive a grade above a 'B' for that semester's cumulative clinical practicum grade secondary to the amount of assistance needed to develop the clinical skills identified.

2. The consequences to the student for not following through with the recommendations/ plan will be a grade of "C" or lower for that client.

3. Any clock hours accrued for the client(s) with a "C" grade will not be counted toward the 375 hours required by ASHA.

No externship will be undertaken until remediation plan is complete and the graduate clinician has the recommendation for off campus practicum placement from the faculty committee.

Oklahoma State University
Communication Sciences and Disorders Department
Clinical Practicum Action Plan (Format)

Start Date: _______________
Student: ________________________________
Supervisors: _______________________________
Clinic Coordinator: __________________________

Area(s) needing attention:

Recommendations (with timelines and consequences):

Outcome:

Date Achieved:

Oklahoma State University
Communication Sciences and Disorders Department
Clinical Practicum Action Plan (Example)

Start Date:
Student:
Supervisors:
Clinic Coordinator:

Area(s) needing attention:
Ability to enforce limits, maintain interest and control direction of therapy.
*Reading client's verbal and nonverbal cues and making modifications based on them; giving reinforcing feedback (enthusiasm and excitement that engages client)

Recommendations (with timelines and consequences):
I will analyze therapy situations in which the client's response ratios are low or uncooperative and come up with several possible reasons and different techniques to

increase responses. I will discuss these with my supervisor. Timeline: 1 week.
Consequences: Poor grade/reassignment of client

Outcome:

1. Discussed client's likes/dislikes with supervisor and family and decided to always have a back-up activity for "off-days."
2. Clinician made a visual file with "rules" and at the beginning of each session reviewed them with the client.
3. Clinician began enthusiastically praising the client when responses were correct, which increased on-task responses and decreased off-task behaviors.

Date Achieved:

SECTION 2

BEGINNING OF SEMESTER

CONFIDENTIALITY POLICY/HIPAA

All information concerning past or present clients is strictly confidential. Specifically, the following information is not to be divulged in any manner to anyone except the referring physician, PA, or nurse without specific permission from one of the clinic supervisors and a current *Authorization for Disclosure of Protected Health Information* form.

1. ALL pertinent client's information.
2. The type or nature of the problem.
3. Any identifying information concerning the client.
4. Family information.
5. An audio or video recording of the client's speech.
6. Treatment plans for therapy sessions.
7. Test results or other diagnostic information.
8. Observation reports.
9. Rough draft or final draft of clinical reports.

For an *Authorization for Disclosure of Protected Health Information* form to be valid, it must be **filled out by and signed by the client or parent/guardian** specifying who the clinic can exchange and/or send information to. Off-campus practicum sites may have their own Release of Information forms and confidentiality policies that must be adhered to. It is the clinician's responsibility to learn and follow the policies of the off-campus sites.

TECHNIQUES FOR INSURING CONFIDENTIALITY:

1. All student clinicians, front office staff, faculty and supervisors in the clinic must sign *Graduate Student/Staff Confidentiality Statement* and complete online HIPAA training yearly. Certification of a passing grade (85%) should be given to the Clinic Coordinator and/or Graduate Advisor and will go into your student file.
2. Before observation begins, completion of the online HIPAA training and certification of a passing grade (85%) will be turned into the front office at the same time they turn in their signed *Observation Confidentiality Statement*. Record of completion will be with the undergraduate student observation clock hours form.
3. Before having any conversation or sending documents with other professionals besides the referring physician, physician's assistant or nurse, a valid *Authorization for Disclosure of Protected Health Information* form must be in the client's EMR file.
4. Any audio/video recordings of the clients are not to be taken out of the clinic for analysis.
5. Under no circumstance should any client information be saved on the hard drive of ANY computer.
6. **If you need to email information to your supervisor, it must stay within the OSU email system.** To encrypt the body of the email message, put [encrypt] in the

subject line. Any attachments can also be password protected for another level of security.

7. If it does not have [encrypt] in the subject line or is not sent from/to an okstate.edu email address, any email communication should not contain the client's name in the body of the email but should be referred to by clinician/supervisor - day/time.
8. Information put in the subject line is not encrypted. **Do not put client information in the subject line.**
9. Weekly Therapy Plans that are placed in the observation rooms should have the client's name and birth date that are on the top and bottom of each page blacked out with a permanent marker. You must black out the front and back side so that it cannot be read through. Shred the WTP immediately following the session.
10. *Observation Reports* for classes and *Observation Clock Hour* forms should not include any information that can identify the client.
11. Reports from the client's EMR are not to be printed for any reason for later use by the clinicians or observers.
12. All discarded or unused paper that has client information on it needs to be shredded IMMEDIATELY. Do not throw in the recycle container or trash. Do not leave lying around in computer lab, office, or work room. This includes the WTP from the observation room.
13. Print clinic work or color prints from the copier in the front office room # 042. Class work is printed from the printer in the computer lab room #024.
14. If you attempt to print a report in the computer lab and for some reason it does not print, make sure to delete the print job from the computer before you leave. TIP: When on a computer for the first time, change your default printer to SSH042-CanonC58508, this prints in the front office.
15. If you are working on paperwork/EMR on a computer in the clinic and need to leave the room for any reason, close the file or lock the screen so it will not be accidentally seen.
16. If you need to discuss a client with a parent, invite the parent into the therapy room for the discussion so it will be confidential. Do not discuss client progress, goals, etc. in the waiting room or hallways.
17. When you discuss a client with your supervisor, ensure that doors are closed so that others do not overhear the conversation.
18. While it is professionally appropriate to discuss your client's therapy goals and activities with other SLP students in the clinic setting to gain ideas and knowledge from each other, it is not appropriate to discuss client's personal issues or to hold any of these conversations outside of the clinic setting.
19. Stamps that state "Confidential" and "Copy" are kept in the front office and will be used to mark all copies of reports that will be mailed. A valid *Authorization for Disclosure of Protected Health Information* form must be included with all reports sent to external agencies/professionals with the exception of the referring medical professional.

20. If email communication is to occur between the clinician and the family and/or other professionals, the client or his family must give permission for this by completing the *HIPAA Email Consent* form.
21. If tele-therapy is part of the client's therapy schedule, the client or his parents must be educated as to how to use the tele-therapy platform and sign the OSU *Informed Consent to Participate in Tele- therapy*.
22. Conduct teletherapy from a secure location to protect the client's privacy. Using headphones will decrease the chance that others will overhear the client. Be aware of others who could come into the room and observe the session.

BEGINNING OF SEMESTER PROCEDURES

At the beginning of each semester make sure you read *the Beginning of Semester Information* checklist. It will be very important to read the information carefully and keep it handy for reference since this is your reminder of due dates.

Examples of all forms available online at the STW-GraduateClinicManual. Join by going to **https://canvas.okstate.edu/enroll/9NB6MB** . The forms can also be found in the front office file cabinet.

NOTIFICATION OF CLINICAL ASSIGNMENTS

You will be notified of your assigned client by receiving an encrypted email. The copy "*Clients to be Scheduled*" (*CTBS*) form with the notification of scheduling written on it (supervisor, clinician, days, time for therapy, and the room number) is in the document folder in CounselEar. The supervisor will receive the same notification of the client assignment. It is your responsibility to get in touch with the supervisor and arrange a meeting time **early in** the first week of school. Being prompt in contacting the supervisor is important.

PREPARATION FOR INITIAL CONFERENCE

Follow the "*Initiation of Treatment Checklist*" or *Beginning of Semester Information* checklist as a guide. Before you meet with your supervisor, read your client's EMR files. It is important at this time to define the problem, think about short- and long-term goals, and any testing or retesting that may be necessary. Use the *Client File Information* form in the STW CDIS Graduate Students community or the front office file cabinet to assist you in obtaining important information from these files. You are expected to come to the first meeting with your supervisor with **a *first draft of Semester Treatment Plan and a Weekly Therapy Plan*** for the first week of therapy.

At the initial conference with your supervisor, they will want you to express your impressions and some recommendations for beginning treatment. If you are a Beginning Clinician, the supervisor will understand that it is your first semester in therapy. You may feel as if you have more questions than answers, but that is natural. Do not be timid about asking any of the

questions you may have, no matter how simple they may seem. Keep in mind that therapy is a learning situation and asking questions is one of the best ways to learn.

Your supervisor will also share their suggestions and impressions with you when you guide the conference by your questions and topics. The supervisor will let you know when *Semester Treatment Plans, SOAP/Daily Therapy Notes* and *Weekly Therapy Plans* are due.

NOTIFY THE CLIENT

It is your responsibility to call the client the first week of school, introduce yourself and confirm the start date and time. Please use the main clinic office phone in Room #042, so parents will have the correct number to call back. The client will have already been called by the clinical coordinator or the office staff and will be expecting the clinician to call. HIPAA allows leaving messages regarding appointment days and times if you are unable to reach the client or his family. (Don't use your cellphone until you have the authorization form signed by the family and you feel comfortable with them having your phone number)

EXAMPLE: BEGINNING OF SEMESTER INFORMATION

FALL 2024

FROM: Kristi Carpenter, Clinical Coordination

BEGINNING/ENDING DATES:

Start – Monday August 26th, 2024
End – Friday November 22, 2024
Holidays (Clinic Closed)
Labor Day (Monday) – September 2nd
Thanksgiving Break – November 25-29

STEPS TO BEGIN THERAPY:

1. Make sure the Clinical Coordinator has your correct schedule.
2. Clients To Be Scheduled (CTBS) form with scheduling information on it. This is your notification of your clinical assignment.
3. Make Appointment with assigned supervisor the first week of school.
4. Get the appropriate Beginning of the Semester forms from the front office.
    a. FOR EACH CLIENT YOU NEED
        i. *Client/Parent Confidentiality Statement
        ii. *Authorization for Disclosure of Protected Health Information
        iii. *Permission for Clinical Services
        iv. *Permission to leave telephone message and electronically transmit information.
        v. *Notice of Privacy Practice/Receipt of Notice of Privacy Practices Written Acknowledgement
        vi. *HIPPA Email Consent
        vii. Informed Consent to Participate in Teletherapy (as needed)
5. Read electronic medical records (EMR) information thoroughly.
6. **Call client the first week of school** to confirm the start day and time. Notify supervisor and clinical coordinator of any change or problem.

7. Discuss with supervisor at 1st meeting:
    a. Baseline Semester Treatment Plan draft
    b. Need for yearly re-evaluations and/or hearing screenings.
    c. Initial weekly Therapy Plan draft
    d. Day to start therapy and time.
    e. Times for weekly supervisor conference and when paperwork is due to supervisor.
8. Plan and learn to use materials and equipment. Materials can be found in SSH 047 in Stillwater,
9. Learn how to use recording and communication systems in therapy rooms.

Throughout Semester

- Your Weekly Therapy Plan (WTP) needs to be completed in the EMR by the Friday of the previous week.
- SOAP notes should be completed in the EMR the same day as your session.

INITIATION OF TREATMENT CHECKLIST FOR CLINICIANS

The clinician should use this list to see that all of the necessary steps for the initiation of treatment with a client have been completed. Check the columns as they are completed.

CLINICIAN: ___________________________ CLIENT: __________________________________

SUPERVISOR: _________________________THERAPY DAYS/TIMES: __________________

S= Supervisor C=Clinician

	C	S
1. Client's EMR File: file has been read (use Client File Information form for notes if needed).		
2. Early in the week, the clinician contacted the client to specify the first day/time of therapy and introduce themselves.		
3. Clinician created drafts of baseline treatment plan and first Weekly Therapy Plan		
4. Meeting with supervisor to discuss: a. the client's history and if re-evaluations are needed		
b. semester treatment objectives on baseline treatment plan		
c. weekly therapy plan for first week		
d. schedule weekly supervisor conference and determine when paperwork is due		
5. Become familiar with clinic audio and video recording systems		
6. Locate therapy materials and supplies		
Beginning of Semester Forms		
1. OSU Confidentiality Statement (signed by clinician first semester only) 2. Signed by Family/Witness by Clinician and put in Front Office for filing (annually at eval) a. Client/Family Confidentiality Statement b. Authorization Release or Obtain Information c. Permission for Clinical Services d. Permission to leave telephone messages e. Notice of Privacy Practice (NPP) f. HIPAA Email Consent g. Informed Consent to Participate in Teletherapy Services 3. Daily Clock Hour form for each client (Typhon)		
4. Baseline Treatment Plan: approved and signed by supervisor dated first day of therapy.		

CLINICIAN SCHEDULE

CLINICIAN SCHEDULE
OSU Speech Language Hearing Clinic
YEAR: ______ SEMESTER: _________

NAME (as you want it on mailbox):______________________ Degree BS/BA):____________
FALL ADDRESS:__________________________________ PHONE:__________________
E-MAIL:____

SPECIAL REQUESTS/CONSIDERATIONS: (work, child care,etc.)______________________
____
____
____
____
____

PREVIOUS SEMESTERS AS CLINICIAN: #_______

NOTIFY CLINIC COORDINATOR OF ANY SCHEDULE CHANGES

SHADE IN THE BLOCKS OF TIME THAT YOU HAVE CLASS

DAY	8:30 9:30	9:30 10:30	10:30 11:30	11:30 12:30	12:30 1:30	1:30 2:30	2:30 3:30	3:30 4:30	4:30 5:30	5:30 6:30	6:30 8:00
M											
T											
W											
TH											
F											

CLIENTS TO BE SCHEDULED (CTBS)

Oklahoma State University-Speech-Language-Hearing Clinic
042 SSH Stillwater, OK 74078
Phone: (405) 744-6021 Fax: (405) 744-8070

CLIENTS TO BE SCHEDULED (CTBS)

Semester:________Year:_____New:_____Returning:_____**Current ICD-10CM:**____________________________

PATIENT'S NAME:____

BIRTHDATE:________________AGE:______SEX:_____________RACE/ETHNICITY:______________

ADDRESS:____

PHONE:______________________________(home) PHONE:_______________________________(cell)

PHONE:____(work & name of person)

BEST TIME TO CALL:____

RESPONSIBLE PARTY:____

RELATIONSHIP TO PATIENT:______________________________PHONE:_____________________

BILLING:(CHECK ONE)

_____OSU STUDENT/FACULTY OR DEPENDENT _____COMMUNITY (no 3rd party payment)

_____MEDICAID/SOONERCARE CASE #____

_____OTHER: SPECIFY____

If Insurance is paying, provide your insurance card to front office each semester.

LIST ANY FOOD OR LATEX ALLERGIES:____

NUMBER OF RECOMMENDED SESSIONS PER WEEK:_______

RECOMMENDED SESSION LENGTH:____1/2 OR ____1 HR.

SPEECH-LANGUAGE PROBLEM: Check problem in age category

AGE	FEEDING DYSPHAGIA	SPEECH	LANG. COG	VOICE	FLUENCY	HEARING	SCHEDULE
							TIME:
ADULT							SUPV:
SCHOOL							CLN:
PRESCH							ROOM:

SCHEDULING: Preferred Times: Use / to divide box for half hour.
Lightly shade in boxes indicating time **AVAILABLE**.

DAY	8:00 9:00	9:00 10:00	10:00 11:00	11:00 12:00	12:00 1:00	1:00 2:00	2:00 3:00	3:00 4:00	4:00 5:00
M									
TU									
W									
TH									
F									

ROOM REQUEST:____

CLINICIAN'S SIGNATURE:______________________________DATE:__________________________

SUPERVISOR'S SIGNATURE:_____________________________DATE:__________________________

Revised: 05/24– Clinical Manual – Carpenter

PERMISSION, RELEASE AND CONSENT FORMS POLICY

The purpose of permission, release and consent forms includes:

1. To inform the client and protect the rights of privacy of the client and their family per HIPAA regulations;
2. To document informed consent to evaluate, treat and bill the client;
3. To allow the clinic to send information to agencies who are paying for the services or exchange information with other professionals who are treating the client; and
4. To document permission for telephone and electronically transmitted information
5. To document education/permission for Teletherapy

It is important to remember these reasons when we ask parents or clients to sign permission, release and consent forms every semester. These include:

- *Authorization for Disclosure of Protected Health Information*
- *Permission for Clinical Services*
- *Permission to Leave Telephone Message and Electronically Transmit Information*
- *HIPAA Email Consent*
- *Informed Consent to Participate in Teletherapy*

The client /family will also receive an *OSU Speech-Language-Hearing Clinic Notice of Privacy Practices (NPP)* and return the *Receipt of NPP* form.

The Clinician and Supervisor are responsible for having the parents or client sign the forms at the annual evaluation and to sign as a witness on those that require it. Clinicians are responsible for having forms signed annually at the beginning of August each year. It is highly recommended that you HAVE THE CLIENT/FAMILY SIGN THE FORMS IN THE CLINIC. Experience has shown that if you send them home, there is a high chance they will never make it back.

Authorization for Disclosure of Protected Health Information

Before speaking with any other professional besides the referring medical professional OR to an adult client's family/spouse about your client, check to make sure there is a current signed *Authorization for Disclosure of Protected Health Information* form.

It is good clinical practice to send a copy of reports to the referral source. HIPAA allows us to send reports to the physician, PA or LPN that refer the client to us without an authorization form signed by the client. However, it is good practice to obtain the *Authorization for Disclosure of Protected Health Information* even for the referring physician, so the client or his/her parents are aware a report will be sent to them. When sending reports or speaking with anyone other than the client or a minor child's parents, the current *Authorization for Disclosure of Protected Health Information* must be signed and uploaded into the EMR. This includes a college student's parents as they are considered adults. An *Authorization for Disclosure of Protected Health Information* form for any school/medical agency/counselor must be signed if it is not the referring physician/medical professional.

Parents and adult clients may refuse to sign the *Authorization for Disclosure of Protected Health Information* form for reasons they prefer not to reveal or if there is no one they want the report sent to.

Permission for Clinical Services

The *Permission for Clinical Services* helps ensure that your client understands since OSU-SLH Clinic is both a teaching and service center, that clinical treatment and training will be supervised by a licensed SLP via observation and recordings. Additionally, it assures that the client understands that CDIS students may observe the client as part of their coursework and that confidentiality will be maintained. Permission for medical emergency treatment is also granted if the family is not available. The client/family needs to select "am/am not" on the form to grant permission for any audio/video recording **to be used for educational purposes**. If the family chooses "am not" willing to permit recordings to be used for educational purposes, the clinician is allowed to record for their own data collection and for supervision purposes. The recording will then be promptly deleted/destroyed. Choosing "am not" should not reflect negatively on the client or their family in any way, as they have the right to privacy. At the end of the form is a section informing the family of their financial responsibility.

Permission to Leave Telephone Message and Electronically Transmit Information

The *Permission to Leave Telephone Message and Electronically Transmit Information* form allows the clinician and others in the clinic to leave messages with persons other than the parent/client. It additionally addresses the use of cell phones and other wirelessly transmitted information such as voice mail, e-mail, faxes, and texts. These policies protect the privacy of the client and allow them to decide if (and where) messages can be left.

Notice of Privacy Practices (NPP)

The **HIPAA Privacy** Act requires health plans and covered health care providers to develop and distribute a **notice** that provides a clear, user friendly explanation of individuals' rights with respect to their personal health information and the **privacy practices** of health plans and health care providers. The *OSU Speech-Language-Hearing Clinic Notice of Privacy Practices* is given to all new clients and each returning client every semester. The client is encouraged to keep the written information for their records. They sign and return the *Receipt of Notice of Privacy Practices Written Acknowledgement Form*. This form requires a witness signature.

Informed Consent to Participate in Teletherapy Services (Select clients only)

Oklahoma and many states require that providers obtain written informed consent before providing teletherapy. The consent includes potential risks, statements that the client has been adequately trained to use the equipment and that they are voluntarily participating.

If a parent or client refuses to sign any of the permission forms, discuss it with your supervisor and/or clinical coordinator immediately after the session.

Permission to Leave Telephone Messages and Electronically Transmit Information

Department of Communication Sciences and Disorders
042 Social Sciences and Humanities
Stillwater, OK 74078-3015 P: 405-744-6021

Client Name: ______________________________DOB:____________________

The Oklahoma State University Speech-Language-Hearing Clinic has permission to leave a message concerning my appointment with the following people either at my home or at my place of employment.

☐ I understand OSU SLH Clinic will not share information by voice mail, answering machine, text messages, or fax machines unless it is between secure sites or I have given them express permission to do so

☐ I understand eavesdropping is possible when communicating information via cell phone or other wirelessly transmitted sources

☐ I give the clinic permission to leave a message or to discuss appointments times on my (circle all that apply):

- Answering Machine **YES** or **NO**
- Voicemail **YES** or **NO**
- Text Messaging **YES** or **NO**
- Work Voicemail **YES** or **NO**

•I give the clinic permission to discuss with me personal client information from my clinician's personal cell phone: **YES** or **NO** (circle one)

Please list **ALL** phone numbers that should apply to this policy:

____ ________

Signature of Client or Legal Representative Date

Permission for Clinical Services

Department of Communication Sciences and Disorders
042 Social Sciences and Humanities
Stillwater, OK 74078-3015 P: 405-744-6021

PERMISSION FOR CLINICAL SERVICE

Client Name____________________ DOB: __________________

I understand that the Oklahoma State University Speech-Language-Hearing Clinic is both a teaching and service center. It serves the training needs of students preparing for careers in Speech-Language Pathology and provides diagnostic and remedial services to persons with speech, language, or hearing disorders.

I understand that the clinical treatment carried out by student clinicians requires regular observation and/or participation by clinical supervisors. I also realize that the use of audio and video tape recordings is valuable in the professional training of speech-language pathologists and audiologists.

Therefore, I give my permission for evaluation and/or clinical treatment and for observation of my diagnostic and/or therapy sessions by clinical personnel and others approved by the clinical supervisor, as long as (I am/my child) is receiving services at this center. In the unlikely event that emergency medical attention is needed (in the absence of a legal guardian or incapacitation of the client), I give permission for such medical attention to be obtained.

*****IMPORTANT: Please DON'T FORGET to check the following box:**

I **(☐ am / ☐ am not)** also willing to permit audio and/or videotaping to be used for educational purposes (e.g., classroom instruction, workshops, and other research participation). I also understand that all information about me will be kept confidential and that my privacy will be protected.

FINANCIAL AGREEMENT

I understand that I am responsible for all charges associated with any of the services provided and that payment is due at the time of service for evaluations and monthly for ongoing clinical services. In the event that I do not submit payment after 30 days of billing, future services will be suspended until all accounts are satisfied.

______________________________ ______________________________

Signature of Client or Legal Representative Date

______________________________ ______________________________

Signature of Witness Date

Client Confidentiality Agreement

Department of Communication Sciences and Disorders
042 Social Sciences and Humanities
Stillwater, OK 74078-3015
P: 405-744-6021
cdis.okstate.edu

Client/Parent/Legal Guardian Confidentiality Agreement

Client Name: ________________________ Date of Birth:____________________

Confidentiality means that information about patients and families in our clinic will remain private –that it will be kept in confidence. Medical and educational professionals are ethically and legally restricted from disclosing confidential information about patients. New federal guidelines require that confidentiality and privacy policies be provided to persons served by medical professionals.

Since you will be able to see other patients, parents and family members in our clinic waiting area, it is important that all the persons in the clinic respect the privacy of the other persons and families. It will be important for us all to remember not to reveal other patient's or family member's names or other personal information to persons not in the clinic. It will also be important that we not share information about patient's or family's behavior or abilities with others. Think about how you would feel if someone discussed you or your child with another person in a public place. For example, if you were in the grocery store and you heard someone talking about the problem a person had over at OSU, you might become upset if that person was your son, your nephew, your younger sibling, or your grandson.

Many families consider information about skills, abilities, problems, issues, concerns, achievements, behaviors, and family make-up to be very private. To ensure that you feel safe about your own family's participation in the clinic and that you understand about the privacy and confidentiality of other families, we would like you to sign the following confidentiality agreement.

I, ___________________________________understand that information about the identity, family, behavior, skills and abilities of each person in the clinic is confidential. I understand that the privacy of children and families is important. I agree not to discuss any information about persons in the clinic with anyone outside of the Oklahoma State University Speech-Language-Hearing Clinic.

____________________________________ ____________________________
Signature of Client or Legal Representative Date

____________________________________ ____________________________
Signature of Witness Date

Authorization for Disclosure of PHI

Oklahoma State University-Speech-Language-Hearing Clinic
042 Murray
Stillwater, OK 74078
Phone: (405) 744-6021 Fax: (405) 744-8070

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

(Make sure all blanks are filled in. Failure to do so may prevent or delay release of information.)

Client Name: ______________________________ DOB: ____________________
Client Address: ____
Phone Number: _________________________

Disclose information From/To: OSU Speech-Language-Hearing Clinic
42 Murray Hall
Stillwater, OK 74078
(405) 744-6021
Fax: (405) 744-8070

Disclose information From/To: ____
Name of Provider and/or Clinic

____
Street Address, City, State, Zip Code

____
Phone and Fax Number

DO YOU HAVE A SCHEDULED APPOINTMENT? If so, when: __________________

Information to be disclosed:

Complete Health Records from: ☐ Last 1yr ☐Last 5yrs (if you would like another date range, please indicate on the Other line.)

Speech-Language
☐Evaluations
☐Daily Notes
☐Progress Reports

Audiology
☐Audiograms/Tymogram Results
☐Hearing Evaluations/Screenings Report

☐Other: ____

PURPOSE OF DISCLOSURE:

☐Transferring Care as of (Date):___________ ☐Continuing/coordination of care
☐Personal access to PHI ☐Other: ____________________

I understand that certain records may be protected by federal or state law, including alcohol/drug treatment, communicable diseases, mental health information and information protected by State and Federal Laws related to a Minor.

This authorization will expire on the following date, event or condition: (pt to insert exp. date) unless otherwise revoked, effective for no longer than one year from the date on which it was signed.

I understand that if the person or entity that receives the described records/info is not a health care provider or health plan covered by federal privacy regulations, the records/info may be redisclosed & no longer protected by those regulations.

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to Oklahoma State University's Speech-Language-Hearing Clinic.

I understand that I have the right to inspect the information to be disclosed upon the proper notification to and under the appropriate conditions established by Oklahoma State University's Speech-Language-Hearing Clinic. The covered entity will not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization.

The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to extent indicated and authorized herein.

____________________________________ __________________
Signature of Client or Legal Representative Date

____________________________________ __________________
Relationship to Patient Date

Printed Address & Phone Number of Legal Representative: ____

June 28, 2016

Receipt of Notice of Privacy Practices

Department of Communication Sciences and Disorders
042 Social Sciences and Humanities
Stillwater, OK 74078-3015
P: 405-744-6021
cdis.okstate.edu

Receipt of Notice of Privacy Practices Written Acknowledgement Form

Client Name: _______________________________DOB: ___________________

I, ______________________________________ have received a copy of Oklahoma State University Speech-Language-Hearing Clinic's Notice of Privacy Practices.

____________________________________ ____________________
Signature of Client or Legal Representative Date

____________________________________ ____________________
Signature of Witness Date

Informed Consent to Participate in Teletherapy Services

Department of Communication Sciences and Disorders
042 Social Sciences and Humanities
Stillwater, OK 74078-3015
P: 405-744-6021

Informed Consent to Participate in Teletherapy Services

I, or my child , ______________________________, have/has been asked to receive speech/language therapy services via teletherapy. I understand that I/they will be receiving health care services through interactive videoconferencing equipment. I understand that, at this time, there are no known risks involved with receiving my/their care in this way. I understand that the equipment will be shown to me/them and I/they will see how it works before I/they receive any services. I understand that my/their participation in this is totally voluntary and I/they may decide to quit at any time. My/their privacy and confidentially will be protected at all times. When I/they am receiving services over the video, I/they can see who is in the room at the other site.

I understand the services I/they receive will become part of my treatment record. I understand that if there are healthcare providers at both sites, they may have access to any relevant medical information about me/them during the transmission. I understand that there may be fees associated with the speech/language therapy services for which I will be responsible.

I have read this document and hereby consent to participate in teletherapy under the terms described above. I understand this document will become a part of my/their medical record.

Please check the appropriate box below.

□ I agree to participate in and receive speech/language therapy services via teletherapy.

□ I have chosen not to participate in teletherapy sessions.

_____________________________________ _____________________

Printed Name of Client Date of Birth

____ ______________________

Signature of Client or Legal Representative Date

Relationship of Legal Representative (If applicable*) _________________________________

*May be requested to provide verification of representative status

____ ______________________

Signature of Witness Date

HIPPA Email Consent

Department of Communication Sciences and Disorders
042 Social Sciences and Humanities
Stillwater, OK 74078-3015
P: 405-744-6021
cdis.okstate.edu

HIPAA Email Consent

Client Name:______________________________________ Date of Birth:__________________

HIPAA stands for *Health Insurance Portability and Accountability Act* and was passed in 1996 to establish privacy and security protections for personal health information. Information stored on our computers is encrypted. Most popular email services (ex. Hotmail ®, Gmail ®, Yahoo ®) do not utilize encrypted email.

When we send you an email or you send us an email, the information sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once you receive the email, someone may be able to access your email account and read it.

A modification to the HIPAA act provides guidance on email and HIPAA:

– http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf

The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email.

Option 1 – ALLOW unencrypted email

a. I understand the risk of unencrypted email and do hereby give permission to the OSU Speech-Language-Hearing Clinic to send me personal health information via unencrypted email.

Signature (Parent or guardian if patient is a minor)	**Date**	**Printed Name**	**Printed Email Address** Use backside of paper if you need more space

b. With the exception of highly sensitive PHI (for example, mental health, substance abuse or HIV information), I give permission to the OSU Speech-Language-Hearing Clinic to send therapy related personal health information via unencrypted email **to service providers** I have authorized the following:

____

Service Provider's name and occupation

Signature (Parent or guardian if patient is a minor)	**Date**	**Printed Name**	**Print PROVIDER'S Email Address** Use backside of paper if you need more space

Option 2 – DO NOT ALLOW unencrypted email

I do not wish to receive personal health information via email

Signature (Parent or guardian if patient is a minor)	**Date**	**Printed Name**

Consent remains in effect for 6 months.

Student Clinician / Staff Confidentiality Agreement

Department of Communication Sciences and Disorders
042 Social Sciences and Humanities
Stillwater, OK 74078-3015
P: 405-744-6021

Student Clinician/Staff/Faculty Confidentiality Agreement

Confidentiality means that information about patients and families in our clinic will remain private - that it will be kept in confidence. Medical, educational professionals/students, staff working in the health care field are ethical and legally restricted from disclosing confidential information about patients. New federal guidelines require that confidentiality and privacy policies be provided to persons served by medical professionals.

Because you work with patient information and see patients that are served by the Speech-Language-Hearing Clinic, it is important to respect the privacy of the patients and families. It is important to remember not to reveal patient or family member names. It is also important not to share information about patients, their abilities, or family behavior with others. Patient skills, abilities, problems, issues, concerns, achievements, behaviors, and family make-up are to be kept in strict confidence.

Within the clinical setting, any discussion, about the patient or family should be conducted in an area where it can not be overheard. Potential areas in the clinic where conversations are easily heard by others include the patient waiting area, clinician's work room, or front office, and the hallway.

To ensure that you understand the privacy and confidentiality of the information you process daily, we require that you sign the following confidentiality agreement.

I, ______________________________, understand that information about the identity, family, behavior, skills, and abilities or information that is in patient charts is confidential. I agree not to discuss any information about patients in the clinic with anyone outside of the Oklahoma State University Speech-Language-Hearing Clinic. I will only release information to schools, insurance companies or other health care providers with written consent of the patient or guardian of the patient and permission from the licensed OSU supervisor. I further understand that violations of this policy may result in dismissal from the program or termination of employment.

________________________	__________	____________________	__________
Student/Staff/Faculty	Date	Witness	Date

Revised 08/1/2021

WRITING GUIDELINES FOR PROFESSIONAL REPORTS

1. Use third person pronouns (e.g., he, she, they) and names (John, the clinician) instead of "I, we, you."
2. Use one tense throughout the document – preferably past tense. Whoever is reading the report will be doing so after the event. (e.g., John, a 3 year 4-month-old male, was seen at the OSU…). Future tense is appropriate for Objectives, Recommendations and Plans. These will be in future tense (e.g., The client will ….; the client should be given preferential seating the classroom).
3. Abbreviations may be used as long as they are meaningful to those reading the note. The first time an abbreviation is used, write out the entire word and then include the abbreviation that will be used for the rest of the document. For example: Pressure Equalizing tubes (PE tubes).
   a. Acceptable medical acronyms are allowed and can be found at ncems.org
4. Diagnostic Test names should be written out and italicized the first time used.
   a. Abbreviations for test names are also italicized. For example: *Preschool Language Scales – 5 (PLS-5)*
5. You can choose to use numbers or write out the words for the number.
   a. For example: The client initiated requesting an object 3 times this session.

PROCEDURES FOR SEMESTER TREATMENT PLANS

To develop a good Treatment Plan, you should:

1. conduct a thorough review of the client's EMR/chart, paying special attention to past objectives, client's rate of improvement, and recommendations on the last progress report,
2. speak with the prior treating clinician, if possible, to clarify information and gain more information about subtle behaviors and methods not mentioned in the past reports,
3. ascertain if formal and/or informal re-evaluation of skills will be needed to establish baseline data for the semester (in your final progress report, you will need to write about the improvements over the semester and to do this you should always gather baseline data for a comparison),
4. and confer with your supervisor about proposed objectives.

TIMELINE

1. Baseline Treatment Plan – draft prior to starting. In EMR, first day of treatment
2. Second Treatment Plan – generally in EMR after 1 – 2 sessions of collecting baseline data. OR after completion of re-evaluation.

The **TREATMENT PLAN** is the first report due each semester when clinic begins. It will give a brief summary of the client's communication issues, previous treatment/evaluations and current semester treatment objectives. Two treatment plans are usually appropriate each semester, although more can be written if needed.

A draft of your Treatment Plan is written and taken with you to your initial supervisor meeting **prior to beginning therapy**. The **baseline** TREATMENT PLAN is generally dated the first day of treatment and should be in the EMR the day you start therapy. The baseline Treatment Plan will have objectives to gather baseline data in the areas of need identified in your first supervisor meeting. Or this Treatment Plan could have one goal to complete a diagnostic evaluation to determine direction of therapy if it is time for the client's yearly re-evaluation. The baseline treatment plan **must be finalized** by the beginning of the first week of therapy so you can write your SOAP notes.

Baseline data will be collected during the first 1-2 sessions of treatment. A second Treatment Plan known as the Semester Treatment Plan should be written before the second week of therapy and should be written with the objectives that include the SMART goal format: specific, measurable, attainable, relevant, and timebound. Once it is finalized, it is a good idea to have a brief client/family conference to go over the Treatment Plan. If the client and family understand the purpose of activities, this usually improves cooperation with home activities and homework assignments.

Baseline treatment plans are not necessary immediately following an initial evaluation as well during the summer semester. Reminder that following an initial evaluation or re-evaluation your client must have a new semester treatment plan. (not baseline treatment plan).

COMPONENTS OF A TREATMENT PLAN

In CounselEar, the HISTORY section is used for **CLIENT INFORMATION and REASON FOR REFERRAL**. Use the templates provided for these parts of the TP. They include:

CLIENT INFORMATION

- Age
- Address
- Telephone
- Parent/Guardian (if applicable)
- Referred BY (Referring Doctor preferred)
- Current Diagnosis*
- ICD-10 *(CHECK the CTBS form to make sure you have the correct codes)
- Date of Treatment Plan:

*Always include any **medical diagnosis** as well as speech/language/hearing codes. Chronic Otitis Media, Down's Syndrome, Prematurity – all impact communication and provide a "medical necessity" component that is required by most insurance companies.

REASON FOR REFERRAL

Client's name; age; month/year the client was first seen in the clinic, referral source; reason for referral; pertinent past diagnosis and severity, important developmental and

medical information; past therapy objectives; current diagnosis and severity; and any current concerns. SoonerCare requires that we report on the client's native/dominant language and if they will be treated in that language. **DO NOT PUT THE NUMBER OF SEMESTERS THE CLIENT HAS ATTENDED.**

Example:
John, an 8-year-old male, was referred to this clinic in January of 201x secondary to his pediatrician and parental concerns about incorrect speech sounds and poor language development. John has had a history of middle ear infections, delayed gross motor development, and "late talking." John had Pressure Equalizing (PE) tubes when he was young, but currently had normal hearing with infrequent ear infections. Objectives have focused on improving speech intelligibility, increasing receptive comprehension of questions and directions, and improving expressive language structures. He continued to demonstrate moderate impairments in articulation and a moderate-to-moderate severe language disorder. He currently lives at home with his mother, attending public school in Stillwater, Oklahoma. He received additional speech and special education services there. John's native language is English, and he will receive services in that language.

The next section in CounselEar is RESULTS. Nothing goes there for Treatment Plans as they are plans - not data or results.

RECOMMENDATIONS - is the next section in CounselEar. Long Term Objectives and Semester Objectives go in this section. Use the templates to get started on these.

OBJECTIVES / TREATMENT GOALS

Treatment goals will be constructed using the S.M.A.R.T. goal format, please see below. SMART is an acronym used for creating goals that are clear and attainable.

LONG-TERM OBJECTIVES

Long Term Objectives are anticipated levels of performance to be achieved by discharge and/or within a year (Confer with supervisor to see which is preferred). These could be achieved in the current semester or in later semesters depending upon client progress.

Long Term Objectives are measurable expected outcomes for the client related to present level of performance. Long Term Objectives can and should be changed if they do not currently seem attainable or if they have been achieved and more progress is possible.

If you have Short Term Objective addressing speech, language, voice, fluency, feeding, etc., you should have a Long-Term Objective for those areas also.

Components of Long Term Objectives: SMART goal format

1. Specific – Each goal should specifically state what the child should do. Goals should include what the client will do, what setting it will be done in, what accuracy it should be done with, and what type of support needed (such as cueing level).
2. Measurable-Each goal should specifically state how the skill should be measured, example 80% at word level,
3. Attainable – Make sure the goal set is something that can be reasonably achieved in the given time frame.
4. Relevant – The goal should be relevant to each client's need.
5. Timebound – Each goal should explicitly state the time frame it will be achieved.

LTO Examples:

- The client will increase speech intelligibility with unfamiliar listeners in conversation to 80% intelligible.
- The client will establish safe and functional cognitive communication and/or swallowing skills to meet the needs of their prior known living environment 100% of the time.
- The client will demonstrate age-appropriate expressive language skills as measured by standardized testing, MLU and completion of short-term objectives at 80%.
- The client will demonstrate *developmentally* appropriate pragmatic, expressive, and receptive language skills in conversational speech 75% of the time.
- The client will improve his functional communication in home and school settings so that familiar listeners understand basic wants and ideas over 50% of the time.

SHORT TERM OBJECTIVES

These are the anticipated levels of performance at the end of the current semester. Each full semester is 13 weeks of therapy and summer semester is 6 weeks of therapy. The semester objectives should include any anticipated evaluation or reevaluation of needed skills. For the most part, the goals should be written as client-oriented goals (e.g., The client will complete a speech/language evaluation and semester objectives will be set based upon results). One exception to this rule is the home program goal. (e.g., The clinician will provide the client/family …….).

Semester Objectives are measurable intermediate steps between present level of performance and Long-Term Objectives. They serve as milestones for measuring progress toward discharge levels. The same questions and components used for Long Term Objectives are required, but more specific.

In addition to the SMART goal format see below for further information that should be included in the goals.

1. **Who**? - Client Family Caregiver
2. **Performance**? - specific functional behavior/skill that can be measured
    - “produce age-appropriate final consonants (e.g.,/ p, b, t, d, k, g/)
      “increase MLU to 2.5”
    - “correctly produce the /r/ phoneme”
    - “discriminate /s/ from /f/ by raising his hand”
    - “produce easy onset of voice”
    - “identify pictures by pointing”
3. Under what **Conditions**? You should define the unique circumstances that will support the new behavior. How will the skill be presented, under what conditions you will facilitate, observe, and measure the behavior? This includes the environment, specialized instructional materials (visual/verbal cueing), equipment, amount of assistance (imitation versus spontaneous) level of response (word, sentence, conversation).
    - “in imitation in the initial, medial and final positions of words”
    - “spontaneously produced monosyllabic target words during structured therapy tasks”
    - “given a field of three”
    - “given multiple choice answers”
    - “for 5 minutes with cueing <10% of the time”
4. **Criteria/measurement?** How Often/How Well? Use measurement terms to define accuracy, duration, frequency “80%, accuracy”
    - “7 out of 10 attempts”
    - “3 sessions in a row”
    - “10 times per session”
    - “80% of first twenty productions”

Semester (STO) Examples:

- The client will use appropriate voicing when producing the phonemes /k, g, t, d/ in initial and final positions at word level with 80% accuracy in structured therapy activities.
- The client will develop his expressive language abilities by increasing verb phrase elaboration, VP = (modal) + (aux.) + V + (aspect), 5 – 7 times per therapy session (individual and group combined).
- The client will increase phonemic awareness as demonstrated by blending and segmenting 3 – 4 syllable words and CVC words with 80% accuracy during therapy activities.

- The client will produce easy onsets of voice in a 3-minute conversation 95% of the time without cueing.
- The client will increase speech intelligibility by producing /s,z/ in the medial and final positions at the sentence level using delayed model with 80% accuracy.
- The client will demonstrate an understanding of simple contrastive concepts (e.g.; big/little, hot/cold, wet/dry, empty/full) by following commands including these words 10 times a session.
- The client's comprehension of basic concepts for kindergarten and 1st grade will be assessed and those concepts, which are not mastered, will be targeted in therapy.
- The clinician will provide weekly activities to promote carryover into spontaneous speech by completing a home program 4/7 days per week. **
- The parent will participate in the last 10 minutes of the therapy sessions and model techniques taught by the clinician to facilitate two-word utterances. **
- The clinician and parent will communicate via e-mail on a weekly basis and information will be shared regarding therapy objectives and techniques to target at home and any parental questions or concerns. **
- Parents will be given a home program and will observation sessions 50% of the time. **
- A yearly hearing screening and speech/language evaluation will be conducted. **

**SoonerCare requires that families be involved in the therapy sessions 50% of the time. An objective MUST be written addressing that area. "Involvement of the parent/caregiver includes, but is not limited to, direct participation in the child's session, instructional methods and practice assignments relayed by email or telephone, or instructional methods and practice assignments documented in a notebook along with data collection and parent/caregiver signatures.

- Documentation should clearly indicate:
- the method by which the parent/caregiver was instructed (e.g., in person, electronically, etc.)
- what goals and objectives were targeted; and
- how the parent/caregiver was educated to reinforce, support and, in general, carry out the treatment plan outside of the therapy session."

***SoonerCare clients hearing acuity must be screened every year and reported on in the progress report every 90 days. To help remember this, it should be the last objective on the Treatment Plan/Progress Report.

ATTESTION / CERTIFICATION OF MEDICAL NECESSITY

The next section in CounselEar is the **CUSTOM SECTION**: This is where you find the Attestation Statement - ONLY FOR SOONERCARE, as well as the Certification of Medical Necessity Statement-ONLY FOR MEDICARE clients. These are templates you need to add to the report for SoonerCare or Medicare clients.

Referring Physician, Additional Recipients

If the treatment plan will be sent to insurance, referral sources, and/or parents, include that information in the **Referring Physician** and **Additional Recipients** sections of CounselEar.

First step: When you are writing your report, you must identify the referring physician and include them in the Professional Report by inserting their name in the Referring Physician section. *Do not type in the name* but select Edit Referral to locate the physician. The Referring Provider DOES NOT require an *Authorization to Release Protected Health Information* completed/signed form. Only one name can go in this section.

After you select Edit Referral, go to the Search box at the bottom of the page and type the last name of the referring provider. If they are in the system, their name appears in SEARCH RESULTS. Click on the name and it will be inserted in the boxes above. The front office prefers to Fax the reports and many of the doctors already have the number included.

Second Step: On the recipient tab use the drop-down menu under **delivery method** to select **fax** for physicians.

If your referring provider (doctor, PA, RN) is not in the system, fill in the name, address, and the fax number (either call the referring provider's office to get it or ask the front office if they have it). Select the box "Add current referral to the Physician's List" so they are there for future reports. Select the grey bar button to Save- Continue Editing to add them.

Third Step: After you have selected the recipient, you can customize the FAX coversheet if you want. Go to the Fax Coversheet tab. The Patient's name will automatically appear in the Fax Coversheet and you do not need to type it out. Write what you want to add in the white edit box. Then click the box by Display Fax Cover Notes and Save - Continue Editing.

If you wish to add a Cover Letter specific to the report that would follow the Fax Coversheet, select the Cover Letter tab. Use the Dropdown to select the specific cover letter form. There are Cover letters for the Evaluation and Progress Reports for the different places the report is to be faxed. You can use the wording that appears or edit it. Make sure to click the box by the Display Cover Letter. Then Save - Continuing editing.

Fourth Step: Add any additional recipients that the client has completed the *Authorization to Release Protected Health Information* form for. Go back to the MAIN SCREEN. Under the Referring Physician is a box for Additional Recipients. Multiple Additional Recipients are allowed. You will follow the same steps to add these individuals. 1. Add Additional Recipient 2. Add the individual by searching their name.

If they are not there, add them, address if known and their fax number. (Add to current providers if new). Select the Fax Cover Letter box. Save. Add any Cover Letter that is appropriate. Select the Display Cover Letter box. Save. Repeat with any other recipients.

Fifth Step: **On the recipient tab** use the drop-down menu under **delivery method** to select **fax** for physicians.

Sixth step: Check your work by selecting the PDF icon to the right. The first icon will show the fax cover sheet, any cover letter you included, and the report. The second PDF icon shows any Cover Letter and the report. The envelope icon can be used by the front office when things are mailed. You can edit more if you find a mistake or you can delete the entire thing with the trash can.

REPORT OPTIONS:

Add the TREATMENT PLAN report title, by completing the bottom section called **Report Options -Edit Report.**

If the TP is to be sent to the client/family, check the **Patient Portal** box.

Baseline Treatment Plan #1 Baseline EXAMPLE

CURRENT CLIENT INFORMATION
NAME: John Speech
AGE: 4 years
BIRTHDATE: 04/20/1X
ADDRESS: 802 Hall St., Stillwater, OK 74075
TELEPHONE: (405) 777-7777
PARENT/GUARDIAN: Jim/Joan Speech
REFERRED BY: S. Smith, M.D.
CURRENT DIAGNOSIS: Moderate receptive/expressive language disorder, mild articulation/phonological processing disorder secondary to chronic otitis media
ICD-10: F80.2, F80.0, H65.20
DATE: 08/27/201X

REASON FOR REFERRAL:
John, a four-year-old male, was referred by Dr. S. Smith and his parents due to concerns about speech and language development. John's parents were also concerned about how his language/speech would affect his learning in PreK. John was evaluated at the OSU Speech-Language-Hearing Clinic on July 25, 201X and presented with a moderate receptive/expressive language deficit and mild articulation disorder. Hearing acuity was screened at that time and found to be normal in both ears. John does have a history of chronic otitis media and has had PE tubes since he was 18 months. Tympanograms obtained in the evaluation indicated patent PE tubes. Therapy in past semesters has addressed his speech and language deficits and these will continue to be the focus this semester. John is English speaking and treatment will be conducted in this language.

LONG TERM OBJECTIVE
LONG TERM OBJECTIVE #1
The client will increase speech intelligibility with unfamiliar listeners in conversation to 80% intelligible.

LONG TERM OBJECTIVE #2
The client will demonstrate age-appropriate expressive language skills as measured by standardized testing and completion of semester objectives with 80% accuracy.

SEMESTER OBJECTIVES
Objective #1: Baseline data will be collected on the phonological process of stopping of /s, z/ in all positions of words at the word and phrase level.
Objective #2: Baseline data will be collected on the pronouns "my", "your" and "they're" in imitation and spontaneously.
Objective #3: Baseline data will be collected on the use of "is/are" + verb + "ing" in short sentences with and without visual cues.
Objective #4: Baseline data will be collected on the client's conversational turns in a 5-minute conversation with and without visual/verbal cues.
Objective #5: Due to history of otitis media, the client's hearing acuity and middle ear functioning will be screened on a semester basis.

ATTESTATION STATEMENT
****SoonerCare Only**

CC
Parents

Semester Treatment Plan #2 EXAMPLE

CURRENT CLIENT INFORMATION
NAME: John Speech
AGE: 4 years
BIRTHDATE: 04/20/1X
ADDRESS: 802 Hall St., Stillwater, OK 74075
TELEPHONE: (405) 777-7777
PARENT/GUARDIAN: Jim/Joan Speech
REFERRED BY: S. Smith, M.D.
CURRENT DIAGNOSIS: Moderate receptive/expressive language disorder, mild articulation/phonological processing disorder secondary to chronic otitis media
ICD-10: F80.2, F80.0, H66.93

DATE: 08/27/201X

REASON FOR REFERRAL:
John, a four-year-old male, was referred by Dr. S. Smith and his parents due to concerns about speech and language development. John's parents were also concerned about how his language/speech would affect his learning in PreK. John was evaluated at the OSU Speech-Language-Hearing Clinic on July 25, 201X and presented with a moderate receptive/expressive language deficit and mild articulation disorder. Hearing acuity was screened at that time and found to be normal in both ears. John does have a history of chronic otitis media and has had PE tubes since he was 18 months. Tympanograms obtained in the evaluation indicated patent PE tubes. Therapy in past semesters has addressed his speech and language deficits and these will continue to be the focus this semester. John is English speaking and treatment will be conducted in this language.

LONG TERM OBJECTIVE
LONG TERM OBJECTIVE #1
The client will increase speech intelligibility with unfamiliar listeners in conversation to 80% intelligible.
LONG TERM OBJECTIVE #2
The client will demonstrate age-appropriate expressive language skills as measured by standardized testing and completion of semester objectives with 80% accuracy.

SEMESTER OBJECTIVES
Objective #1: The client will decrease the phonological process of stopping by producing the phonemes /s, z/ in all positions of words and phrases during structured therapy tasks with 80% accuracy.
Objective #2: The client will produce the target pronouns "my", "your" and "their" with 90% accuracy in structured play activities and 50% spontaneously.
Objective #3: The client will use "is/are" + verb + "ing" spontaneously 80% of the time in short sentences with visual cues as needed.
Objective #4: The client will take 4 – 5 conversational turns a minimum of 2 times per session with visual/verbal cues as needed.
Objective #5: Due to history of otitis media, the client's hearing acuity and middle ear functioning will be screened on a semester basis.
Objective #6: The client will participate in a home program addressing the above goals on a weekly basis 80% of the time in order to promote carry-over.

ATTESTATION STATEMENT
****SoonerCare Only**

CC
Parents

TREATMENT PLAN CHECKLIST

CLIENT INFORMATION (Goes in HISTORY section of CE)	
	Age: Report in year/month up to adolescents; matches Reason for Referral
	Birthdate (optional)
	Address
	Telephone
	Parent/Guardian (delete Guardian/Parent if not appropriate)
	Referred By: Put referring physician/physician assistant/nurse before parent
	Current Diagnosis: (severity and communication disorder & medical etiology
	ICD-10-CM: (No F codes for BCBS. Use R codes)
	DATE (matches the visit dates in CE)
REASON FOR REFERRAL – SoonerCare-be specific & detailed they don't read past reports	
	Name of client (refer to client in same form throughout)
	Age of Client
	Referral source and reason for referral
	Initial diagnosis and severity ☐ add any updated diagnosis and severity if client seen several years
	Important developmental and medical information
	Past therapy objectives and progress towards them – if returning client
	Current diagnosis and severity – if different from original
	Current focus of therapy – 2nd / Semester TP only not on Baseline TP
	Native language of client and if therapy will be conducted in it (SoonerCare)
LONG TERM OBJECTIVES (goes in RECOMMENDATION section of CE)	
	LTO addresses each major communication area that has been diagnosed
	Each LTO has the following parts ☐ Performance ☐ Condition (optional) ☐ Criterion
SHORT TERM OBJECTIVES	
	If SoonerCare, each objective must have a statement on medical necessity
	Each STO has the following parts ☐ Performance ☐ Condition ☐ Criterion
	Include Family objective/home program (must for SoonerCare)
	Include need for re-evaluation objective in one year (must for SoonerCare)
ATTESTATION STATEMENT (SoonerCare only) – CUSTOM section of CE	
MEDICAL NECESSITY STATEMENT (Medicare) – CUSTOM section of CE	
REFERRING PHYSICIAN (separate section in CounselEar) – ***if you want TP sent to people-typically don't send out TP plans unless requested***	
	Select the name of referring physician or add if not in CE
	Check that the name is correct. Select FAX as the preferred delivery
	From Tabs, create a FAX and Cover Letter from the dropdowns in CE

ADDITIONAL RECIPIENTS (separate section in CounselEar) – If you want TP sent to people	
	Parent of Client's name entered
	Edit recipient and Select EHR as preferred delivery
	Make sure client email is present -if not add – or it will not email to them
	Create a Cover Letter using the tabs/dropdowns
	Select any other professionals/individuals the client has a signed *Authorization to Release Protected Health Information* form for. -Select Fax or Email (EHR) options for others and create appropriate Cover Letters.
CC: - Should automatically populate if you did the above correctly	
REPORT OPTIONS (separate section in CounselEar)	
	Treatment Plan selected on dropdown Week
	Formatting and title are correct - CHECK PDF OF REPORT
PATIENT PORTAL (separate section in CounselEar)	
	Only check Box if you want sent to family/client.
PROFESSIONAL GRAMMAR AND WRITING STYLE	
	☐ No first-person pronouns ☐ Past tense ☐ Complete Sentences
	☐ Sentence structure not over complicated or wordy
	☐ Correct Formatting of report/paragraphs/headers -**CHECK PDF OF REPORT**

WEEKLY THERAPY PLANS (WTP)

The purpose of weekly therapy plans (WTP) is to serve as your treatment plan for the week. Your first WTP of the semester will be based on your semester treatment plan. All following WTP's will be based on the previous week's SOAP note.

WTP Components

Column #1: This column will be an abbreviation of semester objective.
Column #2: This column will be an abbreviation of the weekly target.
Column #3: This column will be your strategy/activity or resource to address the weekly target.

WTP EXAMPLE

Weekly Therapy Plan Template: WTP

Client: T/R 3:30
Dates: 5/28/24 – 5/30/24

Semester ST Objective	**Weekly Objective**	**Strategies/Activities/Foods**
1.R 90% sentence level	R 70% word level	Mighty mouth for placement cues, mirror, tongue blades, target words.
2.Tolerate 5 new foods	1 new food	Old foods to bring: New food to bring:
3.Imitate 2 word phrases	Imitate 5 new single words	Baby Signs to pair with words Functional Words: Hi, up, open, help

*Additional Comments:

SOAP NOTES

The SOAP note is used to record and analyze data pertinent to a client's performance in therapy during a session. SOAP notes should be written as concisely as possible. SOAP notes should be written the **same day** that the session occurred. SOAP Notes are written in the *PROFESSIONAL REPORT* section of CounselEar. The entirety of the SOAP is written in the *RESULTS* section of the *Professional Reports*. **Report Options** must be chosen to get the correct document title SOAP Note.

***If a re-evaluation is being done in a treatment session and/or if the client needs multiple sessions to complete the evaluation, the Evaluation Report is entered into the EMR in place of the SOAP note. If it takes further sessions to complete the re-evaluation then subsequent entries will be a SOAP note to briefly document what occurred in the session, using the standard SOAP note format.**

SOAP Note Template

<u>SOAP NOTE Template</u> – Results & Report Option sections of CounselEar

1. ***Results section of CounselEar***

Time In/Out
Total Minutes

S:

O:
OBJECTIVE #1 – Semester treatment objectives only. Not Weekly Therapy objectives
OBJECTIVE
#2 ETC
A:

P:

Attestation Statement - Delete if not **SoonerCare

2. ***Report Options of CounselEar***

Select the SOAP note title from the drop down.

Components of a SOAP note

The initial information will be the **Time in/Time out** and **Total Minutes.** Record the Time In/Out & Total Minutes out you spend with each client on the SOAP note. This will be from the time you pick them up in the waiting room until you walk them out of the clinic area and they leave.

The four components of a SOAP note are Subjective, Objective, Assessment, and Plan. The length and focus of each component of a SOAP note varies depending on the session**.**

S (Subjective): DO NOT write the same statement every SOAP note.
Describe your impressions of the client in the subjective section. Include your impressions about the client's/client's level of awareness, motivation, mood, willingness to participate. You may also list here anything the client and/or family may say to you during a session. Use direct quotes to support statements when possible. Subjective impressions could include:

- A **description** of how the client feels (e.g., *Mr. Gadni was in good spirits today. He laughed and joked with the clinician during activities.*)
- The client's, the clinician's, or the family's **impression** of the client's behavior (e.g., the clinician's observation that: *Mr. Lee's attention span was very limited*; or the spouses observation: *Mrs. Jones reported that her husband was communicating better today.*)

- A description of **physical characteristics** (e.g., *Mr. Herring seemed to have greater use of his right hand today.*)
- A report on **sensory characteristics** (e.g., *The client's wife reported that her husband's hearing aid was not working right*.)
- Comments about **conditions of the therapy** situation (e.g., *Johnny was distracted by the sound of the lawn mower cutting grass outside*. Or *Mr. and Mrs. Smith were both in the room when Johnny was being treated.*)

Include any information to be shared with other professionals or information not related to our field, but of importance to the client. This could include:
(Examples)

- S: Client has been enrolled in day care.
- S: Client now has P.E. tubes in both ears.
- S: During a difficult task, Shawn persevered during the beginning of the session on going to the bathroom. Snack reinforcement increased his attention. The hands-on flower activity was great for his attention and ability to sequence. He told his mother about it after the session.

O (Objective):
Facts belong in the objective part of the SOAP note. Write measurable information in the *objective* section. Your data goes here. Cueing given goes here. Common errors go here. Supervisor preferences and client needs will be a determining factor of the types of information to include in this section.

1. Use all of the Semester Objectives from the most current *Semester Treatment Plan* approved by your supervisor. **Do not use Weekly Objectives.**

2. Write about the measurable data related to the objective for that session(s). Include raw data and the percentages for goals/objectives worked on, and any quantitative information – such as cueing and common errors.

3. You may use charts or narrative statements, there is no need to use both, unless the narrative provides extra needed information.

Table example

/l/	Word level	Sentence level
Initial	8/10 – 80% imitation	4/10-40% moderate cueing
Medial	2/10 – 20% imitation	N/A

Remember performance/results are based on the Objective criteria and not a description of the activity. Add results of activities such as the **percentage of correct responses, how much assistance and modeling were needed, what common errors were.**

A (Assessment):

Describe your analysis of the session in this section. This is the interpretation section. Use past tense. Use objective numbers and match them to the Objective in the O section.

1. **Compare the client's performance across sessions.** May include comments on both strengths and weaknesses. Hypotheses for why change did or did not occur may be included.
2. Be concise. If several objectives were not targeted, make one statement noting that.

(Example) –

- #1. Production of initial /s/ increased from 65% accuracy during the last session to 75% accuracy during today's session secondary to consistent home practice.
- Obj. #2 5 were not addressed today.
- #3. "My" "your" improved from 75% last sessions to 80% today; "their" decreased from 75% to 50% correct, possibly due to less opportunities to practice. No carryover noted spontaneously either session.
- #4. Withdrawal of visual models resulted in a decrease in accurate production of single syllable words.
  Or
- #1,2,3,4 No previous data to compare with as baseline data was collected today.

Tables also be used to compare sessions in the A section. If tables are used, please add an analysis of the data.

Last addressed:	This session:
/s/ isolation: 40%	/s/ isolation 80%

Comment: client understood difference between "skinny" versus "tapped air"

Last Addressed	This session
90% accuracy (9/10) min cues	50% accuracy (2/4) min cue

Comment: decrease likely due to significantly fewer trials administered.

P (Plan):

After the information in the above sections is analyzed, decide how it affects future sessions. The P section is a simplified way to plan for your next session and should be relevant and helpful to your upcoming WTP. Any changes to objective, criterion levels, activities, reinforcement schedules, behavior management should be included.

If you need to change or add a semester treatment plan, do that in this section. Then carry the goal forward into future SOAPs and WTPs. i.e., Semester Objective #3 will be modified to (write modification); Semester #4 has been consistently met and will no longer be addressed.

(Examples)

Increase weekly objective 1 to: Sam will correctly imitate /s/ in the final position of words in 50% of his attempts and spontaneous produce initial /s/ in words with 80% accuracy.

Continue current treatment plan with weekly session objective #2 upgraded to 80%.

Refer client to audiologist as they failed the hearing screening.

<u>If there are limited changes, you might simply state</u>:

Continue training production of the target pronouns "my," "your," and "their" with 90% accuracy in a structured play activity and 50% spontaneously.

Continue current treatment plan with goals remaining at the same performance and criterion levels.

The phoneme /z/ in final position will be only targeted at the syllable level during the next session.

If Shawn still feels unwell next session and requests his father, he will be asked to join in the sessions.

Writing Guidelines for SOAP notes

1. For most clients, there should be a SOAP Note for each date that the client was seen. There may be exceptions to this dependent upon your supervisor and the setting (e.g., school setting), which can be a weekly SOAP Note.
2. All Semester Objectives from the client's *Treatment Plan* should be included on the SOAP note. However, you are not always expected to address each objective each session. Objectives addressed will depend on your client's needs and the time available. Under the objective in the O section, write: Goal not addressed today. OR Goal will not be addressed for several weeks.
3. If you planned on addressing an objective and did not get to it that session, mention this in the Plan section: "Language objective of category naming was not addressed due to time constraints OR client's late attendance. Will be first activity next session."
4. Maintain the same objective numbers on your SOAP note as you did on the Weekly Therapy Plan/Semester Treatment Plan.
5. If you add a new semester objective during the semester, do not go back and re-write the Treatment Plan. If you add, suspend, or meet an objective during the semester, write this information in the Plan section of the Daily Therapy/SOAP note. If you make <u>significant changes</u> to the Semester Treatment Plan, you should create a new Semester Treatment Plan on the date the changes were made.

SOAP NOTE EXAMPLE – Baseline data

Time In/Out: 9:31-10:24
Total Minutes: 53 minutes

S: The client appeared nervous and timid at first; however, the client warmed up to the clinician quickly. The client was in a great mood and actively participated.

O:
Objective 1: Baseline data will be collected on the client's ability to eliminate the phonological process of final consonant deletion with the phonemes /t, n/ spontaneously at phrase and sentence levels 90% of the time.

/n/	6/10 (60%)
/t/	9/9 (100%)

Objective 2: Baseline data will be collected on the client's ability to produce the phonemes /k, g/ in the CV, VC, CVCV and CVC levels with 80% accuracy with cueing as needed.

/k/	CV: 2/5 (40%) VC: 4/5 (80%) CVC: 9/9 (100%)
/g/	CV: 2/5 (40%) CVC: 2/5 (50%)

Objective 3: Baseline data will be collected on the client's ability to correctly produce the phoneme /f/ at the VC and final position of CVC syllables with 80% accuracy spontaneously and at the CV, medial position of VCV and initial position of CVC syllables in imitation with 50% accuracy.

/f/	CVC Final: 4/5 (80%)

Objective 4: Baseline data will be collected on the client's ability to correctly produce the phoneme /s/ at the VC and final position of CVC syllables with 80% accuracy spontaneously and at the CV, medial position of VCV and initial position of CVC syllables in imitation with 50% accuracy.

/s/	VC: 4/5 (80%) CV: 0/5 (0%)

Objective 5: Baseline data will be collected on the caregiver's ability to participate in therapy by observing, completing take home tasks, and reporting progress to the clinician 80% of the time.

The caregiver observed the entire session and mentioned that they work on articulation often at home.

A: No previous data to compare as baseline data was collected.

P: Baseline data will be continued to be taken on 6/18/20XX

Attestation Statement
I was present with the student clinician during the entire speech therapy treatment session and actively participated. I discussed the session with the student and agree with the findings and plan as documented in this daily therapy note.

SOAP NOTE EXAMPLE – after second treatment plan written

Client: John Speech **Date: 9/4/1X**

Time In/Out 3:35 pm -4:20 pm
Total Minutes 45 minutes

S: John was late today because of behavior problems at school. He was very resistive the first 5 minutes, but soon began participating in all activities.

O:
OBJECTIVE #1: The client will decrease the phonological process of stopping by producing the phonemes /s, z/ in all positions of words and phrases during structured therapy tasks with 80% accuracy.

Correct 80% at the word level after model (32/40 trials); some spontaneous production noted during game.

OBJECTIVE #2: The client will produce the target pronouns "my" with 90% accuracy in structured activities and 50% spontaneously.

With carrier phrase "This is my____." modeled for him by the clinician, imitation was 85% correct. Spontaneously, only 30%.

OBJECTIVE #3: The client will use "is/are" + verb + "ing" spontaneously 80% of the time in short sentences with visual cues as needed.

"is" + verb+"ing = 50% (5/10) spontaneously during structured tasks; 4/10 with verbal cueing; 1/10 with verbal/visual cueing.

“are” + verb+”ing = 30 % (3/10) spontaneously; 1/10 with verbal cue; 5/10 required verbal/visual cueing; 1/10 was not produced correctly even with cueing.

OBJECTIVE #4: The client will take 2 - 3 turns during a describing game with verbal and visual cues as needed twice per session.

He learned to take turns quickly with visual/verbal cueing with 8/8 correct attempts. Spontaneous verbal turn taking - 3 times/twice; 2 times/twice. Needed cueing to take turn 6 times.

OBJECTIVE #5: The client will participate in a home program four times weekly in order to promote carry-over into settings outside of the clinic.

Client completed last homework 3 times with parent (per report). New home activity with /s/ given to parent. Practice 4 times/week encouraged.

A:

1. /s/ in isolation improved from 40% on 8/29/13 to 80% this session as client seemed to understand the idea of “skinny” versus “tapped” air.
2. Carrier phrase increased the production of “my” from 50% imitation on 8/29 to 80%. He used it spontaneously with 3 novel objects.
3. “Is” improved from 40% to 50% spontaneously; “are” decreased from 50% to 30% spontaneously; accuracy with verbal cueing the same between sessions; less visual cues needed with “is” this week (10% versus 30%)
4. First time visual photo cues used – improved turn taking with objects with some carryover into verbal turn taking. Last session only 2 turns/twice per session verbally.
5. Parent did homework 3 times this week compared to twice last week.

P:

Objective #3 could not be fully addressed due to late start. Will be the first activity next session. Increase #1 to 90% in imitation and 40% without model. Continue #2 and add the concept of “your” in imitation. Increase #4 to 3 – 4 turns three times per session. Continue #5 with different home activity.

Attestation Statement

**SoonerCare Only

SECTION 3

GENERAL CLINIC PROCEDURES

CLINIC CANCELLATION PROCEDURES

LATE CLIENTS

1. The waiting periods for clients who are late are as follows:
2. The clinician will remain available for 15 minutes.
3. After 10 minutes the clinician should attempt to contact the client.
4. After 15 minutes have passed the clinician will notify the front office of the no show and clean the therapy room.
5. If the client arrives after the specified waiting period, the front office staff will explain to the client that the clinician did not think he or she was coming and left after the prescribed waiting period of 15 minutes.
6. Please let the front office staff know before you leave.

Clinicians need to communicate this rule to their clients at the beginning of therapy. Also, clients need to understand that the clinician cannot extend therapy past the scheduled time if the client comes late. Tight scheduling of therapy rooms, as well as the schedules of supervisors and clinicians, does not permit extending the length of a therapy session.

CANCELLATION POLICY

Clinician Cancellation

The decision to enroll in practicum should be viewed as a serious commitment. The clinician is expected to attend every scheduled therapy session. In the case of an emergency or illness, please make every attempt to give adequate notification to the supervisor and client/parent prior to canceling therapy. You may be asked by your supervisor to re-schedule the session for later in the week or in the following week. Schedule doctor's and other appointments at times that do not conflict with your clinic or class schedule. Vacation during the school semester is not a valid reason to cancel or reschedule therapy.

Clinicians are to contact their supervisor **prior** to canceling a therapy session. If the supervisor is unavailable, contact the Clinical Coordinator. When the supervisor or Clinic Coordinator cannot be reached, the clinician can cancel therapy for medical reasons. The clinician must contact the front office to cancel the session in the EMR and should leave a message for the supervisor if they are not available. ***Please call the client directly to cancel treatment***. Do not ask the front office staff or supervisor to cancel therapy for you unless absolutely necessary. The front office will post the cancellation on the whiteboards in the front office above the copy machine.

Client Cancellation

If a client must cancel a session the day of therapy, they are asked to notify the **clinic office** as soon as possible. The client should be discouraged from contacting the clinician directly.

However, if this happens, the clinician MUST notify the front office immediately, so the supervisor and others are notified, and the client is taken off of the EMR schedule for that session.

If the client knows they will be unavailable for an upcoming session and tells the clinician in advance, they are responsible for informing their supervisor AND the front office staff so the client can be taken off the EMR schedule. In Stillwater, the front office staff will write the cancellation on the whiteboards on the file cabinet in room 042.

EXCESSIVE CLIENT ABSENCES

A client can be dropped from therapy who has three unexcused absences or excessive excused absences (20 – 25% of sessions missed). * The clinician will be assigned a new client unless there are unusual circumstances. The clinician is responsible for seeing that the parents or the client are informed of this policy at the beginning of the semester. Clients and their family need to understand that progress will be limited if the client does not attend regularly. Excessive absences can also be a problem for the clinician's experience and hours needed. Additionally, a reserved room may prevent an assignment to another clinician or client who needs services.

The supervisor and clinical coordinator will decide what steps to take in dealing with excessive absences. However, as much of the responsibility as possible should be placed upon the clinician for it is a necessary part of learning to be a professional. The clinician will need advice and perhaps a model of what to say and do, from the supervisor. Excessive absences excused or unexcused, and the decision to deactivate the client will be made by all involved.

If the client misses a therapy session without notifying the clinician or the clinic, the clinician should call the client. It is important to let clients know that they are missed, and the clinician is concerned about their welfare.

The Clinic Coordinator also needs to be informed within a week or so if a client has poor attendance as they may need to assign another client who is more consistent in attendance to the clinician so they can achieve the hours they need to graduate. They will also assist in the decision to dismiss the client from therapy.

* If your client attends **twice a week**, they need to attend at least **20** of their scheduled **26** appointments.

If your client attends **once a week**, they need to attend at least **10** of their scheduled **13** appointments.

CLINIC SECURITY

The clinic's security refers to maintaining client confidentiality and safety and building maintenance such as turning off the lights and other electrical equipment, locking doors, and leaving therapy rooms in order.

Therapy rooms: The rooms used for clinical activities will be opened by the office staff before the first scheduled therapy of the day. **Clinicians are responsible for locking the treatment and observation rooms if they are the last clinician of the day and/or the room is used by the clinician past the normal lock-up time.**

Do not prop open any exit doors or the doors to the therapy hallway during business hours.

Clients: Upon arrival, the clients or clinician MUST check in at the reception window in the waiting room with front office staff. If they do not go into the waiting room, the front office must be told by the clinician that the client has arrived. (During the COVID19 pandemic, the waiting room policy may change to limit the number of clients there.)

Checking in the client prior to going back to the therapy room is so that we know who is in the clinic area in case of emergencies. Check-in is also used to verify attendance in the EMR scheduling program. The clinician escorts the client to the therapy room and the family to the observation room. For security and noise reduction we do not allow parents or clients to enter the therapy areas unescorted.

Family/Visitors/Observers: If there are no pandemic concerns, family members will need to request a Visitor Badge from the front office if planning on observing their child in therapy. Observers also must check in and select an Observers Badge. Anyone in the clinic therapy area must be checked in at the front office and wear an identification badge. If you see someone in the therapy area without an identification badge, please ask them to go to the front office, check-in, and request a badge.

CLINIC FEES

Clinicians should refer all clients' questions regarding clinic fees and billing to the financial assistant, Errin Hanshew. Please do not try to answer their questions about insurance or fees.

GENERAL CLINIC OFFICE PROCEDURES

Office Conduct

The front office and waiting room are to be used for business purposes only. Students are not to leave coats, books, purses, etc. in these areas. Please do not linger and interfere with the duties of the front office. The department head's office, the clinic coordinator's office, therapy hallway, front office and client waiting areas should be considered *work zones*. Clinicians should not be holding conversations in these areas – especially if it concerns client information. Clinicians may choose to wait for their clients in the sitting area across from the waiting room *or* in the clinic hallway. (Please let the front office know where you will be).

Faculty and Clinician Mailboxes

All graduate students and faculty members are assigned a mailbox. Student mailboxes are located in the Materials room (047). Faculty mailboxes are located in the main office (042).

Keys / Card Swipe

If you are a GTA/GRA, you will be issued a key or lockbox code for entry to the office to which you are assigned by the Administrative Assistant Office. This key will be returned at the end of your assistantship. If lost or not returned, the cost of the key will be billed to your Bursar account.

Your OSU student identification card will allow you to use the card swipe at the front door, computer lab/workroom room 024, and doors to therapy hallway.

If you need access to a therapy/observation room that has been locked, use the keys hanging next to the faculty mailboxes. If you need the key to the testing cabinets, you must request it from the front office. You will be required to sign out and back in the keys for the testing cabinets.

Do not ask to enter a faculty member's office without authorization from the faculty member and escort from the front office staff.

- **Keys should always be returned immediately.**
- **Under no circumstances should keys be removed from the clinic or kept overnight**

Unlocking/Locking Therapy Rooms

The Administrative Support Staff unlocks all therapy and observation early in the morning and they remain unlocked during the day. If you need something unlocked, check out the key from the front office. If you are the first session for the day, take the trashcans from the hallway into your therapy room.

During the day, leave your therapy room unlocked when you finish your therapy session except for the last session. ***After the last session, the clinician is responsible for turning off the lights and locking the doors to the therapy room and observation room.*** The clinician should take out any trash cans with trash out to the hallway from the therapy and observation rooms if full or contain food items.

Supplies

A limited number of necessary supplies are kept in the clinician's workroom for all to use for clinic use. To restock staples, pens, paper clips, etc. in the workroom, ask the front office for them. Paper and copier ink for the computer lab printer is also obtained from the front office. If supplies are low or the ink reorder light comes on the printer/copier in the computer lab, it is the

student's responsibility to inform the front office. The ink cartridge will often need to be ordered so alerting the front office as soon as the light goes on is important.

Laminator Guidelines

The laminator is located in the front office(s) and is intended for use with therapy materials that will be used multiple times. Any requests for lamination over 10 pages need to be approved by the Supervisor. The laminator is only to be operated by the front office staff or other qualified staff. The front office staff will be glad to assist in all your laminating needs; however, you will be responsible for cutting the items apart once laminated. Do not cut apart your items prior to laminating as it wastes lamination. Place any UNCUT items that require lamination in the red Lamination Requests notebook (located in the mailboxes in the front office). Complete a "Lamination Request" slip and the Lamination Log. Attach the Lamination Request to your materials to be laminated and place in the red binder. Please remember to give the front office staff ample time to have your laminated documents ready (48 – 72 hours).

Shredding

All paperwork with any client information on it needs to be shredded. Never put any paperwork that has confidential client information into the trash, recycle bin or "shredding box." You will shred the documents yourself in the front office or the workroom/computer lab room 24. Do not put more than 5 sheets of paper at a time into the shredder. Remove any paper clips. Staples can be shredded.

Mailing Reports

If client/family request a paper copy in addition or in place of the Patient Portal you will need the following:

- Signed Completed Report – printed off.
- Completed Authorization for Release of Information form for each recipient – printed off.
- Stamp front page "Confidential," stamp located in front office desk drawer.
- If mailing hand to front office staff.

Clinic Forms Location

Clinic forms may be obtained from the front office files or **online at the *STW CDIS Graduate Students' community.*** To join, go to: **https://canvas.okstate.edu/enroll/9NB6MB**

Clinic Equipment Check-Out

The clinic has electronic equipment that can be used in therapy including digital recorders, FM Systems, iPads, PC laptop with CSL (Computerized Speech Lab/MultiSpeech key), sound level meters, audiometers, OAE, and tympanometer. Additionally, we have blood pressure cuffs, stethoscopes, peak flow meters and otoscopes. Equipment in the Voice Lab requires supervisor support.

If any equipment is not working properly, the administrative assistant or Clinic Coordinator should be notified immediately. They will help you problem solve or request a repair.

Do not store electronics in your office or in the workroom during normal business hours. Others may need them, and they are hard to locate if they are in offices. Check all electronics back in to the front office by 5:30. No overnight check out.

Procedures for checking out equipment:

1. Find the Equipment Checkout binder in the front office.
2. Fill out the appropriate form for the equipment you would like to check out.
3. Get the equipment from the shelves below the faculty mailboxes or iPad cabinet.

When you have finished using the equipment:

- Return all equipment to the clinic office immediately.
- Sign in the items on the appropriate sheet.
    - **Write a note and tell the Clinic Coordinator if an item is damaged or malfunctioning.**
    - **If equipment needs to be charged or batteries need to be replaced, inform the front office staff.**

After-hour's procedures:

1. Place all other electronic items in your cubby in the Material Room closet (out of sight)
2. First thing the following day (before therapy starts), return the items to the clinic office and sign them in on the appropriate sheet.

By checking out electronics, you are agreeing to accept responsibility for that item. If an item goes missing or gets broken, notify the Clinic Coordinator and/or clinic office staff IMMEDIATELY! They will help you problem solve or request a repair.

IMPORTANT: Electronic equipment **CANNOT** be taken out of the clinic or kept overnight. If equipment is needed at an off-clinic sight it can be checked out through your supervisor.

REQUESTING NEW IPAD APPS

We are able to get new iPad applications for our clinic iPads. However, OSU requires us to buy applications via a set process for legal reasons. To request an app for client use, complete the

iPad Application Request Form located online or in the front office and put it in the Clinic Coordinator's mailbox.

COMPUTERS, PRINTING AND COPYING

Computers in the computer lab, clinician workroom, supervisor's offices, GTA offices and seminar room have a printer connected to them. Stillwater student clinicians are to print any clinic paperwork from these computers to the copier in the front office. Remember select the printer in Devices and Printers on your computer that connects to the front office *if the material. is related to direct client care*. This printer to select for front office is MUR042-CANONirADVC5535 on casprint.cas.okstate.edu

If doing a project for a faculty member, the GTA/GRA/RA uses the copier in the front office.

If you are **printing classwork**, you must use the printer in the computer lab/workroom 024 as these supplies come out of "tech fees" paid every semester. For classwork, use the printer titled SSH042-CanonC58508.

Color Printing

If you should need color printouts for therapy materials, and you cannot print from the workroom to the office printer, you can email your documents to Errin Hanshew (errin.hanshew@okstate.edu) or Brooke Kraybill (brooke.grossman@okstate.edu). Please give at least 1 days' notice. Please be aware of which items need to be in color versus those that will work just as well in black and white. Please limit the number of color copies you request (5 pages or less).

RECORDING SESSIONS FOR MEDICAL RECORDS

https://ipivs.com/wiki/VALT_Manual

If you or your supervisor know you want to save the recording for the medical record, ask the front office for the Video Archive flash drive. This flash drive will need to be given to the front office staff along with a *Video Archive Record Form* (Section 2) so that it can be archived and placed in the patient file.

Client Reinforcers

When incorporating reinforcers in your therapy sessions you can find them in the front office. The reinforcers are intended ONLY for clients, not clinicians, siblings, or other visitors.

Feeding Supplies

Feeding supplies are found in the break room. Feeding supplies are only intended for use with clients. They are not to be eaten by clinicians.

- Feeding supplies should be labeled with an F before placed into cabinets or refrigerators.
- Once food has been opened it should be placed into a different container or baggie and labeled as feeding and the date opened.
- Chips and crackers can remain in their original packaging as long as it can be closed properly to maintain crispness.
- Always check the freshness of food before giving to a client
- ALWAYS clean your utensils after use. Do NOT leave dishes in the sink or drying rack. They must be cleaned and put away promptly-this means the same day.
- Prior to beginning therapy, sanitize the table.
- Prior to beginning therapy, you and your client must wash your hands.
- After therapy sessions, you must always clean the therapy room. This includes the tables, chairs, and floor. Vacuums, brooms, and mops can be found in the front office or in the clinic materials room. Sanitizing wipes are in the therapy room cabinets.
- Do not allow your clients to reach into food bags to get their own food with their hands.
- Notify a supervisor when laundry needs to be washed.
- *Always double check food allergies before presenting food to your client.

Ordering Feeding Supplies

- ❖ Assemble your grocery list weekly.
- ❖ Email your weekly grocery list to Ms. Ashley and your supervisor no later than 9:00 a.m. each Friday.
- ❖ Check all cabinets, including the black filing cabinet, and the refrigerator for the item BEFORE you order it.
- ❖ The grocery list MUST be detailed. For example. 2 red apples, 1 package long carrots, 2 heads of broccoli. Give brand names, if necessary, pictures and links are helpful.

CLEANING CLINIC

Twice a semester, each clinician is required to spend 2 – 3 hours cleaning the clinic areas as a part of a team. The sign-up sheet is posted at the beginning of each semester. The week the student clinicians are to clean, the *Cleaning Checklist* will be used to complete the job. Working together, the students will thoroughly complete all the items on the checklist and will then bring the checklist to the Clinic Coordinator or one of the Front Office staff to be approved. If the checklist has not been completed to the effect that is desired, you may then be asked to re-do the task to satisfaction.

CLEANING CHECKLIST – OSU Speech/Language/Hearing Clinic

Date:

Assigned Clinicians:
____

Clean on Friday after 2:00 p.m. Rooms to clean include **Clinician workroom – Room 24, Materials room 47, All therapy rooms, observation rooms, waiting area and break room.**

Cleaning supplies are located in the Workroom 047 cabinet and above the sink in that room. Vacuum/broom are in the Workroom's closet or front office. Dust Buster is supposed to be on bottom shelf of middle cabinet on west wall by closet.

Cleaning Duties Therapy/Observation Room 1 – 9, 50

________*Vacuum* tile floor (and rugs) in each therapy room and observation room.
________*Mop* the floors in the treatment & observation rooms with the Swiffer mop.
________ *Clean* BOTH sides of Observation Windows *with window cleaner.* Anything else leaves streaks.
________ *Remove* all therapy materials from therapy rooms and return to materials room – (except the car garage/ramp toy in cabinets)
________ Make sure all basic furniture is present in the therapy and observation rooms.
________ Straighten up all furniture in therapy rooms and observation rooms.
________ Clean tables in the therapy rooms with bleach spray and paper towel.
________ Fabric chairs can be cleaned with Lysol disinfect spray or a wet rag, upholstery cleaner if they have spots - no bleach spray disinfectant.
________ Disinfect the doorknobs, sink handles, and light switches.
________ Check supplies in each room (above sink or in cabinet) for items listed on page 2 of this Checklist. Restock supplies needed. (Most supplies are stored in main office and in workroom closet)
________ Put trash cans in hallway for removal by custodian.

Workroom 024

________Vacuum carpet.
________Clean up any trash/put trash in hallway.
________Wipe off/disinfect tables and computers.
________Clean microwave
________Check refrigerator for expired foods.

Materials Room 047

IMPORTANT: ROOM 47 - Fire regulations mandate no materials may be stored on top of the cabinets. Please remove and store any materials there in other places.

_______ Clean and organize materials in rooms 047. Put manipulatives, cards, and books on the correct shelf/bin.
_______ Cabinets should be organized and all boxes with labels, cards, and books should face outward so they can be read easily.
_______ If any toys in drying racks, return them to correct location.
_______ Wipe off/disinfect worktables and counters.
_______ Vacuum and mop floor

Waiting Room (040)

_______ Organize children's Books & Magazines back onto the rack.
_______ Wipe off/disinfect any toys and tables.
_______ Vacuum floor/rug if needed. Mop if needed.

SUPPLY CHECKLIST (Please restock what's missing. Return this sheet to Clinic Coordinator)

THERAPY ROOM	Kleenex	Paper Towels	Bleach Spray Disinfecting Spray	Hand Sanitizer	Tongue Blades	Gloves	Hand Soap
1							
2							
3							
4							
5							
6							
7(in cabinet)							
8							
9							
50							

Extra cleaning supplies in room 047 – big closet or above the sink. Kleenex, paper towels and other things are in the front office. **Ask the front office staff if you can't find something.** If more cleaning supplies need to be ordered let the front office and Clinic Coordinator know.

Appropriate Clinic Dress

We require that you either wear work casual clothes or black/gray scrubs. You can purchase your own scrubs anywhere. In Stillwater, the Uniform Shop offers a 20% discount if you tell them you are an OSU CDIS student. They are located at 1120 N. Duck (405 624-0625) or in Tulsa at the OSU Center for Health Sciences 1111 W. 17th St. Tulsa, OK 74107. (Phone: 918-561-1170).

- ❖ **You are only allowed to enter the clinic office and the clinic therapy wing if you are dressed by these guidelines.**
- ❖ **Sweatshirts and T-shirts are not allowed with scrubs. You must have a scrub top on with your scrub bottoms.**

Do's:

Wear your Student ID badge.

Designated colored surgical scrubs with provided OSU name tag (Nice athletic shoes may be worn with the scrubs)

OR

Work clothes including:

Summer dresses-either sleeveless or short sleeved (not spaghetti strap or halter)

Slacks, loose-fitting capri pants or crop pants

Dress sandals/shoes

Sleeveless or short sleeve Blouses

Do Not's (most of these apply in all settings):

Worn out Athletic shoes

Casual Sandals such as: Teva's, Birkenstocks, Doc Martens, "flip flops"

Baseball caps/hats

Overly conspicuous body jewelry

Jeans/Jean shorts

Dresses with spaghetti or halter straps

Backless Sundresses

Low Cut Shirts and Dresses

Excessive or dangling jewelry

Sweatshirts or T-shirts with pictures or logos

Leggings with T-shirt or short top

Short skirts

Crop tops

Visible tattoos

THERAPY MATERIALS ROOM PROCEDURES

Therapy materials are located in SSH 047. This room operates on an honor system. Clean and return the materials immediately after each session whenever possible. Check items in promptly when not in use. *Please do not store materials in room 24*.

Any materials being taken to an offsite clinic must be checked out in the office in the binder labeled equipment checkout. It must be returned the same day and checked back in.

Check out a whole kit (e.g., artic card box, game). By doing so you can keep all pieces in the correct container. ***Return items, sanitized (if needed), to the same location and organize the item/pieces. Do not shove items into random places. If items are broken or missing pieces take the item to the clinic coordinator to order a replacement.***

DIAGNOSTIC TEST MANUALS & PROTOCOLS

Diagnostic test manuals and protocols are NOT TO LEAVE THE BUILDING. All testing materials are locked in the cabinets. The keys to the cabinets are located in the front office. The keys need to be checked out every time you need into the cabinets and return them to the front office as soon as you have grabbed the test materials. The keys are NOT to be passed off at any time.

Diagnostic test manuals are located in the hallway. Tests are shelved by their acronyms *GFTA-3* for *Goldman Fristoe Test of Articulation – 3rd edition.* Test protocols are kept in the office. Do NOT take the last test protocol. Bring the last one to the Clinic Coordinator and she will order more.

Diagnostic materials are to be checked out and in by writing the information in the *Equipment Checkout* notebook in the front office. You MUST check diagnostics in and out. Many clinicians use the same diagnostic tests, and it is important that we know where they are at all times. If you are not actively using the diagnostic materials, return them immediately to Room 048. Do not leave them on tables, in offices, etc.

To take a test to an offsite location you must check it out and in as stated above. You must return it promptly after use. It may not be kept overnight.

You must RESERVE a test for a future evaluation in the Equipment Checkout notebook on the *Test Reservation* page. **The day you use it,** put that information on the *Checkout In/Out* page. Before you check out a test for review or an evaluation, double check that another clinician has not RESERVED it.

When looking over, administering, or scoring tests, **take the whole container** versus just the examiner's manual or test manuals. This will prevent someone else from taking the container and thinking all the pieces are there. It also prevents test manuals being put back in the wrong

container. It's really embarrassing to get into an evaluation without all the necessary materials. *Diagnostic tests can be checked out overnight for review only with the Clinic Coordinator's permission.* - Document this permission in the Equipment Checkout notebook.

Risk Management for Infectious and Chronic Communicable Diseases Policy and Procedures

It is important to maintain clean and disinfect materials. The OSU Speech-Language-Hearing Clinic must take proactive steps to prevent the transmission of infectious and communicable diseases. Reasons include:

1. Due to laws of confidentiality, the Clinic may be unaware if a client has a chronic infectious disease.
2. If the Clinic is aware of the chronic condition, the option of refusal of treatment may not be a possibility due to antidiscrimination laws, which have been adopted by many states. (COVID-19 does not fall under antidiscrimination laws).
3. It is hard to tell when someone has a contagious infection as there may be no overt signs.
4. We want to protect the health of our clients, staff, and students.

If you or our client has the following symptoms, do not conduct therapy.

1. Temperature over 100 degrees.
2. Diarrhea or vomiting.

You or the client should be symptom free for 24 hours before returning. If it was a viral or bacterial infection, you or the client can return after taking the antibiotic/antiviral medication for one full day.

PREVENTION:

The single most effective way to break the transmission chain is hand washing. The following hand washing technique is required before and after client contact:

1. Use liquid soap and lather hands, wrists, and forearms.
2. Rub hands vigorously with soapy lather for 60 seconds. Rub palms together, between your fingers, the back of your hands and under your fingernails.
3. Rinse thoroughly, allowing water to drain from fingertips to forearms.
4. Use paper towels to dry hands.
5. Turn off faucets and handle doorknobs with dry paper towels AFTER drying hands.

Hand washing is the key to prevention of transmission of communicable diseases. Accordingly, it is strongly suggested that **clinicians** wash their hands in the following situations:

1. Always before and after working with a client.
2. Immediately after coming in contact with saliva, blood, or other body fluids.
3. Before and after wearing latex gloves.

CDC also recommends that all **children** wash their hands.

- upon arrival,

- before and after eating,
- after using the toilet,
- after handling pets, pet cages, or other pet objects, • whenever hands are visibly dirty, and
- before going home.

In addition to traditional hand washing with soap and water, CDC is recommending the use of **alcohol-based hand rubs** (not towelettes) by health care personnel for client care. When using an alcohol-based hand rub, apply product to palm of one hand and rub hands together, covering all surfaces of hands and fingers, until hands are dry. Note that the volume needed to reduce the number of bacteria on hands varies by product.

At the end of each treatment or diagnostic session, tabletops, chairs, and work surfaces in treatment rooms will be cleaned with an EPA recommended disinfectant or a bleach solution (1/4 cup bleach + 1 gallon of water or 1 tablespoon beach + one quart**.) Thoroughly wet the surfaces and allow the disinfecting solution to remain on the surface for the recommended amount of time for disinfecting.**

Paper towels, disinfecting spray and spray bottles containing bleach solution can be found in therapy rooms' closets and in the material's room (047). *Make sure that the bleach solution is stored away from children in the cabinets/closets when you have finished.*
Procedure:

1. Spray the table (top and edges) and chair with solution. Minimum contact time to disinfect depends upon the product and can range from 5 minutes to 10 minutes.
2. If no one is in the room after you, you can let it air dry. Otherwise, after the required amount of time, put on gloves and wipe excess moisture off with paper towel.

Disinfect commonly touched areas including doorknobs and light switches in the therapy room and observation room before leaving.

Play materials used in treatment and diagnostics will be cleaned after *each* use with the bleach solution. This is the responsibility of each clinician.
Procedure:

1. Put toys to disinfect in tub. Put on gloves. Pick up a toy, spray with solution. Place toy in dish drainer to dry.
2. If toy needs to be used right away, wait 10 minutes minimum and wipe dry.
3. If toy does not need to be used right away, leave in dish drainer to air dry**. It is the clinician's responsibility** to return toys to their place the next day.

Toys which cannot be easily cleaned such as stuffed toys or toys made with fabric should be used at the clinician's discretion. If such objects should come in contact with bodily fluids, please consult with your supervisor and Clinic Coordinator regarding future clinic use. These toys are machine washed periodically, but if they get used frequently, the Clinic Coordinator should be informed so that more frequent washing can be performed.

Books, articulation cards, games and other items that cannot be washed can be stored overnight before returning them to their shelf. Do this if your client has obvious cold symptoms. Most germs will not survive on a surface after this length of time (most germs will die within 20 minutes to 2 hours).

SECTION 4

END OF SEMESTER INFORMATION

END OF SEMESTER PROCEDURES

1. *End of Semester* memo is sent to clinicians and supervisors by Clinical Coordinator.
2. Clinician writes draft of Semester Progress report.
3. Schedule final end of semester conferences with clients and/or family – last week of therapy.
4. Clinicians checks authorization and consent forms are complete and in the EMR.
    - *Authorization for Disclosure of Protected Health Information* – for any progress report to be sent other than to the client and/or the parent.
    - *Client/Parent Confidentiality Statement*
    - *Permission for Clinical Services*
    - *Permission to leave telephone messages and electronically transmit information*
    - *Notice of Privacy Practice/Receipt of Notice of Privacy Practices Written Acknowledgement*
    - *HIPAA Email Consent*
    - *Informed Consent to Participate in Teletherapy* (AS NEEDED)
5. Finalize all reports/notes in EMR.
6. Put all diagnostic protocols, in "Routine Daily Scanning" file in front office.
7. Confirm correct email address for client so that the report can be sent via the Patient Portal in CounselEar.
8. Check which professionals other than the referring physician the family/client want reports sent to. Confirm there is a signed *Authorization for Disclosure of Protected Health Information* in the EMR for that person. (these reports will be faxed from the EMR)
9. If client or family request a printed copy to be mailed, make copy of finalized Progress Report and *Authorization for Disclosure of Protected Health Information.* Create a cover letter for each report to be mailed using cover letter template in front office. (See Cover Letter instructions below.)
10. Before final supervisor meeting, complete an *Evaluation of Clinical Experience* for that supervisor (on Typhon)
11. Complete evaluation of yourself *Student's Self-Evaluation of Clinical Skills.*
12. Forms for student to complete/bring to final supervisor meeting and review
    Student's Self-Evaluation of Clinical Skills
    CTBS or DEACTIVATION Form
    Checklist for Final Supervisor-Clinician Conference.
13. Check the minutes on SOAPs and Evaluation against those recorded in *Typhon.*
14. Fix any clock hour errors identified on the Typhon program.
15. Make a copy of the signed *Supervisor's Evaluation of Clinical Skills* for your records.
16. In the file cabinet in the office, file the client's *CTBS or Checklist for Deactivation of Client Folder* forms, *Clinician's Schedule* (for next semester), and *Checklist for Final Supervisor-Clinician Conference* form.

Checklist for final Supervisor – Clinician Conference

This form is to guide the clinician and supervisor through the necessary steps in completing the semester's clinical work and as a guide for the final conference. Take this to the conference on each client. Check the columns as they are completed. Forms are given to the clinic coordinator by filing them in the appropriate folders in the designated Student Confidential box in the clinician workroom.

CLINICIAN ________________________________ CLIENT TIME/SITE_________________________

1	Client's Electronic Medical Record (EMR) complete and filed/scanned correctly by date	**C**	**S**
	Completed Authorization to release of Information form(s)		
	Signed Permission for Clinical Services form		
	Signed Receipt of NPP Acknowledgment form		
	Signed Client/Family Confidentiality form		
	Signed Permission to leave telephone messages & electronically transmit information		
	Signed HIPAA E-Mail Consent		
	Signed Informed Consent to Participate in Teletherapy		
	End of Semester family conference reported in SOAP		
	SOAPs finalized		
	Treatment Plan(s) finalized		
	Progress Report finalized		
	Completed test forms (with client name, date of testing, clinician's name)		
	Evaluation Report Finalized (if applicable)		
	WTP'S -dated and formatted		
	Examples of work, visual aids – (if applicable – with client name & date)		
2	Final conference with supervisor held		
	Student Evaluation (completed on typhon) of supervisor		
	Student's Self-Evaluation of Clinical Skills completed and reviewed w/ supervisor		
	1) all therapy dates /visit dates correct in CE		
	2) front office alerted if client's address has changed		
	Clock hour record – verified and finalized by supervisor in Typhon		
3	Disposition information (one or the other)		
	1) CTBS completed and signed by supervisor and clinician		
	2) Procedure for Deactivation of Folder form completed and turned in if client is dismissed and folder is complete.		

DEADLINES FOR THE CLOSE OF THERAPY

Final Therapy Dates

1. Last Day of Therapy: **Friday, November 22nd / Friday April 25th (**unless arrangements made with supervisor)
2. Parent conferences completed by: **Friday, December 6th / Friday May 2nd** unless arrangements have been made with your supervisor.
3. Final supervisor/clinician meeting completed by **Friday, December 6th / Friday 2nd .**

Progress Reports

4. First Drafts of Progress Reports Due: **Tuesday, November 12 / Tuesday April 15** (Discuss with supervisor). All patients must have a progress report for each semester.
5. **Supervisors**: Return First Drafts By: **Friday, November 15th / Friday April 18.**
6. **Clinician:** Please have second drafts to them no later than **Tuesday, November 19th / Tuesday April 22**. At this point, clinicians should have all the final progress data collected and can insert the numbers and description of final skills.
7. Supervisors return Second drafts by **Friday, November 22nd / Friday April 25th** .
8. **Clinician:** Finalized Progress Reports in EMR Due **Tuesday December 3rd / Tuesday April 29th .** (This date is a MUST).

Supervisor Meetings/Grades

1. **Prior to Final Supervisor Meeting:** The *Student Self Evaluation of Clinical Experience* (available for preview in the clinic manual) must be completed before you meet with your supervisor. Complete the evaluation online via the Typhon website. The supervisors/faculty will be given your evaluation of them AFTER your grades are submitted and there is no identifying information. It is important to us that you give honest feedback on strengths and weaknesses so that we as supervisors can continue to improve.
2. Before meeting with your supervisor, score yourself on the *Student's Self-Evaluation of Clinical Practicum* using the *Competency Level Descriptors* included in your clinic manual appendix, Canvas STW_GraduateClinicManual, Typhon website or available in the front office.
3. Individual Clinician-Supervisor Grade Conferences should be held PRIOR TO **Friday, December 6th / Friday May 2nd.** Have the Checklist for Final Supervisor-Clinician Conference and your Student's Self-Evaluation of Clinical practicum available. Clinicians should check to make sure their Daily Clock Hour Form matches the minutes documented in your SOAPs/Evaluation reports so the supervisor can verify your time and you can put into Typhon during or after the final meeting.
4. Sign and make a copy of each *Supervisor's Evaluation of Therapy Practicum* for each client or site. Keep one for your records, send the Clinic Coordinator one of the signed forms also.
5. Clinic Grades Due to the 5210 Instructor: NO LATER THAN **Friday, Dec 13 / May 9th.**

Final paperwork

1. EMR documentation Must Be Completed by: **Tuesday December 3rd / Tuesday April 29th.** (The Checklist for Final Supervisor-Clinician Conference will help you in this process.)

This includes ALL reports, treatment plans, release of information, confidentiality statement, etc. Missing paperwork will result in a grade of "I" for practicum.

2. Submit the patient's CTBS (for schedule in fall) or Deactivation Form (for discharge from program) by **Friday December 6th / Friday May 2nd.** PLEASE complete ALL of the CTBS forms before turning in (It really slows me down when I have to look up phone numbers and people's names when I am trying to schedule the next semester's clinic).
3. Please submit your Spring Clinician Schedule by **Friday, December 6** / **Summer Clinician Schedule Friday May 2nd.**

Sending reports: Client reports will be sent in the Patient Portal in CounselEar to the clients and their families unless you inform the front office that they want it mailed. Referring physicians will be faxed the report by the front office through CounselEar. For additional recipients, the Clinicians and Supervisors must check the patient's DOCUMENT tab in CounselEar for current Authorization for Disclosure of Protected Health Information. Parents/clients and referring physicians do not need an Authorization for Disclosure of Protected Health Information - any other additional recipient must have a signed Authorization form.

SUPERVISORS -- Once the progress report has been finalized and is ready to be sent and all Authorization Forms are verified, send a TO DO task to Brooke and Errin in the front office. (Report - ready to be sent in dropdown) Make sure you put the date of the Progress Report visit so they can identify the correct report quickly.

In file cabinet of office, place the following:

Clinician's schedule for next semester: Due by **Friday, December 6** / **Friday May 2nd.**
CTBS or Deactivation Forms: Due by **Friday, December 6** / **Friday May 2nd.**
Checklist for Final Supervisor-Clinician Conference by **Friday, December 6 / Friday May 2nd.**

End of semester client/family conference; SOAP procedure; Clock hours

In addition to occasional conferences that may be conducted by the clinician throughout the semester, it has been the policy of this clinic to schedule routine conferences at the end of each semester. Conferences are also scheduled prior to a client's dismissal from treatment. These client/family conferences are documented in a SOAP.

During these structured conferences, the clinician defines the short- and long-term therapy goals; presents a comparison of past and present speech, hearing, and/or language behavior; explains the therapy approaches and techniques employed to attain treatment goals; discusses the response and progress in therapy; and outlines the recommendations. Often a presentation of therapy materials and a brief recording of the client's therapy session are valuable tools for

clarification. In some cases, the parents have been actively observing and discussing the treatment throughout the semester, whereas other parents may not have participated as actively. The clinician needs to consider the structure of the conference based upon the needs of the family at that time.

The clinician is expected to be organized and well prepared with a relaxed attitude. The conference room should be free of interruption. It may be easier to have a discussion with the parents of a very young client if the client is not brought to the conference. Ideally, the conference is a **dialogue** with the parents commenting or questioning, rather than a monologue by the clinician. It is important to stick to the point and not let the discussion drift into irrelevant topics.

SOAP Note

The family conference will be reported in a SOAP note. If you conducted therapy that day, put all information in one note (therapy results + family conference objective). Just **add a new objective # after your last session objective.** The goal will look something like:
Objective 6: An *end of semester family conference will be conducted, and progress and further recommendations discussed*. You can find a template of this goal in Counselear.

If you are **just conducting the family conference** – no therapy, delete all the STO and make it the only objective, Objective 1: An *end of semester family conference will be conducted, and progress and further recommendations discussed*.

In the **O** section after the Objective, write a brief summary of the information presented to the client and/or family.

The client/family response and any new information gathered from the family are included in the **A** section– as it is more subjective.

The **P** section would include any recommendations for continued therapy or for dismissal.

Scheduling and Clock Hours for Client Conferences

Family/client conferences are considered family education and are considered by ASHA and insurance companies as part of therapy. No special scheduling is required in the EMR – it is considered treatment. Clock hour minutes for conferences are entered the same as treatment session minutes. In typhon, you will code the session as Treatment in the same categories used during the semester (e.g., speech, voice).

INTRODUCTION TO PROGRESS REPORT

Although the format needs to be consistent, the content should be flexible and will depend upon your supervisor's guidelines.

The rough draft of the Progress Report is written in its entirety and submitted by the clinician at the close of clinic each semester or anytime a client is discharged. **The clinician is expected to proofread the report carefully and to check spelling and punctuation before submitting the first draft to the Supervisor.** You may want to discuss progress with the supervisor and outline the contents of the report before starting to write. Many considerations are involved in a report including the following:

1. Who are the intended audiences? Will they be able to understand it? Did you give examples for professional terminology?
2. What evidence can be submitted for statements made? Will the next clinician know the level attained by reading this report? If you were discussing the case with the next clinician, what would you tell him/her?

Procedures for Writing Progress Reports

1. CounselEar allows you to pre-date the report by creating a visit for the day of or day after the last planned day of therapy clinician.
2. Make your next semester recommendations as specific as possible. If you were the next clinician and had never seen the client, what would you want to know?
3. Follow the deadlines on *the End of Semester* memo.

Writing Guidelines for Professional Reports

1. Use third person pronouns (e.g., he, she, they) and names (John, the clinician) instead of "I, we, you."
2. Use one tense throughout the document – preferably past tense. Whoever is reading the report will be doing so after the event. (e.g., John, a 3 year 4-month-old male, was seen at the OSU…). Future tense is appropriate for Objectives, Recommendations and Plans. These will be in future tense (e.g., The client will …; the client should be given preferential seating the classroom).
3. Abbreviations may be used as long as they are meaningful to those reading the note. The first time an abbreviation is used, write out the entire word and then include the abbreviation that will be used for the rest of the document.
   For example: Pressure Equalizing tubes (PE tubes).
4. Diagnostic Test names should be written out and italicized the first time used. Abbreviations for test names are also italicized.
   For example: *Preschool Language Scales – 5 (PLS-5)*
5. You can choose to use numbers or write out the words for the number.

6. DO **NOT** cut and paste from any program including CounseEar. It will mess up the formatting so much that it is difficult to fix. It is quicker to re-type it.
7. Do **NOT** use IPA symbols in reports they do not work correctly in counselear.
8. When creating professional reports, make sure to **PROOF the PDF** in CounselEar and fix any spacing and line issues prior to sending to your supervisor.

Components of Progress Report Sections

The information in **BOLD** are the section headings in CounselEar.

HISTORY
CLIENT INFORMATION (Use template in CounselEar history section)
Birthdate:
Age:
Address:
Parents/Guardian: (delete guardian if not applicable or both if client is an adult)
Telephone:
Referred By: (referring physician should be listed first)
Date: (Day after last day of therapy)

DIAGNOSIS:
Current Diagnosis
ICD-10: (check with supervisor and/or CTBS form to make sure you have the correct codes)

Always include any **medical diagnosis** as well as speech/language/hearing codes. Chronic Otitis Media, Down's Syndrome, Prematurity – all impact communication and provide a "medical necessity" component that is required by most insurance companies.

CLINICAL SCHEDULE
Sessions per week
Number of Clinic Visits

REASON FOR REFERRAL (Use template in EMR) – *Needs to be updated each new report.*
Introduce this brief summary by describing the client in terms of

- his/her age,
- medical/developmental diagnosis,
- who referred,
- type of speech services received.
- Described any important medical or developmental conditions & include dates (i.e., date of onset), when appropriate.
- Include the severity of the speech/language disorder at time of diagnosis, and current status, if changed.

(If there were past diagnostic reports that go into detail about the medical and/or speech/language disorder, refer to them instead of rewriting all the details.)

- If *new* medical, educational, environmental and/or speech/language/hearing information was obtained over the semester from an outside source, include it here.
- *Briefly summarize the current semester's objectives and progress. If behavioral, attendance, or other factors influenced overall progress, include it here.*
- Child's native language and if therapy was conducted in it - or what accommodations were made.

*NOTE: All speech/language diagnostic information done in this clinic must be written up in a "formal" report for it to count toward ASHA diagnostic clock hours. There are several formats for reporting diagnostic information depending upon the amount of testing done. If testing was a stated Objective on the Treatment Plan or a SOAP Note, it should be written up as a Speech/Language Evaluation for the date(s) of testing and then briefly summarized in the corresponding Objective in the corresponding section of the Progress report. If it is a small amount of information (like a *Goldman-Fristoe 3* summary), the results could be written on the Daily Therapy Note and then re-summarized in this report under the corresponding Objective.

EXAMPLES of Reason for Referral:

Jane, a ten-year-old female, was seen at the OSU Speech-Language-Hearing Clinic this semester for articulation and language therapy. Jane was diagnosed with a moderate to severe language disorder, mild articulation disorder and a moderate to severe cluttering disorder on June 20xx by the OSU Clinic (see report for full details). She had also been diagnosed with Attention Deficit Disorder – Impulsive Type by the Child Development Center in Oklahoma City (see report dated September 19, 20xx). She also received speech and language therapy services from her local public school. Significant progress was made on the treatment goals this semester focusing on improving Jane's reading skills, speech rate, and sociolinguistic and pragmatic skills. Therapy was conducted in English, Jane's native language.

Ms. Smith, a 45-year-old female, was seen for voice therapy at the OSU Speech-Language-Hearing Clinic during the Spring 20xx semester. Ms. Smith was referred to our clinic due to her recent diagnosis of dysphonia by Dr. W of Tulsa ENT group. Dr. W diagnosed Ms. Smith with silent reflux and dysphonia in December 20xx. Her chief complaint was having a "tired and weak voice" that interferes with communication at work and home. Ms. Smith has a history of vocal nodules diagnosed 5 – 6 years ago. These were removed by laser and she received voice therapy for several months at the OCU Medical Center. Objectives this semester have focused on easy on-set of voice, elimination of vocally abusive behaviors, and appropriate diaphragmatic breathing. Ms. Smith met all her goals this semester.

John, a 7 year 6-month-old male, has been receiving language and articulation therapy since June 20xx at the OSU Speech-Language-Hearing Clinic. He also received therapy through XX Public School. He displayed a moderate expressive language disorder, mild receptive language disorder, moderate pragmatic deficits, and a moderate articulation disorder at the time of the

initial evaluation. Although the mother had taken John to numerous physicians, no formal diagnosis had been given. The school was conducting a three-year re-evaluation and the results should be available by next semester. Therapy this semester has focused on maintaining eye contact and appropriate rate during activities, understanding the concept of sequencing with 3 – 4 steps, increasing his understanding of basic concepts, and increasing phonemic awareness. Inconsistent progress was made on the objectives this semester due to inconsistent attendance. John was scheduled once weekly, and he attended 8 of the possible 14 sessions. John speaks both English and Spanish and therapy was conducted in both with a bilingual clinician.

RESULTS SEMESTER PROGRESS

LONG TERM OBJECTIVES (Use template in CounselEar results section)

- Should be the same as that on the evaluation and/or treatment plan. If circumstances and/or progress/lack of progress require a change in this objective, state why and set new long-term objectives at the end of the report. If Objective has been MET, add that here.

EXAMPLE: The client will demonstrate developmentally appropriate receptive and expressive language skills in day-to-day communication 90% of the time within one year. **GOAL MET**

SHORT TERM OBJECTIVES (Use template in CounselEar results section) **Objective #1, etc.** Use Semester Objectives from the TREATMENT PLAN and any new ones added on the SOAP Note. Use the same numbering system (e.g., 1, 2.)

PROGRESS/RESULTS (put under each Objective)

First Paragraph- After each behavioral objective write a brief statement summarizing procedures and methods used. Don't list activities unless they're important to treatment planning (e.g., See Example 2.)

Second Paragraph- Write information about baseline performance. This is important to objectively document progress over the semester.

Third paragraph- Write progress made toward each objective. *Describe strengths as well as skills the client continues to struggle with.* This will help justify next semester's recommendations that follow and give the next clinician a better idea of the client's skills.

Example #1

Objectives #1: The client will maintain fluent speech with a dysfluency rate that does not exceed 5% in natural settings.

Progress/Results

Initially, Mr. Wolf was taught the skills of fluent speech: nasal inhalation, minimal amount of oral exhalation prior to initiation of phonation easy phonatory onset, and vowel prolongation. Therapy was started at the modeled word level and progressed to words, phrases, sentences, and conversational speech in the clinic. Verbal reinforcement was provided. Corrective feedback was given for dysfluencies or failure to manage a target behavior. Mr. Wolf was then required to correctly repeat his utterance. After the client had progressed to conversational speech, he was taught to chart his dysfluencies and failure to use a target behavior. Mr. Wolf orally read stories and then summarized what he

had read. Other graduate clinicians periodically participated in the treatment session to engage in conversation with the client.

In two clinic baseline samples of a conversational speech and a home baseline sample, Mr. Wolf's dysfluency rates were 22%, 21%, and 19%. Each sample consisted of 50 utterances sampled from the client's conversational speech.

Two clinic samples and a home sample were obtained after the client began using the target fluency skills in conversational speech at the end of the semester. Each sample consisted of 50 utterances sampled from the client's conversational speech. Dysfluency rates were 15%, 12%, and 10%. An analysis of the two samples taken in the clinic were further analyzed with the following results:

Dysfluency Types	**Frequency**
Interjections	23
Pauses	17
Part Word Repetitions	1 Whole Word
Repetitions	3 Phrase Repetitions
2	
Sound Prolongations	20
Silent Prolongations	6
Incomplete Phrases	2

The results show Mr. Wolf's fluency improved over the course of the semester. He was about 21% dysfluent at the beginning of treatment compared to 13.5% at the end of the semester.

Example #2

Objectives #1: The client will increase his MLU to 2.75 during a 10-minute conversation.

Progress/Results

Play therapy activities were used to elicit language. The clinician would comment on activities and would expand the client's single word and two-word utterances using the targeted language structures. The client enjoyed activities with balls, cars, puzzles, and realistic toys, but had a very adverse reaction to different textures such as play dough, glue, and finger paints.

A language sample was taken during the semester. At the beginning of the semester, the client had mostly two-word utterances with a MLU of 1.75. Sentence types were primarily Subject – Verb or Verb- Object,

The client made significant progress toward this goal over the course of the semester. His MLU at the end of the semester was 2.66, which remained one standard deviation below the norm for his age. According to the predicted age range of 31 – 34 months, a delay of approximately 20% in syntactic development was seen. Some of his sentence structures were missing the verb. No nouns were used as subjects, only pronouns. Many of the nouns that should be used as the subject were at the end of the sentence as in "Do go up bus" when the gloss was "The bus is going up." The language sample showed his use of "do" to request and as a declarative in 30% of his utterances. The abnormalities of the language he used suggested that a language disorder was present in addition to the language delay.

Summary/Diagnosis

(Use template in CounselEar results section)
This section should provide an adequate basis for understanding the recommendations. A short paragraph summarizes progress (no numbers), based upon your above report. New information should not appear here if it was not referred to in the body of the report. **Describe the current diagnosis; also give an indication of severity.** Include information about hearing acuity for SoonerCare clients. The summary section can also include the strengths and weaknesses of the client.

D.R. met or made progress towards all of his short-term goals in articulation and language. Observation in therapy indicated that DR would benefit from language goals that address pragmatic deficits in the area of turn-taking and asking/answering "WH' questions. He also continued to demonstrate speech intelligibility issues that would be considered fair to good with the context known and poor to fair if context was not known or the listener was unfamiliar. For these reasons, his speech/language deficits would continue to be considered moderate to severe in nature depending upon the listener and the context. Hearing acuity was screened this semester and results were normal for both ears.

Recommendations:

THERAPY RECOMMENDATIONS (use template in CounselEar Recommendation section) This section should BEGIN with recommendations regarding the need for speech/language or discharge. **Start by providing a** summary sentence related to progress along **with a statement of continued severity**. Then add specific suggestions for the number of sessions per week. (Do not put down the amount of time you are recommending, just the number of days per week.)

Example:

While D.R. made good progress in all speech/language areas, he continued to demonstrate moderate impairments in receptive and expressive language. It was recommended that he continue to receive language therapy twice weekly for treatment of his receptive/expressive language delay focusing on the objectives below.

If your client is <u>SoonerCare</u> **a statement of medical necessity can go here.**
Due to XX significant language delays, secondary to her diagnosis of Down Syndrome and chronic middle ear dysfunction, the client is at risk for continued language deficits without skilled speech therapy services.

Long Term Objectives

(use template in CounselEar Recommendation section)
Long-term objectives must be **measurable.** They can be the same long-term objectives as written in the Results section of your report but can be changed as needed for client changes in performance.

Examples:

1. The client will increase speech intelligibility with unfamiliar listeners in conversation to 80% intelligible.
2. The client will demonstrate age-appropriate expressive language skills as measured by standardized testing, MLU and completion of short-term objectives at 80%.
3. The client will demonstrate *developmentally* appropriate pragmatic, expressive, and receptive language skills in conversational speech 75% of the time.

The client will improve his functional communication in home and school settings so that familiar listeners understand basic wants and ideas over 50% of the time.

Short Term Objectives

All short-term goals **MUST** include measurable criterion and be specific to the skills to be addressed– don't just say improve receptive language, give the specific areas to work on and at what level and what % correct.

With SoonerCare children (and most children), you must have a goal that shows that the parent/guardian is an active participant in the therapy session – either by completing a home program that is documented complete and/or a communication journal/e-mail summary of therapy sent weekly to the parents.

As of August 2021, SoonerCare was requiring a statement of medical necessity on each STO. See examples below in the section of SoonerCare Requirements for examples.

In addition to a parent/home program objective, it is recommended that you have a yearly speech/language/hearing evaluation objective with the month/year it needs to be completed.

Example:

Short Term Objectives:

1. The client will initiate and expand topics with appropriate turn-taking 75% of the time.
2. The client will consistently use plurals, prepositions, and possessives at the conversation level 90% of the time.
3. The family will participate by observing therapy and completing a home program focusing on the above goals more than 50% of the time.
4. Yearly re-evaluation of D.R.'s current speech, language skills and hearing acuity will be conducted in September of 20XX.
5. Communication will be maintained with Stillwater Public Schools, and other professionals currently treating D.R. on a monthly basis.

Prognosis

(use template in CounselEar Recommendation section)

The prognostic statement should include the probability of the client reaching your long-term objective, why (reasons) you are making this prediction, and anticipated length of treatment. Here are your choices:

PROGNOSIS (*select the prognosis factors, range, and the length of time from the parenthesis and then delete the parenthesis)*

Due to the client's *(motivation - Age - Family support - Severity of disorder- progress thus far)*, prognosis for improvement with skilled speech treatment is *(Excellent, Good, Fair, Poor)* for the client to reach the long-term objectives listed above. It is anticipated that the client will need at least (*a year - 6 months) of* treatment to obtain this level of functioning.

Example 1 **(more than one long term objective):**

Due to age-appropriate receptive language skills, family support and client motivation, the prognosis for improvement with skilled speech treatment is good for the client to reach the long-term objectives listed above. It is anticipated that the client will need at least a year of treatment to obtain this level of functioning.

Custom

(use the template in CounselEar custom section)

Attestation Statement **SOONERCARE ONLY**

I actively participated in the formulation of this progress report and agree with the statements and the objectives documented here.

Certificate of Medical Necessity Statement **MEDICARE ONLY**

It will be understood that the treatment plan mentioned above is certified medically necessary by the documenting therapist and referring physician mentioned in this report. Unless the physician indicates otherwise through written correspondence with our office all further referrals will act as certification of medical necessity on the treatment plan indicated above.

Thank you for this referral. If you have questions regarding this plan of care, please contact us at (405)744-6021.

I certify the need for these services furnished under this plan of treatment while under my care.

___I have no revisions to the plan of care.
___Revise the plan of care as follows.
____
____
____

Physician Signature____
Physician Name____
Date: _______________________

Referring Physician

- Select the name of the referring physician or add it if not in CounselEar. Select FAX as the preferred delivery.
- Create a FAX and Cover Letter from the tabs/dropdowns in CounselEar.

Additional Recipients

- Put family or adult client here. Select EHR and create a cover letter using the tabs/dropdowns.
- Select other professionals/individuals the client has signed an *Authorization to Release Protected Health Information* form for. Select FAX as the preferred delivery and create Fax Cover and Cover letter from the tabs/dropdown.

CC

The referring physician and any additional recipients should show up automatically.

Report Attachments

Add any PDF file to the report here. Best option for large tables created in WORD or use of IPA symbols.

Report Options

Choose Progress Report for the title.

Patient Portal

Make sure the box is checked immediately prior to finalizing the report, after all edits have been made.

Progress Report Checklist

CLIENT INFORMATION	
	Age: Report in year/month up to adolescents; matches Reason for Referral
	Birthdate (optional)
	Address
	Telephone
	Parent/Guardian (delete Guardian/Parent if not appropriate)
	Referred By: Put referring physician/physician assistant/nurse before parent
	Current Diagnosis: (severity and communication disorder & medical etiology
	ICD-10-CM: (No F codes for BCBS. Use R codes)
	DATE (Last day of therapy + does it match the visit dates in CE)
	Time in / Time Out:
	Total Minutes:
REASON FOR REFERRAL – SoonerCare-be specific & detailed they don't read past reports	
	Name of client (refer to client in same form throughout)
	Past tense
	Describe client
	• Age (matches Age in Client Information above)
	• First time seen in clinic / severity / dates
	• Who referred (must for SoonerCare) and why
	• Past and any NEW medical/development diagnosis(s) or therapies
	• Current communication status/severity
	• Briefly summarize the goals and progress this semester
	• If any behavioral, attendance, or other factors effect progress
	• Native language of client and if therapy was conducted in it (SoonerCare)
LONG TERM OBJECTIVES (same as Treatment Plan)	
PROGRESS TOWARDS SEMESTER OBJECTIVES – 3 paragraphs for each objective	
	Paragraph 1 Brief Summary of procedures/methods (don't list activities)
	Paragraph 2 Baseline performance a. % plus numbers (e.g., 90% and 9/10) b. Level of cueing
	Paragraph 3 Progress toward objective a. % plus numbers (e.g., 90% and 9/10) b. Level of cueing c. Describe strengths as well as common errors
SUMMARY/DIAGNOSIS (no new information)	
	Summarizes progress from report / Current functional level
	Describes diagnosis and severity (include medical DX)
	Briefly include strengths and weaknesses

	Hearing Acuity (MUST be reported for SoonerCare – report last screening results)
THERAPY RECOMMENDATIONS	
	Recommendations regarding need for SKILLED speech/language
	Number of days per week of tx
	Medical necessity for skilled speech/language therapy (must for SoonerCare)
LONG-TERM OBJECTIVES	
	SoonerCare prefers a LTO for each major area addressed in the STO-lang, speech, feeding, etc.)
	Each LTO has the following parts ☐ Performance ☐ Condition (optional) ☐ Criterion
SHORT -TERM OBJECTIVES	
	If SoonerCare, each objective must have a statement on medical necessity
	Each STO has the following 3 components ☐ Performance ☐ Condition ☐ Criterion
	Include family objective/home program (must for SoonerCare)
	Include need for speech/lang/hearing re-evaluation in one year (must for SoonerCare)
PROGNOSTIC STATEMENT	
	Probability of client reaching LTO, why, and length of time – 6 months or one year
ATTESTATION STATEMENT (SoonerCare)	
MEDICAL NECESSITY STATEMENT (Medicare)	
REFERRING PHYSICIAN (separate section in CounselEar)	
	Select the name of referring physician or add if not in CE
	Check that the name is correct. Select FAX as the preferred delivery
	From Tabs, create a FAX and Cover Letter from the dropdowns in CE
ADDITIONAL RECIPIENTS (separate section in CounselEar)	
	Parent of Client's name entered
	Edit recipient and Select EHR as preferred delivery
	Make sure client email is present -if not add – or it will not email to them
	Create a Cover Letter using the tabs/dropdowns
	Select any other professionals/individuals the client has a signed *Authorization to Release Protected Health Information* form for. -Select Fax or Email (EHR) options for others and create appropriate Cover Letters.
CC: - Should automatically populate if you did the above correctly	
REPORT OPTIONS (separate section in CounselEar)	
	Evaluation Report selected on dropdown
	Formatting is correct - CHECK PDF OF REPORT
REPORT ATTACHMENTS (separate section in CounselEar)	
	PDF only can be attached – use for any IPA symbols you need as they can't go in tables/charts

PATIENT PORTAL (separate section in CounselEar)	
	Box checked before finalizing report
SUPERVISORS	
	Sent a TO DO to front office to send reports to client/family and medical professionals. • Send date and name of report in the to-do
PROFESSIONAL GRAMMAR AND WRITING STYLE	
	☐ No first-person pronouns ☐ Past tense ☐ Complete Sentences
	☐ Sentence structure not over complicated or wordy
	☐ Correct Formatting of report/paragraphs/headers **-CHECK PDF OF REPORT**

Progress Report Example

CLIENT INFORMATION

NAME:	Jeff Brown
AGE:	2 years, 8 months
ADDRESS:	1 North Street Perkins, OK 74059
PARENTS:	Jim and Sally Brown
TELEPHONE:	(405) 555-5555
REFERRED BY:	Dr. Clark, Lynn Jones, M.A., CCC-SLP
DATE:	7/19/XX

DIAGNOSIS:
Current Diagnosis: Speech and language delays secondary to Autism Spectrum Disorder
ICD-10: F80.0, F81.2, F84.0

CLINICAL SCHEDULE
Sessions per week- 2
Number of Clinic Visits- 12

REASON FOR REFERRAL
Jeff Brown, a two year eight-month-old male, was referred to the Oklahoma State University Speech-Language Hearing Clinic for speech and language therapy by his physician, Dr. Clark and his SLP, Lynn Jones from Sooner Start. This summer Jeff was diagnosed as being in the mild to moderate range of the Autism Spectrum Disorders after being seen by developmental psychologist, Dr. Diana Mobley. Jeff attended all of the scheduled sessions (12/12). Therapy goals for Jeff this semester focused on joint attention, imitation, turn taking, eye contact and an introduction to initiating requests. Therapy was conducted in English which was Jeff's native language.

RESULTS/SEMESTER PROGRESS

LONG TERM OBJECTIVES
The client will demonstrate developmentally appropriate receptive/expressive language skills in day-to-day communication 90% of the time within one year.

SHORT TERM OBJECTIVES
Objective #1: The client will engage in joint attention of objects or activities during play with a clinician or other individual eight times per one structured activity.

Progress/Results
This goal was targeted in both individual and group therapy. This goal focused primarily on engaging Jeff's attention to toys and activities that included more symbolic, imaginative play versus toys with repetitive motor actions, such as stacking blocks and nesting cups.

At the beginning of the treatment period, Jeff shared attention to activities and toys that were simpler and more repetitive in nature an average of five times per session.

At the end of the treatment period, he engaged in joint attention to more abstract, imaginative activities an average of ten times per activities of high interest.

Objective #2: The client will imitate the clinician or other individuals' actions, sounds or prosody five times per one structured activity.

Progress/Results

This goal was targeted in both the group and individual sessions and focused on Jeff's imitating actions and prosody. Vocal play such as raspberries and babbling were used by the clinician to elicit the prosody portion of this goal. Simple phrases such as "help me" were vocalized with repetition throughout the semester by the clinician whenever Jeff expressed a need or desire using gestures. Singing simple repetitive songs was used to encourage the client to imitate prosody as well. All types of play activities were used to elicit the actions portion of this goal. Jeff was bombarded with many models of actions, including playing with toys, such as pushing cars or the vacuum cleaner, spinning the airplane propeller, dropping items in their respective buckets when play was over, splashing in a water bucket, playing with musical instruments etc.

At the beginning of the treatment period Jeff imitated prosody by humming simple CV syllables an average of one time per session. He imitated the actions of others an average of five times per session.

At the end of the treatment period, he imitated both prosodies, through humming, and simple words, such as bye -bye, an average of four times per session. The range went from a low of 0 on days he was having trouble cooperating to 15 in one session. Jeff also imitated actions an average of five times per session at the end of the treatment period. The range again varied due to the client's ability to cooperate from a low of 0 to a high of 8.

Objective #3: The client will engage in turn taking during play with objects or activities with a clinician or other individual ten times during one therapy session.

Progress/Results

This goal was targeted in both individual and group therapy. This goal was targeted by following Jeff's lead with whatever toy he wanted to play within a certain session. The clinician would let Jeff begin playing and then let Jeff know she wanted to become involved by saying "my turn." Jeff was stopped from continuing the activity until the clinician took a turn. Toys used for this goal were primarily ones with repetitive motor actions as these activities would sustain Jeff's attention for much longer and more turns could be taken. For the group sessions, the clinician would become involved with other clients and clinicians in activities that would pique Jeff's interest (such as building blocks) and then invite Jeff to join by handing him a toy or setting Jeff on her lap.

At the beginning of the treatment period, he took turns with only his own clinician an average of six times per session. Hands-on assistance was required approximately 50% of the time.

At the end of the treatment period, he took turns with his own clinician, and also other clinicians and other children in the group sessions, an average of five times per session. Hands-on assistance ranged from 0% to 50% depending upon the task and the client's ability to participate that day.

Objective #4: The client will make eye contact with his clinician or other individual for two seconds or more at least eight times per session.

Progress/Results

This goal was targeted in both individual and group therapy. Much progress was made on this goal in the previous semester and seems to be progressing naturally for Jeff. The clinician would stay at eye level with Jeff for most of the individual and group sessions to facilitate this goal. For the most part Jeff would make eye contact with the clinician or others in the room on his own.

He began the treatment period by averaging eye contact with others four times per session, and also ended the treatment period by averaging four times per session. He did make eye contact with more than just his own clinician this semester and was noted to have made eye contact with others whom he never made eye contact with prior to this semester, such as other clinicians and other children.

Objective #5: The client will make a request by signing or using a real object/picture of an object that represents what is being requested at least one time this semester.

Progress/Results

This goal was targeted in individual sessions only. The clinician would use one or two signs, such as "more," repetitively to facilitate this goal. Also, one piece of Jeff's favorite toy, Lego stacking blocks, was left out in the room where Jeff could reach it. Besides this one block, the entire bucket of blocks was put out of Jeff's reach. Much progress was made toward eliciting the sign for "more."

At the beginning of the treatment period Jeff did not use the sign at all unless it was hand over hand assistance.

At the end of the treatment period, he used the sign an average of four times per session. Signs used spontaneously included: more, ball, car, eat/drink, fish, up.

Objective #6: A yearly hearing screening will be conducted.

Progress/Results

A hearing screening was conducted on April 6, 201x utilizing Otoacoustic Emissions testing (OAE) and tympanometer. Results in both ears indicated normal hearing acuity and middle ear functioning.

DIAGNOSIS/SUMMARY

Jeff met or made progress toward each goal this semester including joint attention, turn-taking, imitation of actions and words, eye contact and requesting objects. Although data in numbers revealed little progress in Jeff's behavior (with the exception of imitating prosody and requesting), the activities for each goal this semester placed more demand on Jeff with less cuing from the clinician, while the opposite was true last semester. At the end of the summer semester, he continued to demonstrate severe speech, language, and social/skills delays.

RECOMMENDATIONS

THERAPY RECOMMENDATIONS

Although Jeff made good progress this semester, he continues to demonstrate severe speech, language and social/skills delays. It was recommended that Jeff continue to receive language therapy twice weekly starting in (January, August, June 201X) focusing on the goals listed below.

LONG TERM OBJECTIVE
The client will demonstrate developmentally appropriate expressive language skills in day-to-day communication 90% of the time.

SHORT TERM OBJECTIVES
1. The client will improve his social interaction skills so that he can take turns in play and conversation for 3 consecutive turns.
2. The client will improve eye contact with listeners he is addressing 50% of the time.
3. The client will imitate words and prosodic features accurately 80% of the time.
4. The client will increase imitation of actions to 5 in a 5-minute period.
5. The client will increase joint attention to objects and activities to 5 in a 5-minute period with minimal cueing.
6. The family will participate in therapy by observing and completing a home program focusing on the above goals over 50% of the time.
7. A yearly speech/language/hearing evaluation will be conducted in April of 20XX.

PROGNOSIS
Due to continued progress, family support, and excellent attendance, the prognosis for improvement with skilled treatment is good for the client to reach the long-term objectives listed above. It is anticipated that the client will need at least a year of treatment to obtain this level of functioning.

ATTESTATION STATEMENT (SoonerCare only)

CC
Referring Physician
Parents
Speech Pathologist

SoonerCare Requirements – as of August 2021

1. Re-authorization of therapy varies from client to client. We are allowed to request reauthorization on a yearly basis; however, we often have to request it on a semester basis due to tightened criterion. Re-authorization is typically done in conjunction with the yearly re-evaluation; however, your semester Progress Report sometimes is combined with the re-evaluation report and can be used by themselves depending upon the timing.

2. The supervisor/clinician work with the financial assistant and Clinic Coordinator to make sure that a re-evaluation has been requested and conducted every year (can be requested every 12 months if appropriate for that client – usually should be requested one month prior to date of last evaluation). The re-evaluation CANNOT be started without prior authorization from SoonerCare.

3. The financial assistant will take care of obtaining the physician prescriptions and doctor's office visit notes. REFERRAL SOURCE – needs to be the client's referring SoonerCare doctor for this reason. We also want to send all our referring medical professional semester progress reports and evaluation reports as a professional courtesy.

4. Under REASON FOR REFERRAL section in your PROGRESS REPORT, more *background* information is needed as the reviewers do not look at past reports/evaluations. It should include documentation of referring doctor (and others), relevant medical history, - especially include prematurity, chronic otitis media, any syndrome or other diagnosis such as autism, etc.; relevant speech/language/hearing/ swallowing fluency/cognitive-communication history and diagnosis of a speech/ language /swallowing/fluency/cognitive-communication disorder.

5. You must state the client's native language and what language the evaluation/therapy were conducted in.
   a. Jack's native language was English, and the evaluation/therapy was conducted in this language.
   b. English was Ali's second language, while Arabic was his native language. This evaluation was primarily conducted in English. His mother was present during the evaluation and upon request would translate directions into Arabic.
   c. Therapy will be conducted primarily in English with his mother or sister providing translation into Arabic whenever needed.

6. You must state where the evaluation and/or therapy take place.
   a. The evaluation was conducted at the OSU Speech-Language-Hearing Clinic and therapy will be provided there also.
   b. Therapy was conducted at the OSU Speech-Language-Hearing Clinic

7. Hearing must be screened every year and reported on in the progress report every 90 days. Make it your last objective on the Treatment Plan/Progress Report and report when the last hearing screening was conducted and results – even if it wasn't you that did it that semester.

8. A random number of 30% improvement (minimal clinical progress MCP) has been stated as the minimal amount of progress needed to indicate re-authorization of therapy is needed. At what level this improvement is made is not stated (e.g., word level, sentence, inclusion of "is"). Make specific benchmark objectives not global, hard to measure ones.

9. If you are including **a re-evaluation** in your PROGRESS REPORT, you need to report on Progress toward Short Term Objectives over the past year as well as evaluation results. Have a separate Short-Term Objective just for the evaluation. Most often, it will be easier to write a separate Evaluation Report (See Section 5 Diagnostic for more information on how to write up re-evaluations)

10. Long Term Objectives and Short-Term Objectives must be measurable – with expectations for progress.

11. STO must have a statement of medical necessity included – not related to academic or educational needs. See examples below.

12. Include a statement of the client's expected rehabilitation potential (prognostic statement)

13. Include a statement of the client's present functional level and progress specific to that reporting period (SUMMARY/DIAGNOSIS section). If these is a medical diagnosis, include that as well as the speech/language diagnosis.

14. Changes in the plan of treatment if appropriate (new Long Term and Short-Term Objectives at end of report)

15. Reasonable estimate of time needed to reach goals – one year for Long Term

16. Attestation statement must be on all SoonerCare paperwork.

Examples of Medical Necessity STO

PLEASE try to use some different wording every other objective or so…I have italicized the phrases for you, but they were not in the report.

In the WTP and SOAP, it is not necessary to include the medical necessity phrase as it just makes the notes super long – but have them in the TP and PR as well as evaluations.

SHORT TERM OBJECTIVES:
Due to XX significant language delays, secondary to her diagnosis of Down Syndrome and chronic middle ear dysfunction, the client is at risk for continued language deficits. Progress will be re-evaluated in the Spring 2021, and the need for continued therapy, recommendations and objectives will be determined.

1. *In order to improve the ability to communicate with others during an emergenc*y, the client will verbally produce two-word combinations 15 times, and 3-word combinations 10 times spontaneously per session.

2. *In order to follow procedures related to her safety both at home and in the community,* the client will follow two and three-step directions when prompted by the clinician with 80% accuracy given minimal cueing.

3. *In order to compensate for articulatory and oral motor skill impairments secondary to the client's Down Syndrome diagnosis,* the client will demonstrate increased oral motor skills to benefit articulatory skills, as shown by her ability to imitate oral motor movements with 80% accuracy.

4. *In order to express specific needs in medical situations,* the client will make a choice by verbally indicating a single item when presented with multiple options 10 times per session.

5. *To enhance the client's skilled speech and more effectively communicate as an individual with Down Syndrome,* the client will demonstrate understanding of basic concepts for preschool readiness (i.e., early literacy, early number sense, basic prepositions) by following related verbal directives and/or verbally responding correctly with 80% accuracy.

6. T*o address expressive language delays secondary to the client's Down Syndrome diagnosis*, the client will verbally identify basic colors when prompted by the clinician with 70% accuracy.

7. T*o provide family resources related to Down Syndrome and support the clients through home generalization,* the client's parent will participate in therapy sessions 80% of the time, and the clinician and parent will communicate weekly concerning the client's progress.

8. *To remain aware of any residual hearing loss secondary to the client's Down Syndrome diagnosis and chronic middle ear dysfunction*, the client will receive a hearing evaluation by an audiologist to ascertain hearing acuity status.

Other medical necessity phrases could be.

In order to follow directions effectively and efficiently across environments,
In order to communicate clearly during an emergency,
In order to follow directions and communicate clearly during an emergency,

Example: long narrative that was included in an evaluation in the Summary/Diagnosis section which was approved. You might find some wording here that could help with an older child.

Mild to moderate-severe delays were present in receptive/expressive language skills and social communication/pragmatics. Results of the *LPT-3* indicated that The Client performed below average in the areas of associations and differences. His inability to recognize similarities and differences between objects and ideas will affect his ability to use his senses to perceive and react to emergent situations. For example, recognizing that smoke means fire and clearing the area, or that dark clouds and lightning mean a storm is coming and to stay inside. Having a strong mental representation of emergent situations and their characteristics is important when reacting to and avoiding danger. The client's expressive language and comprehension would impede his sense of judgment.

The client's performance on the *PPVT-4* fell within low average indicating age-appropriate receptive vocabulary skills. The client showed strengths in identifying attributes and found the most difficulty with identifying verbs and unfamiliar nouns. Although The client identifies aspects of known nouns, he has difficulty understanding the meaning of verbs and doesn't use context clues to decode the meaning of unknown words. This poses a threat in emergent situations when given verbal directions such as "Exit the building" or "Remain indoors." Not only will this affect his receptive skills, but his expressive skills in situations where adequate expressive language is required. Scenarios may include describing physical ailments or injuries at the doctor's office or informing a grown-up about what happens if he gets lost and can't find his mom. Low receptive and expressive vocabulary skills will affect The Client's ability to respond and communicate during an emergency.

The client's performance on the *CELF-5* fell 2 standard deviations below the mean in the following subtests- Word Structure, Following Directions, and Pragmatics Profile. Deficits the client expressed in the Word Structure subtest included past, present, and future tense, possessive -s, copula and auxiliary be, and subjective and possessive pronouns. The client's inability to use basic English morphological morphemes decreases the effectiveness of his message during emergent situations such as indicating what happened, or why an adult should be concerned (e.g., there's broken glass, someone fell at recess and hurt themselves). It is also important that The Client can accurately portray events that happened in the past, present, and future. His mom has indicated several times after therapy that the stories he told were not true or contained false information. It is important that he understands the difference between the two. It is also important that The Client has adequate language skills that will inform the listener of missing information. Similar to what was stated under The Client's *PPVT-4* scores, The client's poor score on the Following Directions subtest will prevent him from following directions in emergent situations.

Aside from difficulties comprehending and using language to express his ideas and concerns and to understand important events around him, The Client's low score on the Pragmatics Profile indicates poor verbal and nonverbal communication skills in the context of cultural norms. The client particularly demonstrates difficulties in rituals and conversational skills. Areas of concern include starting and closing conversations, turn-taking, introducing appropriate topics, and introducing himself as well as responding to others. The client also has difficulty asking for, giving, and responding to information. His mother's report indicates difficulties giving and asking for directions, reasoning, and offering help to others. The additional Observational Rating Scale indicates deficits in the following modes of communication- listening, speaking, reading, and writing. The client has difficulty paying attention and following spoken directions. When speaking, he has trouble staying on topic, carrying on a conversation, and rephrasing when the listener doesn't understand what he said. The client's mom expressed concern in areas of reading and writing. He has no phonemic awareness and cannot follow written directions. This can put The Client in difficult situations during emergencies (e.g., reading an Exit sign or directions regarding emergency procedures).

During conversational speech, language was consistent with test results. The patient's errors are not considered to be developmental and are not expected to improve without skilled intervention.

COVER LETTERS

Copies of Reports to Mail: ONLY USED IF CLIENT REQUESTS A PAPER COPY **What you will need:**

- Signed Completed Report - print.
- Cover Letter for Each Recipient of Report - print.
- Completed *Authorization for Release of Information* form for each recipient.
- Set of Stamps located with the Receptionist in the front office – Confidential, Copy

What to do to report before mailing:

- Stamp front page "Confidential."
- Make as many copies of the report as needed.
- Make copies of the Cover Letter(s)
- Stamp the Report copied as "Copy."
    - If mailing to the parent(s), stamp "Parent Copy"
- **COPIES** of the cover letters
    - Place this group in the "Routine Daily Scanning" folder in the filing cabinet.
- **COPY** of the report with each of the **ORIGINAL** cover letters
    - Place these/these groups in the "To Be Mailed" folder in the filing cabinet.

***ALL* reports must have a cover letter, even hand-delivered copies.**

1. Remember to check your client EMR for current *Authorization for Disclosure of Protected Health Information* Forms and make a copy of this form if the report is being sent to individuals other than the client themselves or the referring physician.
2. For all authorized recipients of your progress report(s), use a cover letter available at the front office or create your own using the format provided below. *You are responsible for including the name and address of the recipient on the cover letter*.
3. If you hand-deliver the progress report, a cover letter is still created with all the information completed and HAND-DELIVERED written on the Cover Letter. This cover letter is placed in the Routine Daily Scanning folder.

STUDENT EVALUATION OF SUPERVISOR

The student clinicians evaluate their supervisors on the *STUDENT SURVEY OF INSTRUCTION* AKA *STUDENT EVALUATION OF CLINICAL EXPERIENCE* which is accessed through Typhon. This form substitutes for the course evaluation forms used by the University, which are not appropriate for these courses since many different faculty members are responsible for the course labeled CDIS 5210 and 4010. Supervisors do not see this form prior to assigning practicum grades. Supervisors receive the forms after grades are submitted at the end of the semester.

STUDENT SURVEY OF INSTRUCTION

Rating scale

0=Not applicable 1=Strongly Disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly Agree

1. Supervisor scheduled conferences or made other arrangements for adequate counseling.
2. Clinical concerns were adequately dealt with during conferences.
3. Clinician felt free to express problems she/he may have encountered in therapy.
4. Supervisor was accepting of clinician's input regarding therapy suggestions.
5. Supervisor was familiar with established clinic rules.
6. Supervisor suggested appropriate sources for additional information when needed.
7. Supervisor was familiar enough with patient's needs to influence direction of therapy when needed.
8. Supervisor offered appropriate/consistent suggestions for improvement of therapy.
9. Clinician's strong areas were noted as well as weaker ones.
10. Feedback concerning therapy was adequate, given consistently, and constructive in nature for this patient.
11. Guidance and directions for were provided in an understandable and appropriate form.
12. Suggestions/additions to paperwork were useful in providing direction to therapy.
13. Supervisor was familiar with recent research and terminology or willing to become familiar with it.
14. Supervisor met scheduled conference time or notified clinician.
15. Progress Reports returned within one week of submission by clinician.
16. Adequate attempt was made by supervisor to build rapport with clinician.
17. The supervisor conveyed an attitude of respect and professionalism toward the clinician.
18. Please provide any comments on instruction and your learning experience. NR or NA is not acceptable, we want your feedback good or bad.

SECTION 5

DIAGNOSTIC PROCEDURES

PROCEDURES FOR SPEECH-LANGUAGE DIAGNOSTICS

The purpose of the speech-language diagnostics program is to provide clinical clock hours for students seeking the Certificate of Clinical Competence. An equally important purpose is to provide high quality service to the community consistent with the University Policy.

New Client Diagnostic Appointment Scheduling & Assignment

1. Appointments for new clients usually last one to two hours. However, AAC evaluations and dyslexia evaluations can take considerably longer.

2. When a client calls, a *Client Information Form for Speech-Language Evaluation* form is filled out by the front office. A case history form is sent to the client along with a packet of information which could include the Appointment Information Cover, the *Notice of Privacy Practice* (*NPP*), *Authorization for Disclosure of Protected Health Information* form, and *SoonerCare Parental Authorization* form. The front office staff initiated the paperwork.

3. The case history form and other paperwork can be returned by mail, e-mailed, faxed, or brought to the front office staff. Once the case history form has been returned, a client file in the EMR is created.

4. When all documentation and pre-authorization is completed, the Clinical Coordinator is then notified by the front office staff that the diagnostic needs to be scheduled and given the *Client Information Form for Speech-Language Evaluation* form. (e.g., SoonerCare and Oklahoma Health Choice require pre-authorization before an evaluation can be scheduled)

5. The Clinical Coordinator schedules an appointment during one of the available times and records client information on the *Client Information Form for Speech-Language Evaluation*. It includes information about day/time, supervisor, clinician(s), and room assignments. An encrypted email copy of this form is given to the clinician, the diagnostic supervisor, and the front office staff. The clinician also received a "*Diagnostic Assignment*" form and a "*Diagnostic Planning Form*" via email.

6. The clinician should call the clients the week prior to the evaluation. If there are any changes in the diagnostic schedule, the Clinical Coordinator, diagnostic clinician, supervisor, and the front office staff should be notified.

CLIENT INFORMATION FORM_FOR SPEECH-LANGUAGE EVALUATION

Date: ______________________ Person calling ____

CLIENT________________________ (Parent/Guardian) _________________________________

REASON FOR EVALUATION: ____

PREVIOUS EVALUATIONS? (Ask them to please send copies along with returned case history form. It is possible if prior evaluation was within one year, treatment may begin without evaluation. Clinic Coordinator to determine from reports):

____

ADDRESS: ____

AGE: ______________DATE OF BIRTH: ________________SEX: ______________

TELEPHONE: (home/cell): ___________________________ (work) ________________________

REFERRAL SOURCE: ____

REFERRAL ADDRESS: _________________________________PHONE: _________________

PRIMARY CARE PHYSICIAN: ___________________________ PHONE: _________________

PHYSICIAN'S ADDRESS: ____

STUDENT OR FACULTY (circle if applies) – Asked to bring OSU ID to appointment Yes/No

PRIMARY PAYMENT SOURCE: _______________________ID NUMBER: _______________

POLICY HOLDER(PoH) NAME ON INS CARD: _____________________________________

PoH DOB: _________________ Client's Relation to PoH ________________________________

SECONDARY PAYMENT SOURCE: __________________ID NUMBER: _______________

PoH NAME ON INS CARD: ___________________________ PoH DOB: __________________

PRIVATE INSURANCE

PRESCRIPTION REQUESTED: Yes/No

CLIENT INSTRUCTED TO VERIFY THAT INSURANCE PAYS FOR SPEECH: Yes/No

CLIENT INSTRUCTED TO ASCERTAIN IF PRE-AUTHORIZATION REQUIRED:

Yes/ No

IF PRE-AUTHORIZATION REQUIRED:

DATE OSU REQUESTED _____________PRIOR AUTH DATE CONFIRMED: ___________

SLIDING SCALE- First page of last tax year's 1040 form REQUESTED Yes/No

Non SoonerCare CLIENTS

CASE HISTORY SENT: _________________ DATE RECEIVED IN OFFICE: ____________

SOONERCARE – Go to back page of this form and discuss with client.

SCHEDULE (Clinical Coordinator)

DATE SCHEDULED: __________ TIME SCHEDULED_________ ROOM NUMBER: ______

DIAGNOSTIC SUPERVISOR: ______________ DIAGNOSTIC CLINICIAN: ______________

Pre-Authorization Requirements for Sooner Care Patients

Before we can SCHEDULE an evaluation, we MUST have prior authorization from SoonerCare.
We need 3 documents immediately. Two from the doctor and one from the parent

A. From the physician (or Physician's Assistant/PA, or Advanced Registered Nurse Practitioner/ARNP or Clinical Nurse Specialist/CNS).

1. A prescription written on a prescription pad that says: "speech/language evaluation & treatment as indicated", (Must be current – only good for 90 days).

Requested ______________________
____
____
____
Received_____________________________

2. Copies of the physician's visit/consult note FROM THE CHART dated within the past year that includes:
   a. that the doctor had a discussion with parent/guardian about the need for speech eval and treatment and
   b. that it is medically necessary.

(This may be a well-child visit note, consultation note, etc.) It needs to be from the child's medical record and originate from the treating physician. NOTE: SoonerCare will not take a letter from the physician requesting services, only copies from the child's actual chart.

Requested ______________________
____
____
____
Received_____________________________

Doctor's office should Fax it to (405) 744-8070. OSU Speech-Language-Hearing Clinic. We can then send the information to SoonerCare to request an evaluation.

B. From the Parents

3. SoonerCare Parent Consent Form- signed.

Sent __________________ Received_________________________

Before we schedule the appointment, we also must have

1. OSU Case History Form –Sent ________________ Received____________________
2. The child's IEP from their school if they have one. Requested __________ Received_______________
3. Any other medical or prior evaluation/therapy documentation that could be helpful. Requested __________ Received____________________

Revised 6/15

Clinician Responsibilities Before the Diagnostic Appointment

1. The clinician(s) contacts the diagnostic supervisor to set up a pre-diagnostic conference within 48 hours of receiving the assignment.

2. The clinician(s) should review the case history form, doctor referral/notes and any external reports or IEP documents in the client's EMR file in the DOCUMENTs tab. Check to see all Consent forms were signed.

3. The "Diagnostic Planning Form" should be used by the clinician(s) to write up a proposed plan before meeting with the supervisor.

4. The diagnostic supervisor and the clinician(s) hold a pre-diagnostic conference, at which time the clinician(s) provides the proposed plan for the diagnostic session and final decision about which tests to use are made.

5. Diagnostic instruments must be checked out in the black binder kept in the front office whenever they are taken out of the diagnostic storage room. The clinician will return materials as soon as possible. Diagnostic manuals cannot be kept overnight or taken out of the clinic without the Clinic Coordinator's prior approval. This information should be written on the diagnostic sign-out sheet (in the front office).

6. Do not store diagnostic manuals in the clinician workroom, graduate offices, or therapy rooms if you are not actively using them.

7. A "Test Reservation Sign-up" sheet is also in the black binder in the front office. If you need to give a test at a certain time you can "reserve" the test for that time frame, so others know that it needs to be available to you.

8. **Diagnostics should be recorded on the VALT recording system.** Before the session, make sure you know how to run the equipment. The camera in the room can be remotely moved to get to the area you need to view. If a session is recorded, it will be erased after viewing, unless you are going to include them in the video archive library. Work with the front office if you wish to download and burn a recording onto the Video Archive flash drive. Complete the yellow video archive form (found in the front office) for the client's file, check out the Video Archive flash drive, download and then return the flash drive to the front office staff. Archived recordings on DVDs and flash drives are considered part of the client's medical records and must be stored in a secure location. Students cannot retain client recordings as personal belongings. iPads can be used for recording; however, at this time we are unable to archive them.

9. It is the clinician's responsibility to contact the client to confirm the appointment and do a brief interview within the week of the appointment. This allows the clinician to build rapport with the client and allows the client or their parents to ask any questions they may have.

10. If any changes are made concerning the appointment time or room for the diagnostic, notify the Front office staff, Clinic Coordinator, and the diagnostic supervisor. If you need to schedule an additional day to complete the diagnostic or to have any other meetings related to the diagnostic with the client or family, contact the Clinic Coordinator to schedule a room and the front office to put it on the schedule.

11. Clients should cancel appointments with the Front office staff who in turn notifies the diagnostic supervisor, Clinic Coordinator, and the clinician. There is no charge for cancellation. *You will be given at least 7 days often 14 days' notice before your evaluation. So please plan and be prepared on the day of the evaluation.

DIAGNOSTIC ASSIGNMENT

CONTACT YOUR SUPERVISOR WITHIN 48 HOURS OF RECEIVING THIS ASSIGNMENT.

Time diagnostic scheduled ________________
Clinician Name: ______________
Client Name: _________________________
This diagnostic has been assigned to you and ________________, supervisor.
1)You are to contact your supervisor within 48 hours.
2)You will call and confirm the appointment with the client (should the client need to change the agreed date/time, go back to the diagnostic supervisor for instructions on another date/time, notify front office, and repeat the process.

DATE LOG:

Date diagnostic is scheduled ________________
Room assigned _______________
Date student contacted supervisor _____________
Date student called client to confirm appointment ________________

Check client file for signed:

____ *Client/Parent Confidentiality Statement*
____ *Authorization for Disclosure of Protected Health Information*
____ *Permission for Clinical Services*
____ *Permission to leave telephone messages and electronically transmit information*
____*Notice of Privacy Practice/Receipt of Notice of Privacy Practices Written Acknowledgement*

Check forms/materials needed for diagnostic:

____**Clients To Be Scheduled form (CTBS)**
____Tests (you may need to reserve these!)
____Test protocol forms; oral motor checklist; hearing screening form (in Protocol cabinet in hall)
____Toys, reinforcers (e.g., stickers/snacks)
____Check out digital recorder
____Check VALT recording equipment in room for proper working order
____Check out and practice with Audiometer, tympanometer and/or OAE

DIAGNOSTIC PLANNING WORKSHEET

Client: ________________________________ Age: _____________
Referral Source: ____
Probable Development Level: ____
Chief Complaint: ____
Other Complaints: ____

Areas to Assess	**Specific concerns / Questions**	**Assessment Tools**	**Additional AT to consider**
Hearing ***Oral Motor*** ***Sensory*** ***Other areas***			

*Continue Sections I, II, III on a separate page, if necessary.

IV. Precautions or factors to take into consideration i.e., visual impairment, behavioral problem, etc.

Case History Interview

Indicate areas to be pursued in more detail after reading case history questionnaire.

PURE-TONE / TYMP / OAE SCREENING FORM

NAME: **BIRTHDATE:** **DATE:**

SCREENER: ____

INSTRUCTIONS FOR MIDDLE-EAR SCREENING: For each ear, draw the tympanogram and record the type, canal volume, admittance peak, and pressure peak in the appropriate boxes according to screening results. See flowchart on reverse of this page

RIGHT EAR				LEFT EAR
Draw Tympanogram -400 -200 0 +200		Type		Draw Tympanogram -400 -200 0 +200
		Canal Volume		
		Admittance Peak		
		Pressure Peak		
		Otoscopy? Yes No		

INSTRUCTIONS FOR PURE TONE SCREENING: Present a 20 dB HL pulsed signal at each screening frequency. Not responding to the 20 dB HL tone at any frequency in either ear shall constitute a "refer". Record a "+" (plus) for "pass" or "-" (minus) for "refer."

RIGHT	1000 Hz	2000 Hz	4000 Hz

LEFT	1000 Hz	2000 Hz	4000 Hz

CIRCLE METHOD OF PURE TONE SCREENING: CONVENTIONAL CONDITIONED PLAY

INSTRUCTIONS FOR PHYSIOLOGIC SCREENING: Check the type(s) of physiologic screening completed. Indicate screening results for each ear. Record a "+" (plus) for "pass" or "-" (minus) for "refer" in the appropriate box.

Type of Screening: OAE ☐ **RIGHT EAR** ☐ **LEFT EAR** ☐

SCREENING RESULTS: Pass Refer ☐ ☐

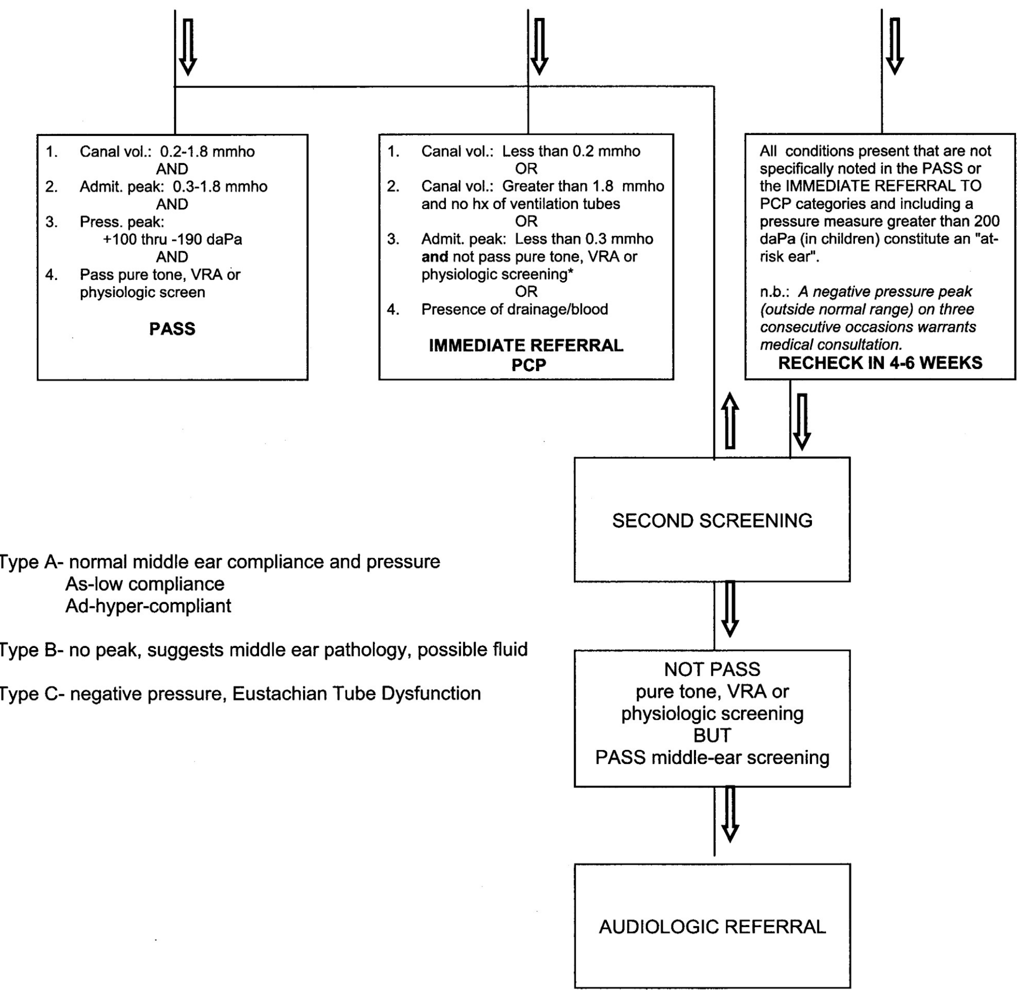
RECOMMENDATIONS: Audiologic Referral PCP Referral ☐ ☐

Re-Check in 4-6 Weeks Other (specify) ☐ ☐

Pass newborn hearing screening? Y N
History of ear infections? Y N
P.E. tubes? Y N If Yes, When? ______________________________

Comments:

MIDDLE EAR / HEARING SCREENING PROTOCOL



*NOTE: IF THE CHILD IS TOO YOUNG TO TEST USING PURE TONE SCREENING AND VRA OR PHYSIOLOGIC SCREENING IS NOT AVAILABLE, THE COMBINATION OF AN ADMITTANCE PEAK OF LESS THAN 0.3 MMHO AND A HISTORY OF MIDDLE EAR EPISODES IN THE LAST SIX MONTHS IS A BASIS FOR AN IMMEDIATE REFERRAL TO A PNP OR A PHYSICIAN.

ORAL MECHANISM SCREENING

NAME: ______________________ BIRTHDATE: ______________________

EXAMINER: __________________ DATE: _____________________________

FACE

1. Symmetry (Normal or Right/Left Droop) ______________________________________
2. Mouth Breathing (Yes/No) _________

Comments: ____

LIPS

1.	Pucker and Protrude (say /u/)	YES	NO
2.	Retract (smile or say /i/)	YES	NO
3.	Place upper teeth on lower lip (say /f/ or /v/)	YES	NO
4.	Strength (press tongue blade against lips):	Normal	Weak

Comments: ____

TEETH/OCCLUSION

1. Condition of teeth: In repair

   ____

   Needs dental attention ____

2. Note missing teeth and edentulous spaces:

   ____

3. Occlusion: Normal ______________ Disocclusion (overbite)______________
   Open bite ___________ Mesiocclusion (underbite) _______________

4. Is there a relation of dental structure to speech problem: YES NO

Comments: ____

TONGUE

1. Protrude and stabilize for 5 seconds	YES	NO
2. Lateralize to right and left rapidly and repeatedly	YES	NO
3. Elevate to alveolar ridge with mandible stable	YES	NO

Diadochokinetic syllable rates (norms on back) SECONDS TO COMPLETE

4. Repeat (a) /pʌ/ rapidly (20 repetitions) __________

   (b) /tʌ/ rapidly (20 repetitions) __________

   (c) /kʌ/ rapidly (20 repetitions)__________

   (d) /pʌ ʌ ʌ t k / rapidly (10 repetitions) __________

Comments: ____

PALATAL/PHARYNGEAL AREA

1. Length of velum (soft palate) Normal Short Long
2. Mobility of velum during /ah/ Good Fair Trace None
3. Are the palatal tonsils normal in appearance? YES NO
4. Is there drainage on posterior pharyngeal wall? YES NO

Comments:____

VOICE/RESONANCE

1. Prolong /ah/ (3 times): ______ seconds _____ seconds ______ seconds

   Norms: Children (minimum 10 seconds), Adults (minimum 15 seconds)
2. Tone (Normal/Breathy/Harsh/Hoarse) ____
3. Pitch (Normal/Too High/Too Soft) ____
4. Loudness (Normal/Hypernasal/Hyponasal) ____________________________________
5. Nasal Resonance (Normal/Hypernasal/Hyponasal/Cul de sac) _____________________
6. Breathing Pattern (Clavicular/Diaphragmatic) __________________________________

Comments: ____

____

Norms in seconds for diadochokinetic syllable rates Age:

Task	6	7	8	9	10	11	12	13
/pʌ / (20)	4.8	4.8	4.2	4.0	3.7	3.6	3.4	3.3
/tʌ / (20)	4.9	4.9	4.4	4.1	3.8	3.6	3.5	3.3
/kʌ / (20)	5.5	5.3	4.8	4.6	4.3	4.0	3.9	3.7
Standard Deviation	1.0	1.0	0.7	0.7	0.6	0.6	0.6	0.6
pʌ ʌ ʌ t k / (10)		10.0	8.3	7.7	7.1	6.5	6.1	5.7
Standard Deviation	2.8	2.8	2.0	2.0	1.5	1.5	1.5	1.5

Day of Appointment

1. The client checks in at the office with the Front office staff. They will be given a parking permit if they need one.

2. The clinician(s) meets the client (and family) in the waiting room. If the client has not signed all of the forms in the case history packet or some were incorrectly completed, have those forms available (e.g.; *Client/Parent Confidentiality Statement; Authorization for Disclosure of Protected Health Information; Permission for Clinical Services; Permission to leave telephone messages and electronically transmit information; Notice of Privacy Practice/Receipt of Notice of Privacy Practices Written Acknowledgement)*

   If the family wants the report sent to anyone other than the referring medical professional, a separate *Authorization for Disclosure of Protected Health Information* form for each individual should be completely filled out and signed by the client or responsible family member. If the form was signed, but no recipient has been identified and/or the address was not written in by the client, it is not valid.

3. The clinician(s) escorts the client to the diagnostic room. Depending upon the situation, the family may be included in the beginning of the diagnostic session, be invited to observe in the observation room, or wait in the waiting area. (Check with your supervisor to make that decision). The family should be aware that no baby-sitting is provided.

4. The supervisor is responsible for observing at least 50% of the diagnostic session. She/he will often be in the room with the clinician(s).

5. If two clinicians conducted the diagnostic session, they can both obtain full credit for the hours ONLY if they follow ASHA guidelines. "Although several students may observe a clinical session at one time, clinical practicum hours should be assigned only to the student who provides direct services to the individual receiving services or the individual's family. Typically, only one student at a time should be working with a client in order to count the practicum hours. Several students working as a team may receive credit for the same session, depending on the specific responsibilities that each student is assigned when working directly with the individual receiving services." (Standard V-C, 2020 Standards and Implementation Procedures for the Certificate of Clinical Competence in Speech-Language Pathology

In other words, when more than one clinician is working with a single client and/or a relevant family member or guardian, or in a group treatment session, each clinician must be ***actively engaged in the planning, implementation and analysis*** of the session at all times in order to receive clock hour credit. For example, one clinician could be collected a language sample while the second clinician works with the client or one clinician leads a group activity interacting with the client while the other acts as a "coach" providing

cueing and prompts to the client involved in the activity to help them complete the activity.

6. If possible, the client (and family) will wait a few minutes in the diagnostic room or waiting area while the clinician(s) and supervisor meet to review the findings. The supervisor, clinician(s), and client (or parents/guardian) will then return to the diagnostic room to discuss the results of the diagnostic testing. If discussion of the results is not possible at the time of the diagnostic, a future meeting set for following week should be scheduled.

7. At the end of the diagnostic conference, if therapy is recommended a "*Clients To Be Scheduled*" form should be completed and given to the Clinic Coordinator.

8. The clinician(s) and supervisor return with the client to the waiting area.

9. Front office staff will handle any billing matters. The front office will file with the client's insurance if they are using it. Self-pay is due at the time of the evaluation (Adjustments can be made if the client completes the *OSU Speech-Language-Hearing Financial Assistance* Worksheet). Bursar, Visa, and Master Card charges can be made.

After the Appointment

1. The clinician is responsible for writing a report after all the findings have been analyzed. There are three reasons for written reports. They:
    a. provide the clinician with practical interpreting results and writing clear reports,
    b. are required by ASHA to obtain diagnostic clock hours,
    c. and fulfill the legal and professional obligations of the OSU Speech-Language and Hearing Clinic.

2. Refer to *Writing Guidelines for Professional Reports* described earlier in this manual (Section 3 and 4) for details about professional writing of reports (e.g., spacing, tense use, abbreviations).

3. All reports are strictly confidential. They can only be discussed for professional purposes. Personal copies cannot be retained. Likewise, audio, or visual recordings are to be erased or archived. The *Authorization for Disclosure of Protected Health Information* form must be signed before any information (verbal or written) can be shared with an outside agency or person other than the referring medical professional.

4. Reports are written following the *Format for Evaluation Reports* in this manual. The reports should be edited for precision and brevity before turning them in to the supervisor.

5. **The initial rough draft is due three days after the diagnostic, unless another date has been arranged with the supervisor.**

6. **<u>Turn in all scored protocols, language sample analysis, and informal testing</u>** with the rough drafts or once you have entered the report in the EMR. The supervisor needs to be able to review them for scoring accuracy and interpretation.

7. All supplements to the reports - testing protocols, examples of client's work - must include the client's name, the date of the evaluation, and the clinician's name. These protocols must be turned into the front office for scanning into the file when the report is complete.

8. The supervisor will edit the rough draft within three days of its submission and notify the clinician. The clinician then makes any necessary corrections and provides the supervisor with the revised report within three days. When no further corrections are needed, the supervisor will finalize the report in the EMR program and alert the front office/clinician it is finalized via a To Do email in CounselEar.

9. If a printed copy is requested, the report should be stamped "Confidential" and stamped as "Copy" and/or "Parent Copy."

10. If a printed copy is requested, cover letters should be filled out or created for the client/parent, referring physician and any other agency that the client wants the report to be sent to. The original cover letters should be attached to the copy of the report. All reports sent to nonreferring physicians and other agencies MUST HAVE an *Authorization for Disclosure of Protected Health Information* form. Copy this form and include it with a cover letter and report.

11. Put the cover letter, *Authorization for Disclosure of Protected Health Information* form, and stamped copy of the evaluation report in the "Reports to Mail" folder in the front office.

12. Put a copy of the cover letter into Routine Daily Filing and it will be scanned into the EMR program by the front office.

Occasionally, summaries and correspondence (including e-mails) with referring agencies are prepared by the clinician or the supervisor. Copies of all correspondence with referring agencies should be made and given to the Front office staff for scanning into the EMR file.

ASHA Clock Hours and Grades

1. The clinician(s) and the diagnostic supervisor schedule a final meeting to evaluate the clinician's performance, level of competency, and to assign a grade. The Diagnostic Supervisor will use the appropriate sections on the "*Supervisor's Evaluation of Clinical Skills*" form to evaluate competency and assign a grade.

2. Before meeting with the supervisor, the clinician(s) should fill out the related sections in the "*Student's Self-Evaluation of Clinical Skills*" form.

3. The clinician(s) and supervisor will discuss the evaluation form and sign two copies – one given to the Clinic Coordinator and one for the student records. It is incorporated into the final grade for Advanced Practicum, CDIS 5210 or CDIS 4010.

4. During this meeting, the supervisor finalizes the student's Clinical Clock Hours in the Typhon program online.

5. The supervisor should also check the EMR program to make sure the report has been finalized and sent out and all paperwork/protocols have been scanned into the Document section.

6. When counting clinical practicum hours for purposes of ASHA certification, only the actual time spent in sessions can be counted, and the time spent cannot be rounded up to the nearest 15-minute interval. (2020 Standards)

EVALUATION REPORT TEMPLATE **(<u>Underlined</u> are the different sections in the CounselEar EMR)**

<u>HISTORY</u>

CLIENT INFORMATION
Age:
Address:
Parents/Guardian: (delete guardian if not applicable or both if client is an adult)
Telephone:
Referred By: (referring physician should be listed first)
Date(s) of evaluation: (List all dates evaluation was given. Put report in CounselEar on the first visit date)
Time in/ Time Out:
Total Minutes:

DIAGNOSIS:
    Current Diagnosis
    ICD-10:
REASON FOR REFERRAL
BACKGROUND INFORMATION

<u>RESULTS</u>

AREAS TESTED/RESULTS
SUMMARY/DIAGNOSIS:

<u>RECOMMENDATIONS</u>

THERAPY PLAN RECOMMENDATIONS
LONG TERM OBJECTIVE
SHORT TERM OBJECTIVES
PROGNOSIS

<u>CUSTOM</u>

Attestation Statement (for SoonerCare)
Certificate of Medical Necessity Statement (for Medicaid)

<u>REFERRING PHYSICIAN</u>

<u>ADDITIONAL RECIPIENTS</u>
<u>CC</u>

<u>REPORT ATTACHMENTS</u>

<u>REPORT OPTIONS</u> (Choose EVALUATION REPORT from dropdown for the title)

<u>PATIENT PORTAL</u> (CHECK BOX before finalizing)

FORMAT AND PROCEDURES FOR EVALUATION REPORT

HISTORY
CLIENT INFORMATION

AGE:
BIRTHDATE:
ADDRESS:
TELEPHONE:
PARENT/GUARDIAN: (Delete guardian if not applicable, delete both if adult client)
REFERRED BY: (This is most often the referring physician and sometimes the client/the parent or school
DATE(S) OF EVALUATION:

Time In/Out - The Hour/minute you picked the client up from the waiting room; and the hour/minute they left. Example: 10:31 am – 11:42 am
Total time: Example: 71 minutes

DIAGNOSIS
Current Diagnosis:
ICD-10CM: (Check with your supervisor for the correct ICD-10CM codes).

Always include any **medical diagnosis** as well as speech/language/hearing codes. Chronic Otitis Media, Down's Syndrome, Prematurity – all impact communication and provide a "medical necessity" component that is required by most insurance companies.

REASON FOR REFERRAL - *no current testing results go into the reason for referral.*
This is an introduction to the report. It includes the following information: (1) name of client; (2) age of client; (3) date(s) of evaluation; (4) place of evaluation; (5) referral source – most often the referring physician (6) position and or relationship of referral source to the client; (7) reason(s) for referral (generally stated according to the viewpoint of the referral source and/or family), and (8) Native language of client and if testing was conducted in same language

If it has been necessary to extend the evaluation over more than one date, briefly state the reason and provide the additional test dates.

BACKGROUND INFORMATION
This section of the report should contain any background information which is pertinent to understanding the client's communication problem (if one exists). Information included in this section will generally be obtained through the case history or parental interview.

When presenting background information, cite the source of your information and the person's position or relationship to the client. (e.g., Information completed by the mother on the case history form indicated….; During interview with the client, ….)

Information pertinent to understanding a person's communication problem will vary from person to person. Below is a list of areas *which might be included*. It is not necessary to use subheadings for each area but organize separate paragraphs for each area. For an adult separate paragraph may not be needed.

<u>Medical and birth history</u>

(Examples: pre-natal, perinatal, and post-natal events of significance, significant illnesses or accidents, hospitalization or extended medical treatment, present medications, general health, etc.) When reporting medical diagnoses, report the person making the diagnosis. Do not report diagnoses which are made by unqualified individuals or a diagnosis that you suspect is present. *Also, do not include confidential information.*

<u>General motor and self-help development</u>

(Examples: motor developmental milestones, general growth norms, present level of help/self-help, etc.). Generally, report development in chronological order.

<u>Educational history</u>

(Examples: extent and nature of education, general academic record, specific academic strengths, and weaknesses). You may wish to expand this section to include work history or occupational goals for adults. For young children, include the preschool attended.

<u>Psycho-social history</u>

(Examples: extent and quality of social relationships among family, peers, community; interests, hobbies, use of free time, positive/negative behavioral characteristics, psychological and/or psychiatric evaluations and/or treatment) Use *same precautions used in reporting medical information regarding confidential information.*

<u>Speech and language development</u>

(Examples: pre-language behavior, speech and language milestones, when and by whom problem was first noticed, management of problem, therapy, when, where, by whom, duration of therapy, etc.; current speech and language status including auditory skills (reported by informants, not result of testing], environmental reactions to speech and language development, etc.)

<u>Family history</u>

(Examples: presence of other speech, language and/or hearing problems in the family, other languages spoken in the home, members of the family unit, education and occupation(s) of parent(s) or spouse, etc., parental disciplinary practices, age, and health of family members, etc.)

RESULTS

AREAS TESTED/RESULTS

Select the skill areas that correspond to the type of assessment you have done. Possible choices are:

Accent Modification/Language Difference
Alternative/Augmentative Communication
Aphasia
Apraxia
Articulation/phonology
Auditory Processing (Discrimination/Memory)
Aural Rehabilitation
Cognitive-Communication
Dysarthria
Dyslexia
Dysphagia
Fluency
Hearing
Language
Oral Motor
Phonological Awareness
Pragmatics/Social Skills
Reading Comprehension Written
Expression
Voice/Resonance
Other

Other: This section can include a description of the client's response to the testing situation (separation from parents, attention span, cooperativeness, etc.). Also included in this section could be informal observations which are important to the client's communication problems but do not fit into any other category. Examples: interaction with parents, unusual or bizarre behavior, motor, and/or visual deficits, etc.

For each area tested, include the following information in paragraph form

1) Describe what the assessment tool is designed to test. Individual subtests should also be described. (See examples below)

2) Report subtests/composite/index **raw scores,** along with **standard scores (e.g., Scaled Scores; Standard Scores**). Often **percentiles (%iles)** are included.

If you deviate from the standardized procedure of a test, you need to indicate the change made and why the change was made. If you question the reliability of your results, you need

to indicate this and the reason(s) why. Important informal observations should also be included under the appropriate heading.

3) Include the **interpretation** of what the scores mean (e.g., average; mildly impaired, severely impaired).

4) After the SS and the severity interpretation, you then write a more **in-depth analysis of areas** that are strengths and those which are significantly impaired and a summary of the performance in each area.

5) When a number of tests are given in any one of the communication areas listed above, you can make headings in the section to help organize it.

Many SLPs and psychologists **do not recommend reporting age/grade equivalencies**. Here are some reasons why they are not valid and are confusing to parents and educators. The extensive problems include:

- These scores lead to inaccurate generalizations about overall performance, especially for those students who are very young or for those who attain extreme scores. For example, let's say that a test age-equivalent score for a 10-year-old is age 3. Educators and parents typically assume that this means the child has an aptitude typical of that of a 3-year-old. In reality, the client may be age appropriate in some ways, and extremely deficient in others, something not reflected in the score. A 3-year-old who scores an AE of 3 probably does so because they have typical developmental skills, while a 10-year-old with an AE of 3 has a completely different developmental pattern not reflected in that score.

- As children grow older, the reliability of these scores decreases because skill development patterns become less reliable. That is, normal children up to age 6 have remarkably similar sequences and patterns to their development, but this predictability fades with children above age 6.

- Age and grade scores decline with increasing age because as students age, it becomes easier for them to fall behind. For example, an 8-year-old can only fall 1-2 years behind in reading skills, but a 17-year-old can fall up to 7-8 years or more behind.

Example:

AREA TESTED/RESULTS

Receptive Vocabulary:

The *Peabody Picture Vocabulary Test- IV- Form A (PPVT- IV-A)* was given to assess vocabulary comprehension. The client received a standard score of 12 on the *PPVT-IV* which indicated receptive single word vocabulary skills to be within the average range for his age.

Peabody Picture Vocabulary Test- IV-A (PPVT-IV-A)

Raw Score	Standard Score	Percentile	Severity
132	12	73ile	Average

Receptive/Expressive Language

The *Clinical Evaluation of Language Fundamentals: Fifth Edition* (*CELF-5*) was administered to assess the client's receptive and expressive language skills. The Core Language portion of the *CELF-5* was administered and consisted of four subtests: Word Classes, Formulated Sentences, Recalling Sentences and Semantic Relationships. Each subtest yielded a raw score that converted to scaled score (Average = 10 +/-3) and a percentile rank as compared to same age peers. The Core Language Index yielded a Standard Score (Average = 100 +/- 15) and percentile rank.

Word Classes

The Word Classes subtest evaluates the client's ability to understand relationships between words (semantics). The client received a scaled score of 10 which indicated average skills for his age in this area.

Formulated Sentences

This subtest evaluated the client's ability to formulate complete, semantically and grammatically correct spoken sentences of increasing length and complexity, while using given words and contextual constraints imposed by illustrations. The client received a scaled score of 7 which indicated borderline average/mildly impaired skills in this area. His sentences often lacked subject content and he incorporated the given words into the beginning of sentences inappropriately. An example would be, *"And raking the yard,"* instead of formulating a sentence like, *"The man and lady are raking their yard."*

Recalling Sentences

This subtest evaluated the client's ability to listen to spoken sentences of increasing length and complexity and then repeat the sentences without changing them in any form. The client received a scaled score of 3 which indicated a severe delay in this area. He presented with the difficulty as the sentences increased in complexity and length over 8 words. This was likely a result of his apraxia.

Semantic Relationships

The Semantic Relationships subtest evaluated the client's ability to interpret sentences that make comparisons, identify location or direction, specify time relationships, include serial order, and express passive voice. The client received a scaled score of 10 which indicated average abilities.

Core Language Score

The Core Language Score (CLS) is a measure of general language ability, and it helps determine the presence or absence of a language disorder. The CLS consisted of scores of the four subtests described above: Word Classes, Formulated Sentences, Recalling Sentences, and Semantic Relationships. The client received a standard score of 85 on the CLS and was in the borderline average/mildly impaired range as compared to age matched peers. However, it should be noted that the significant range of scores ranged from the Average range (Word Classes and Semantic Relationships) to mildly impaired (Formulated Sentences) to Severely Impaired (Recalling Sentences). This reflected good semantic skills receptively and an impairment in expressive skills.

***CELF-5* Subtests**	**Raw Score**	**Standard Score**	**%ile**	**Severity**
Word Classes	31	10	50	Average
Formulated Sentences	21	7	16	Borderline Average/Mildly Impaired
Recalling Sentences	23	3	1	Severe
Semantic Relationships	13	10	50	Average
Core Language Index		85	16	Borderline Average/Mildly Impaired

*EMR tip. You cannot put IPA symbols in Counselear. Avoid IPA symbols. If you insist on using IPA symbols you have to create a table in a WORD document, then convert it to PDF and attach to the report in the REPORT

ATTACHMENT section in the Professional Report tab. Make sure to label it as an Attachment and refer the reader to it in the paragraph describing the articulation testing.

SUMMARY/DIAGNOSIS

This section should include a brief overview of the complete speech and language diagnosis and important contributing factors (behavioral, medical, etc.). When listing the diagnosis, also give an indication of severity. The summary section should also include the strengths and weaknesses of the client. This section should also provide an adequate basis for understanding the recommendations. If the client "referred" on the audiology screening, recommend that the client be seen by an audiologist.

*If you find yourself writing information that has not been described in the body of the report, you need to go back and add that information in the proper area. A "summary" should not contain new information.

Example 1:

Results of the diagnostic indicated that Zach has a severe receptive/expressive language and articulation disorder. Zach's level of symbolic play was also impaired. It should be noted that during the first evaluation session, Zach was upset that his mother was not in the room and had a difficult time attending to the various stimuli presented before him. However, during the second session Zach was more comfortable and was able to attend to most of the stimuli presented to him.

Example 2:

The information obtained from the diagnostic evaluation suggested that Preston had a severe speech intelligibility disorder which negatively impacted his expressive language skills. Speech was characterized by multiple consonant deletions in all word positions and syllable deletion for multi-syllabic words similar to what is seen in children with a severe phonological disorder or childhood apraxia of speech. Due to the discrepancy between his receptive language skills and expressive language and speech intelligibility, speech and language therapy is warranted. On the OAE hearing screening, Preston's results referred in the left ear. The client was referred to an audiologist for more in-depth testing.

RECOMMENDATIONS

THERAPY PLAN RECOMMENDATIONS

This section should include your recommendations regarding the need for speech/language, frequency of therapy, type of therapy, length of therapy and if any medical diagnosis contributed to the communication deficit. (Do not put down the amount of time you are recommending, just the number of days per week and the length up to one year).

Example:

In view of the severity of Sarah's expressive language and speech intelligibility delay secondary to her diagnosis of chronic otitis media, it is recommended that she be seen for skilled speech and language therapy twice a week, for one year beginning in late August 20xx.

LONG-TERM OBJECTIVES

This is a statement of the proposed level of functioning within one year or at discharge whichever one happens sooner.

NOTE: At this time, SoonerCare is recommending **different, measurable** Long-Term Objective for each major communication area (e.g., one for speech, another for language).

Examples:

- The client will increase speech intelligibility with unfamiliar listeners in conversation to 80% intelligible.
- The client will demonstrate age-appropriate expressive language skills as measured by standardized testing, MLU and completion of short-term objectives at 80%.
- The client will demonstrate *developmentally* appropriate pragmatic, expressive, and receptive language skills in conversational speech 75% of the time.
- The client will improve his functional communication in home and school settings so that familiar listeners understand basic wants and ideas over 50% of the time.

SHORT-TERM OBJECTIVES

This section should include your recommendations regarding therapy goals and priorities. This could include:

1. Indicate areas to still need to be probed or re-evaluated more fully.
2. **Write specific measurable, short –term objectives -** *If SoonerCare, include a statement of medical necessity.*
3. Include a family/client objective for home practice.
4. Include a yearly re-evaluation objective.
5. Include other evaluations indicated (medical, audiologist, psychologist) and who is to make the initial contact.
6. Indicate suggestions for classroom and/or home management.

Example:

Short -Term Objectives: - ***Statement of medical necessity only required for SoonerCare.***

Objective 1: *In order to improve the ability to communicate with others during an emergenc*y, the client will improve speech intelligibility by producing CV, CVCV, VC and CVC words with the phonemes in his repertoire 70% of his attempts with moderate clinician cueing.

Objective 2: *In order to express specific needs in medical situations*, the client will combine 3 to 4 words to request during play therapy 10 times per session given a clinician model.

Objective 3: *In order to follow procedures related to safety both at home and in the community,* the client will attend to an activity for 6 turns with 80% accuracy and minimal cueing.

Objective 4: The parent will participate in therapy through observation and completion of a home program that promotes generalization of learned therapy concepts over 75% of the time **

Objective 5: A yearly speech/language evaluation and hearing screening will be conducted.

**ALL REPORTS FOR CHILDREN NEED TO HAVE A PARENT/GUARDIAN OBJECTIVE –FOR IN THE CLINIC OR/AND AT HOME. Also, a SoonerCare requirement

PROGNOSIS (use template in CounselEar Recommendation section)

The prognostic statement should include the probability of the client reaching your long-term objective, why (reasons) you are making this prediction, and anticipated length of treatment.

CHECK WITH SUPERVISOR TO SEE IF PROGNOSIS IS APPROPRIATE FOR LIFE CENTER CLIENTS - if so, a length of time is not needed **Here are your choices:

PROGNOSIS (*select the prognosis factors, range, and the length of time from the parenthesis and then delete the parenthesis)*

Due to the client's *(motivation - Age - Family support - Severity of disorder- progress thus far)*, prognosis for improvement with skilled speech treatment is *(Excellent, Good, Fair, Poor)* for the client to reach the long-term objectives listed above. It is anticipated that the client will need at least (*a year - 6 months) of* treatment to obtain this level of functioning.

Example:
Due to age-appropriate receptive language skills, family support and client motivation, the prognosis for improvement with skilled speech/language treatment is excellent for the client to reach the long-term objectives listed above. It is anticipated that the client will need at least 6 months of treatment to obtain these levels of functioning.

Or you could add the LTO into the statement if you wish:
The prognosis for improvement is excellent for the client to reach his long-term objective of improving his expressive language and demonstrate a MLU of 3.5 and age-appropriate syntactic structures due to family support, age-appropriate receptive skills, and cooperative attitude. It is anticipated that the client will need at least a year of treatment to obtain these levels of functioning.

CUSTOM (use the template in CounselEar custom section) Attestation Statement
SOONERCARE ONLY
I actively participated in the formulation of this progress report and agree with the statements and the objectives documented here.
Certificate of Medical Necessity Statement **MEDICARE ONLY**
It will be understood that the treatment plan mentioned above is certified medically necessary by the documenting therapist and referring physician mentioned in this report. Unless the physician indicates otherwise through written correspondence with our office all further referrals will act as certification of medical necessity on the treatment plan indicated above.

Thank you for this referral. If you have questions regarding this plan of care, please contact us at (405)744-6021.
I certify the need for these services furnished under this plan of treatment while under my care.

___I have no revisions to the plan of care.
___Revise the plan of care as follows
____
____
____

Physician Signature____
Physician Name____
Date: _______________________

REFERRING PHYSICIAN
Select the name of the referring physician or have the front office add it if not in CounselEar. Select FAX as the preferred delivery. Create a FAX Cover and Cover Letter from the tabs/dropdowns in CounselEar.

ADDITIONAL RECIPIENTS
Put family or adult client here. Select EHR and create a cover letter using the tabs/dropdowns.

Select other professionals/individuals the client has signed an *Authorization to Release Protected Health Information* form for. Select FAX as the preferred delivery and create Fax Cover and Cover letter from the tabs/dropdown.

CC
The referring physician and any additional recipients should show up automatically.

REPORT ATTACHMENTS
Add any PDF file to the report. Best option for tables that contain IPA symbols.

REPORT OPTIONS (Choose EVALUATION REPORT from the dropdown)

PATIENT PORTAL (Box is checked prior to finalizing report)

EVALUATION REPORT CHECKLIST

CLIENT INFORMATION	
	Age: Report in year/month up to adolescents; matches Reason for Referral
	Birthdate (optional)
	Address
	Telephone
	Parent/Guardian (delete Guardian/Parent if not appropriate)
	Referred By: Put referring physician/physician assistant/nurse before parent
	Current Diagnosis: (severity and communication disorder & medical etiology
	ICD-10-CM: (No F codes for BCBS. Use R codes)
	Date(s) of evaluation: (Matches the visit dates in CE)
	Time in / Time Out:
	Total Minutes:
REASON FOR REFERRAL – paragraph – NO RESULTS from evaluation go here	
	Name of client (refer to client in same form throughout)
	Age of client (matches Age in Client Information above)
	Date(s) of evaluation
	Place of evaluation
	Referral source with title and/or relationship of referral source to the client
	Reason(s) for referral/purpose of visit – often as stated by parent and/or medical professional
	Brief statement of critical medical and therapy (school) history as related to reason for referral
	Native language of client and if testing was conducted in same language (SoonerCare)
BACKGROUND INFORMATION – use different section(s) as it applies to the client	
☐ Medical and Birth History ☐ General Motor/Self-Help Development	
☐ Educational History ☐ Vocational History ☐ Psycho-Social History	
☐ Speech & Language Development ☐ Family History	
TESTING PROCEDURES & RESULTS (*Language, *articulation, voice, fluency, pragmatics, AAC, *hearing, *oral motor) *SoonerCare requires these four areas to be reported on. Informal observation and data will work for articulation and oral motor) **FOR EACH AREA:**	
	Test Names and what is measured
	Raw Scores
	Standard Scores
	Subtests given AND description of what each subtest measures
	Interpretation of scores including: ☐ Severity ☐ Strengths ☐ Weakness/deficit (or errors)
	Supporting Tables Informal Observations and interpretation
SUMMARY/DIAGNOSIS	
	Communication diagnosis and severity
	Contributing medical, developmental factors to communication disorder
	Strengths & weaknesses of skills – areas tested
THERAPY PLAN RECOMMENDATIONS	
	The need for skilled speech/language therapy (secondary to medical necessity if appropriate
	Frequency of therapy

	Type of therapy
	Further diagnostics or referrals needed
LONG-TERM OBJECTIVES	
	LTO addresses each major communication area that has been diagnosed
	Each LTO has the following parts ☐ Performance ☐ Condition (optional) ☐ Criterion
SHORT -TERM OBJECTIVES	
	If SoonerCare, each objective must have a statement on medical necessity
	Each STO has the following 3 components ☐ Performance ☐ Condition ☐ Criterion
	Include family objective/home program (must for SoonerCare)
	Include need for speech/lang/hearing re-evaluation in one year
PROGNOSIS	
	Probability of client reaching LTO
	Length of time to achieve LTO
	Supporting evidence for prognosis
REFERRING PHYSICIAN (separate section in CounselEar)	
	Referring medical professional
	Check fax and cover letter tabs for correct dropdown selection
	Delivery Option drop down to FAX
ADDITIONAL RECIPIENTS (separate section in CounselEar)	
	Parent of Client's name entered
	Delivery Option drop down menu to EHR
	Make sure email address is present
	Check cover letter Tab for correct dropdown selection
REPORT OPTIONS (separate section in CounselEar)	
	Evaluation Report selected on dropdown
	Formatting is correct
REPORT ATTACHMENTS (separate section in CounselEar)	
	PDF only can be attached
PATIENT PORTAL (separate section in CounselEar)	
	Box checked before finalizing report
SUPERVISORS	
	Sent a TO DO to front office to send reports to client/family and medical professionals
	If therapy recommended on SoonerCare client that will be attending therapy, send an email and TO-DO dated current day that the report is ready to send for authorization to financial assistant.
PROFESSIONAL GRAMMAR AND WRITING STYLE	
	☐ No first-person pronouns ☐ Past tense ☐ Complete Sentences
	☐ Sentence structure not over complicated or wordy
	☐ Correct Formatting of report/paragraphs/headers -**CHECK PDF OF REPORT**

RE-EVALUATION GUIDELINES

Use the Evaluation Report format described above with slight modifications listed below.

REASON FOR REFERRAL

In a ***re-evaluation***, you should also discuss prior evaluations. Write the month/year of prior evaluations. Give diagnosis and severity levels. State the reason for the re-evaluation.

EXAMPLE: Joey Brown, an eight-year ten-month old male, was initially referred to the Oklahoma State University (OSU) Speech-Language-Hearing Clinic by his physician, Dr. Smith and his school speech-language pathologist, Suzy Smith. Joey was initially evaluated on June 11, 20XX and began receiving speech and language services in the fall of 20XX. He presented with a severe receptive/expressive language disorder and a severe articulation/phonological processes disorder. Joey was last re-evaluated on June 19, 20XX, and results indicated a mild receptive/expressive language disorder and a severe articulation/phonological processes disorder. This yearly reevaluation was conducted on July 20, 20XX in his native language of English at the OSU Speech-Language-hearing Clinic to assess his current abilities and treatment objectives.

BACKGROUND INFORMATION

Give detailed background information since the insurance reviewers and others besides the parents do not have this information at the time they are reading the report. Include the same sections such as Medical History, School History, Family History, Gross Motor Development, etc.

In the Speech and Language Development section, summarize the past therapy objectives and the client's progress.

Example:

Joey began to babble at 2 years, use single words at 2 ½ years, and combine words around 3-3 ½ years. His mother first noticed his delayed speech production when he was 2 and "wasn't even trying to talk." When younger, Joey was aware of his speech differences. When his speech was not understood, he used gestures or drawings to communicate. Joey attended preschool at the 1st Presbyterian Preschool when he was 2 years old. At age 3, he was evaluated by the Stillwater Public Schools to qualify him for public school programs. He was enrolled in the Richmond Early Childhood Center (RECC) 3-year-old program. He was referred to the OSU Speech-Language-Hearing Clinic by his SLP at the RECC program, Kim Jones. Joey was initially evaluated at OSU on June 11, 20XX and diagnosed with a severe receptive/expressive language disorder and a severe articulation/phonological processes disorder. He began attending speech and language therapy in the fall of 20XX and therapy focused on improving speech intelligibility and receptive/expressive language skills. He was re-evaluated each summer. His last re-evaluation at the OSU Clinic was conducted on June 19, 20XX and indicated a mild language delay and severe articulation/phonological processes disorder. In the fall of 20XX, it was noted that Joey presented with errors consistent with the diagnosis of childhood apraxia of speech. It was determined at the end of the spring semester in 20XX that his phonological awareness was impaired and limiting his receptive and expressive language skills in the areas of reading and writing. The *LindamoodBell Program for Reading, Spelling, and Speech (LiPS)* was introduced to the client on June 18, 20XX to promote his emerging literacy skills by targeting phonological deficits.

SOONERCARE REQUIRES listing the objectives from the last evaluation report and reporting on progress.

Progress Towards Objectives (Goals set August 20XX)

#1 In order to communicate effectively in an emergency, the client will imitate initial /l,s,j/ at the structured word level with 80% accuracy and moderate cuing. GOAL MET

at 83% by November 20XX. The client continues to have difficulty with Initial Consonant Deletion at the phrase and sentence levels with these phonemes.

#2 In order to convey information about self in a medical situation, the client will produce intelligible utterances with 80% accuracy in conversation speech using 6 – 8-word utterances. GOAL PARTIALLY MET by November 20XX. Intelligibility was 70% when the context was known and below 50% if context was not known. The client continued to (Important to describe errors contributing to the objective not being met) ETC and so on.

RESULTS - AREAS TESTED

Briefly compare last year's testing results with this year's results if comparable in a paragraph after describing the current testing. Standard Scores from two different tests cannot be compared. Sometimes SS may decrease as the child falls further behind his typically developing peers and you should address this also. TABLES with raw score and standard scores/scaled scores are helpful.

GFTA-3 Scores			
Year	Standard Score	Percentile Rank	Severity
2017	52	0.1	Severe
2018	80	9	Mild

SUMMARY/DIAGNOSIS

Discuss progress/lack of progress over the past year as well as results of testing. If there is a medical diagnosis that has impacted the communication disorder, it should be included.

EXAMPLE

Testing results indicated that Steven has made significant improvement in speech intelligibility, auditory comprehension, and verbal expression over the past year. Standardized testing indicated that he was within the average range for overall auditory comprehension/verbal expressive language ability, especially in the areas of semantics and ability to create complex sentences on structured tasks. Results indicated a moderate auditory processing/phonological awareness delay characterized by difficulties blending phonemes into words. Results of a spontaneous language sample indicated a mild to moderate expressive language delay characterized by reduced MLU for his age, occasional syntactic errors, and omissions of grammatical morphemes and words. He also had difficulty repeating sentences exactly. Steven's mild/moderate apraxia continued to limit his ability to produce multiple consonant clusters (e.g., str), multisyllabic words and lengthy utterances and this was reflected in spontaneous speech scores. Steven presented with a mild to moderate delay in oral reading skills characterized by difficulties in rate, accuracy, and comprehension. Writing scores revealed a mild impairment in spelling and a borderline mild impairment in punctuation at the sentence level.

SoonerCare Requirements for Evaluations and Re-Evaluations

1. **REFERRAL SOURCE** – needs to be the client's referring SoonerCare doctor, physician assistant or registered nurse. Always check to verify the referring professional's correct title (e.g., Dr. RPN, PA, etc.)

2. **DIAGNOSIS/ICD 10 codes** – always include any medical diagnosis as well as speech/language/hearing codes. Chronic Otitis Media, Down's Syndrome, Prematurity – all impact communication and provide a "medical necessity" component.

3. **REASON FOR REFERRAL** section – in addition to the above information
   a. Make sure to describe any medical issues that might be related to the communication disorder.
   b. You must state the client's native language and that what language the evaluation/therapy were conducted in
      - Jack's native language was English and the evaluation/therapy was conducted in this language.
      - English was Ali's second language, while Arabic was his native language. This evaluation was primarily conducted in English. His mother was present during the evaluation and upon request would translate directions into Arabic.
      - Therapy will be conducted primarily in English with his mother or sister providing translation into Arabic whenever needed.
   c. You must state where the evaluation and/or therapy take place.
      - The evaluation was conducted at the OSU Speech-Language-Hearing Clinic and therapy will be provided there also.

4. BACKGROUND INFORMATION

a. *should be detailed* as the reviewers do not look at past reports/evaluations. It should include documentation of referring doctor (and others), relevant medical history, - especially include prematurity, chronic otitis media, any syndrome or other diagnosis such as autism, etc.; relevant speech/language/hearing/ swallowing fluency/cognitive-communication history and diagnosis of a speech/ language /swallowing/fluency/cognitive-communication disorder.

5. If you are doing **a re-evaluation** for SoonerCare, you need to report on Progress toward Short Term Objectives listed on the last evaluation report as well as the background information above. If you put GOAL MET or GOAL PARTIALLY MET, go on to explain the current status/residual problems or why goal was not met.

a. In the BACKGROUND INFORMATION section write a subheading **Progress Towards Objectives** (Goals set August 20xx) Example:

BACKGROUND INFORMATION
(All the pertinent medical and developmental history first) Then:

Progress Towards Objectives (Goals set August 20XX)
Objective #1: In order to communicate effectively in an emergency, the client will imitate initial /l,s,j/ at the structured word level with 80% accuracy and moderate cuing. GOAL MET at 83% by November 20XX. The client continues to have difficulty with Initial Consonant Deletion at the phrase and sentence levels with these phonemes.

Objective #2: In order to convey information about self in a medical situation, the client will produce intelligible utterances with 80% accuracy in conversation speech using 6 – 8-word utterances. GOAL PARTIALLY MET by November 20XX. Intelligibility was 70% when the context was known and below 50% if context was not known. The client continued to (Important to describe errors contributing to the objective not being met) ETC and so on.

6. TESTING PROCEDURES AND RESULTS -

a. sections for **Articulation/Phonology; Language; Oral Motor and Hearing** must all be evaluated and reported on. For the very young or unintelligible, this might not be a standardized assessment, but could be for Articulation - a phonemic inventory and syllable shape analysis based on observation and parent report. For Language, it could be the *REEL* or *Rossetti* based on parent interview.
b. If the client does not pass the hearing screening or tympanometry, the resulting action must be addressed – such as referral to the physician for middle ear issues or to the audiologist for more in-depth evaluations. If the client is to be seen by OSU Audiology, there is a form in the front office you need to complete and give to the front office staff so a doctor's prescription for audiology can be made.
c. Report standard score and scaled scores whenever possible. If using language samples, give database information and/or developmental norms for the age you are working with.
d. If a **re-evaluation**, compare last year's testing results with this year's results if comparable.

7. Summary/Diagnosis

Include information related to progress over the past year as well as current status. Any medical diagnosis related to the communication disorder should be stated. Indicate that skilled speech/language therapy is required to address the deficits described.

8. **Long Term Objectives** Long Term Objectives must be measurable – with a length of time anticipated to achieve them. Usually, one year is the standard length for a LT Objective (See Section 2 – Beginning of Semester for detailed descriptions of LT Objectives)

   NOTE: At this time, SoonerCare is recommending **different, measurable** Long-Term Objective for each major communication area (e.g., one for speech, another for language).

9. **Short Term Objectives** must be measurable and include a **statement of Medical Necessity. See Section 4 -** for more examples of how to write STO with a Medical Necessity lead-in phrase than written in this section.

10. SoonerCare requires *that family be involved in the therapy sessions 50% of the time.* "Involvement of the parent/caregiver includes, but is not limited to, direct participation in the child's session, instructional methods and practice assignments relayed by email or telephone, or instructional methods and practice assignments documented in a notebook along with data collection and parent/caregiver signatures. Documentation should clearly indicate: • the method by which the parent/caregiver was instructed (e.g., in person, electronically, etc.) • what goals and objectives were targeted; and • how the parent/caregiver was educated to reinforce, support and, in general, carry out the treatment plan outside of the therapy session."

    Examples

    - The client and their family will promote carryover into spontaneous speech by completing a home program 4 days a week 80% of the time.
    - The parent will participate in the last 10 minutes of each therapy session and model techniques taught by the clinician to facilitate two-word utterances.
    - The clinician and parent will communicate via e-mail on a weekly basis and information will be shared regarding therapy objectives and techniques to target at home and any parental questions or concerns.
    - A home program that addresses the above objectives will be completed by the parents 80% of the time and observation of sessions will occur 50% of the time.

    a. Hearing must be screened every year and reported on in the progress report every 90 days. Make it your last objective on the Treatment Plan/Progress Report.

    - A yearly hearing screening and speech/language evaluation will be conducted.

11. Attestation statement must be on all paperwork.

RE-EVALUATION REPORT CHECKLIST

CLIENT INFORMATION	
	Age: Report in year/month up to adolescents; matches Reason for Referral
	Birthdate (optional)
	Address
	Telephone
	Parent/Guardian (delete Guardian/Parent if not appropriate)
	Referred By: Put referring physician/physician assistant/nurse before parent
	Current Diagnosis: (severity and communication disorder & medical etiology)
	ICD-10-CM: (No F codes for BCBS. Use R codes)
	Date(s) of evaluation: (Matches the visit dates in CE)
	Time in / Time Out:
	Total Minutes:
REASON FOR REFERRAL – paragraph – NO RESULTS from evaluation go here	
	Name of client (refer to client in same form throughout)
	Age of client (matches Age in Client Information above)
	Date(s) of evaluation
	Place of evaluation
	Referral source with title and/or relationship of referral source to the client
	Reason(s) for Re-evaluation – often to assess progress & update objectives as appropriate
	Brief statement of critical medical and therapy (school) history as related to reason for referral
	Briefly list all past re-evaluations, when completed and results
	Native language of client and if testing was conducted in same language (SoonerCare)
BACKGROUND INFORMATION – use different section(s) as it applies to the client	
☐ Medical and Birth History ☐ General Motor and Self-Help Development	
☐ Educational History ☐ Vocational History ☐ Psycho-Social History	
☐ Speech and Language Development ☐ Family History	
SOONERCARE ONLY- ☐ Progress towards objectives listed on last evaluation ☐ If each was met or not & why	
TESTING PROCEDURES & RESULTS-(*Language, *articulation, voice, fluency, pragmatics, AAC, *hearing, *oral motor) *SoonerCare requires these four areas to be reported on. Informal observation and data will work for articulation and oral motor) **FOR EACH AREA:**	
	Test Names and what is measured
	Raw Scores
	Standard Scores
	Subtests given AND description of what each subtest measures
	Interpretation of scores including: ☐ Severity ☐ Strengths ☐ Weakness/deficit (or errors)
	Supporting Tables
	Informal Observations and interpretation
	Paragraph on last year's testing results for that area (lang, artic, etc.) ☐ Tests given and severity results from past years. ☐ Comparison of current testing with prior testing - improvements noted. ☐ If Standard Scores decreased-why? more advanced skills required by same age peers, attention/behavior on day of testing, medical reasons? May need to report raw scores to

	show improvements – or describe functional improvements in skills that have been seen in therapy. ☐ Supporting Tables – both years if same tests given
SUMMARY/DIAGNOSIS	
	Communication diagnosis and severity
	Improvements in areas/skills over the past year/comparison of scores and commun. behaviors
	Contributing medical, developmental factors to communication disorder
	Strengths & weaknesses of skills – areas tested
THERAPY PLAN RECOMMENDATIONS	
	The need for skilled speech/language therapy (secondary to medical necessity if appropriate)
	Frequency of therapy
	Type of therapy
	Further diagnostics or referrals needed
LONG-TERM OBJECTIVES	
	LTO addresses each major communication area that has been diagnosed
	Each LTO has the following parts ☐ Performance ☐ Condition (optional) ☐ Criterion
SHORT -TERM OBJECTIVES	
	If SoonerCare, each objective must have a statement on medical necessity
	Each STO has the following 3 components ☐ Performance ☐ Condition ☐ Criterion
	Include family objective/home program (must for SoonerCare)
	Include need for speech/lang/hearing re-evaluation in one year
PROGNOSIS	
	Probability of client reaching LTO
	Length of time to achieve LTO
	Supporting evidence for prognosis
REFERRING PHYSICIAN (separate section in CounselEar)	
	Referring medical professional
	Check fax and cover letter tabs for correct dropdown selection
	Delivery Option drop down to FAX
ADDITIONAL RECIPIENTS (separate section in CounselEar)	
	Parent of Client’s name entered
	Delivery Option drop down menu to EHR
	Make sure email address is present
	Check cover letter Tab for correct dropdown selection
REPORT OPTIONS (separate section in CounselEar)	
	Evaluation Report selected on dropdown
	Formatting is correct
REPORT ATTACHMENTS (separate section in CounselEar)	
	PDF only can be attached
PATIENT PORTAL (separate section in CounselEar)	
	Box checked before finalizing report
SUPERVISORS	
	Sent a TO DO to front office to send reports to client/family and medical professionals

	SoonerCare client that will be attending therapy, send an email and TO-DO dated current day that the report is ready to send for authorization to financial assistant.
PROFESSIONAL GRAMMAR AND WRITING STYLE	
	☐ No first-person pronouns ☐ Past tense ☐ Complete Sentences
	☐ Sentence structure not over complicated or wordy
	☐ Correct Formatting of report/paragraphs/headers -**CHECK PDF OF REPORT**

EVALUATION REPORT EXAMPLE – PRESCHOOL

CLIENT INFORMATION
NAME: Lauren Jones
AGE: 3 years, 0 months
BIRTHDATE: 06/05/20XX
ADDRESS: 11 S. Street, Tulsa, OK, 74074
TELEPHONE: (918) 696-9899 (Sarah); (405) 833-0777 (Jon)
PARENTS: Sarah and Jon Jones REFERRED BY: Dr. Amy Heard, M.D.
DATE OF EVALUATION: 06/14/20XX
Time In/Out
2:30 pm – 3:45 pm
Total time in minutes
75 minutes
DIAGNOSIS
Current Diagnosis: Expressive language delay; Articulation/Phonological Process delay; Chronic Otitis Media
ICD-10CM: F80.1, F80.0; H65.20

REASON FOR REFERRAL
Lauren Jones, a 3-year, 0-month-old female, was referred to the Oklahoma State University Speech-Language-Hearing Clinic by her pediatrician Dr. Amy Heard due to concerns regarding delays in speech and expressive language skills secondary to chronic otitis media. Testing was conducted in Lauren's native language, English.

BACKGROUND INFORMATION
Medical and Birth History
Lauren was born on June 5, 20XX, and no abnormalities during pregnancy were reported. Lauren had a history of Otitis Media resulting in Pressure Equalization (PE) tubes. Lauren's mother reported that she was seen at Hearts for Hearing, and at her follow-up appointment, her ears were "clear."

General Motor and Self-Help Development
It was reported that Lauren has difficulties with gross and fine motor development and was hypotonic. She has been with Sooner Start since she was 4 months old receiving Occupational Therapy (OT) and Physical Therapy (PT). Recently she had been evaluated by PT and OT for transition into the school setting. She qualified to receive both services at school for development of gross and fine motor skills.

Speech and Language Development
Because of delays, Lauren began receiving speech therapy through Sooner Start at the age of 4 months. On May 2nd, 2018, she was evaluated by Kim Keffer, SLP at Tulsa Public Schools utilizing the *Developmental Profile III (DP-III)* and communication with Lauren's Sooner Start

speech/language therapist. Lauren received an Overall Standard Score of 87 in the Communication Domain, which was in the low average range, but there was a difference between her receptive and expressive abilities. As reported on Lauren's Individualized Education Plan (IEP), Lauren had mostly CV words, and only combined around 2 words. It was reported that her receptive language appears to be a strength for her, as well as her cognitive skills. The family was encouraged by the school SLP to request additional speech therapy services for Lauren over the summer with possible continuation into the school year. She will be seen once weekly for 30 minutes beginning in August of 20XX in the school.

Family History

No family history of speech or language delays was reported.

AREA TESTED/RESULTS

Articulation/Phonology

No formal articulation testing was conducted due to Lauren's ability to attend as well as some shyness. Her articulation and phonology skills were observed by the clinician during language testing. Lauren demonstrated the consonants /d, n, b, m, k, g, f, j, t, v, h, w/. She demonstrated some difficulty with /p/and would voice it so it became a /b/. Final consonant deletion and syllable reduction were present as she used mostly CV syllables for words (i.e., /ha/ for "Lauren," /ti/ for "Jodi," /wʌ/ for "wheel"), and some CVC words (i.e., /vum/ for "car"). Additionally, she sometimes demonstrated reduplication (i.e., /bubu/ for "pool," and /dodi/ for "Jodi"). These phonological processes have generally resolved in children's speech by the age of three.

Hearing

A hearing screening was administered to Lauren. The Otoacoustic Emissions (OAE) test was administered, and Lauren passed in her left ear. No seal was able to be obtained on her right ear, due to difficulties maintaining attention and interest. However, Lauren's mother reported that she was seen recently at Hearts for Hearing where a hearing screening was administered, and no problems were found. For testing today, Lauren demonstrated adequate hearing in at least one ear.

Language

The *Preschool Language Scale, Fifth Edition (PLS-5)* was administered to Lauren to evaluate her expressive and receptive language abilities. The *PLS-5* measures a child's language abilities, from ages 0-7 years. It consists of two subscales, Auditory Comprehension (AC), and Expressive Communication (EC). It also has a Total Language Score (TLS). Both subscales and the TLS yield a standard with a mean score of 100. Standard scores from 85 to 115 are considered to be within the range of average.

The AC subscale assessed how well Lauren understands language. She received a standard score of 89 on the AC portion of the test, indicating that she was in the range of average in her auditory comprehension skills. As testing was discontinued when the client lost interest, her actual auditory comprehension score could be slightly higher. She demonstrated strengths in recognizing action in pictures, understanding spatial concepts (e.g., off, in, on), quantitative

concepts, (e.g., one/all) and identifying colors. She also did well in understanding analogies and making inferences. She had difficulties in identifying objects when described by their use and understanding negatives in sentences. It should be noted that Lauren lost interest after item number 37, identifies colors, and testing for AC was discontinued.

Next, Lauren was administered the EC subscale. This portion of the test measured Lauren's expressive language abilities. Lauren received a standard score of 83 on the EC portion of the test. This score indicated that Lauren was below average in her expressive communication skills. She demonstrated strengths in naming a variety of pictured objects (i.e., bear - /bɛ/, star - /da/, scissors - /na/ (consistent), and elephant - /fɛn/), and using a variety of single word nouns, verbs, and modifiers. She had difficulty in combining 3 or 4 words in spontaneous speech, using present progressive (-ing), and using plurals. It should be noted that because Lauren mostly says CV words, it would be difficult for her to add the syllables necessary to produce those grammatical endings.

Although her expressive language score on the *PLS-5* indicated that she was only slightly below average for her age, Lauren primarily used single words and was not combining more than 2 words together. Her speech production abilities were mainly limited to CV words and reduplicated CVCV syllables which negatively impacted her expressive language skills. Though many of her words are produced in a consistent manner, unfamiliar listeners would only understand a small portion without the mother's interpretation. Her expressive language was also characterized by difficulty with verbalizing words without prompting.

The TLS is a combination of the AC and EC subscale results and is meant to provide a representation of Lauren's global language abilities. Lauren received a standard score of 85 indicating that she was borderline average/ mildly impaired for overall language skills (85-115). The difference between Lauren's AC and EC scores was not statistically significant.

Findings are summarized in the table below.

Preschool Language Scales, Fifth Edition (PLS-5)

Subtest	**RS**	**SS**	**%ile**	**Severity**
Auditory Comprehension	35	89	23	Average
Expressive Communication	31	83	13	Mild
Total Language Score	66	85	16	Borderline Average/Mild

Oral Motor

Lauren's oral motor mechanisms were observed by the clinician, and structures appeared to be functioning within normal limits with some mild hypotonia.

SUMMARY/DIAGNOSIS
Results of the speech and language evaluation indicated that Lauren presented with a moderate speech production/articulation disorders and expressive language delay. Lauren demonstrated difficulty producing some age-appropriate sounds, and used final consonant deletion, reduplication, and syllable deletion during production of most words. Results of hearing assessment indicated a pass in Lauren's left ear. Though no seal was able to be achieved on her right ear, her mother reported a normal hearing evaluation conducted by an audiologist at Hearts for Hearing recently. Lauren has a history of chronic otitis media with PE tubes.

THERAPY PLAN RECOMMENDATIONS
Due to the severity of Lauren's expressive language delay, it was recommended that she be seen for speech therapy at the Oklahoma State University Speech-Language-Hearing Clinic twice a week beginning in Summer 20XX.

LONG-TERM OBJECTIVES
#1. The client will increase her Mean Length of Utterance (MLU) to 3.0 as measured by language sampling and completion of short-term objectives.
#2. The client will increase speech intelligibility and complexity of word structures to age-appropriate levels.
SHORT-TERM OBJECTIVES
OBJECTIVE #1: The client will increase her spontaneous MLU to 2.0 by using two- and three-word phrases to request and describe objects and actions utilizing a variety of nouns, verbs, modifiers, and other parts of speech.
OBJECTIVE #2: The client will eliminate final consonant deletion and syllable reduction with phonemes in her repertoire to correctly produce CVC and CVCV words with 80% accuracy in structured activities.
OBJECTIVE #3: The client will produce age-appropriate phonemes including /p/ and possibly /g, k/ in all word positions with 80% accuracy.
OBJECTIVE #4: The client's family will participate in therapy activities via observation and completion of a home program for a minimum of 50% of the time.
OBJECTIVE #5: The client will be given a yearly re-evaluation of communication and hearing abilities.

PROGNOSIS
Due to the client's age, and family support, the prognosis for improvement with skilled treatment is good for the client to reach the long-term objectives listed above. It is anticipated that the client will need at least a year of treatment to obtain this level of functioning.

ATTESTATION STATEMENT: (SoonerCare only)
Referring physician - Dr. Amy Heard
Additional Recipients - Sarah and Jon Jones
CC Dr. Amy Heard; Sarah and Jon Jones

Patient Portal (box checked prior to finalizing)

RE-EVALUATION REPORT EXAMPLE–SOONERCARE

NAME: Matthew South
AGE: 5 years, 9 months
BIRTHDATE: January 17, 20XX
ADDRESS: 444 E 750 Road, Perkins, OK 74824
TELEPHONE: (405) 269-9547
PARENTS: Tom and Paula South
REFERRED BY: Dr. Stephen Smith
DATE OF EVALUATION: 11/20/20XX
Time In/Out 9:00am – 11:20 am
Total time in minutes 140 minutes

DIAGNOSIS Moderate-to-Severe Receptive and Expressive Language Delay; Mild-to-Moderate
Articulation Disorder; Chronic Otitis Media
ICD-10CM: F80.2, F80.0, H65.20

REASON FOR REFERRAL

Matthew South, a 5 year, 9-month-old male, was referred to the Oklahoma State University Speech Language Hearing Clinic due to his lack of intelligibility by his physician, Dr. Smith. An initial evaluation of speech and language was conducted in December 20XX at Oklahoma State University Speech-Language-Hearing Clinic. Matthew was diagnosed at that time with a severe articulation disorder and a mild-to-moderate receptive and expressive language delay.
Matthew's language and speech was re-evaluated at the Oklahoma State Speech Language Hearing Clinic on November 20, 20XX in English, his native language. This yearly re-evaluation was conducted to assess current skills, progress, and update objectives.

BACKGROUND INFORMATION

Matthew presented with a normal birth history. He met all general motor and speech and language milestones within a typical time frame. Matthew attended kindergarten at Perkins Public Schools where he received group speech-language therapy once a week. He has reoccurring ear infections and occasionally has discharge. The client received Pressure Equalizing (PE) tubes in both ears in January 20XX.

Progress Towards Objectives (Goals set December 20XX)

#1 In order to improve the ability to communicate with others during an emergency, the client will accurately produce initial /s/ blends /sl, sm, sn, sp, sw/ at the word level with minimal verbal cueing with 80% accuracy. GOAL PARTIALLY MET as the client was able to accurately produce /sl, sm, sn, sp/ with 86% accuracy. Matthew still struggled to accurately produce the /s/ blend /sw/ as he was only 46% accuracy with heavy cueing and modeling.
#2 In order to express specific needs in medical situations, the client will accurately produce initial /s/ blends /sk, st/ at sentence level with minimal verbal cueing with 80% accuracy. GOAL

MET as Matthew independently produced the /s/ blends /sk, st/ with 95% accuracy at sentence level.
#3 To enhance the client's skilled speech and more effectively communicate wants and needs in all settings, the client will accurately produce the final consonants /f, k, n, s, t, z/ at the sentence level with minimal verbal cueing with 80% accuracy. GOAL MET as the client produced the final consonants with 98% accuracy at sentence level with no cueing.
#4 To address expressive language delays secondary to articulation errors due to chronic otitis media, the client will accurately produce the plural morpheme /əz/ in a sentence completion task with minimal visual cueing with 90% accuracy. GOAL MET as Matthew was 98% accurate using the morpheme /əz/ in sentence completion tasks. The client still had problems producing the morpheme in spontaneous sentences.
#5 The client's parents will participate in the client's progress towards objectives through attendance at therapy sessions a completion of the home program 80% of the time. GOAL MET as Matthew 's mother was present for every session and completed all homework.
#6 The client will receive a yearly hearing screening to determine status of hearing. GOAL MET as the client's hearing was screened on November 10, 20XX.

AREA TESTED/RESULTS

Articulation/Phonology

The *Goldman-Fristoe Test of Articulation- 3rd Edition (GFTA-3)* was administered to assess Matthew's ability to properly articulate sounds at the word and sentence level. This is a standardized assessment and standard scores falling between 85 and 115 indicate skills within the average range.

Sounds- in-Words

Due to Matthew's age, the Sound-in-Words subtest was used to assess his articulation skills when labeling single words. Matthew's Sounds- in-Words standard score was 77, which was considered a moderate delay. He was able to properly articulate /p, b, d, g, m, n, ng, f, v, s, z, ʃ, w, h/ at word level in all positions (e.g., initial, medial, final) with 80% accuracy or higher. Matthew was unable to articulate the following phonemes with 80% accuracy in some or all word positions /t, k, θ, ð, ʃ, ʤ, ʧ, j, r, l/. For clusters, the client was able to accurately produce /gl, kw, sl, st/ at least 80% of the time. Matthew was unable to accurately produce the following clusters at word level/bl, br, dr, fr, gr, kr, pl, pr, sp, sw, tr/. The client produced 82% (130/159) of the consonants accurately at the word level.

Phonological processes noted in Matthew's speech at the word level included: final consonant deletion (e.g.; "we" for "web"), weak syllable deletion ("ephant" for "elephant"), gliding (e.g. "cwown" for "crown", "pwa" for "plate"), cluster reduction (e.g.; "pider" for "spider"), stopping of voiced and voiceless "th" (e.g.; "broder" for "brother"), and deaffrication (e.g. "teasher" for "teacher", "vestable" for "vegetable"). Matthew added the /f/ phoneme between the /sw/ blend (e.g., "sfwing" for "swing"). By the age of 5, the processes of final consonant deletion, cluster reduction, and weak syllable deletion should have resolved and not be present in his speech. Stopping of voiced/voiceless "th", gliding of /r, l/ and deaffrication are considered age-appropriate errors.

Sounds-in-Sentences
The Sounds-In-Sentences subtest was also administered to assess the client's articulation of sounds while produced in sentences. His standard score for Sounds-In-Sentences was 81, which was considered mildly impaired. The client omitted /θ/ in all word positions and /t/ in the medial word position. The phonological process of final consonant deletion was present with the consonants, /n, t, z, l, θ/. Matthew also glided the /r/ sound in the initial position and presenting with gliding while producing the consonant clusters /bl, br, pl, gr, dr/. The client deleted /s, z/ in consonant clusters /ps, dz/.

Overall, Matthew's speech intelligibility was considered good though occasional low intensity made it difficult for the clinician to understand him. He would periodically use a hoarse voice which also decreased his intelligibility. See Table 5 at the end of report for detailed information on articulation errors.

The *GFTA-3* was utilized to initially evaluate Matthew's articulation for sounds in words in December 20XX. The results indicated that the client was severely delayed in articulation. The re-evaluation displayed progress as results indicated a mild-to-moderate delay in articulation.

Table 1. 20XX *Goldman-Fristoe Test of Articulation- 3rd Edition (GFTA-3)*- Current

Area	**Raw Score**	**Standard Score**	**Percentile**	**Severity**
Sounds-in-Words	29	77	6	Moderate
Sounds-in-Sentences	23	81	10	Mild

Table 2. 20XX *Goldman-Fristoe Test of Articulation- 3rd Edition (GFTA-3)*-Last year

Area	**Raw Score**	**Standard Score**	**Severity**
Sounds-in-Words	44	56	Severe
Sounds-in-Sentences	40	60	Severe

Speech Sample
A speech sample was collected during the evaluation. Similar phonological processes in the *GFTA-3* were also present within the speech sample. For instance, Matthew presented with gliding (e.g., "swipes" for "stripes"), stopping (e.g., "de" for "the") and cluster reduction (e.g., "swipes" for "stripes"). The client also deleted the initial /h/ in "her" and presented with assimilation by saying "cottage" as "tottage."

Hearing
A pure-tone audiometric hearing screening was conducted at 20 dB HL to evaluate the client's hearing acuity. The client correctly identified all tones presented at 1000, 2000 & 4000 Hz in both the right and left ears.

Receptive/Expressive Language

The *Clinical Evaluation of Language Fundamentals, Preschool, Second Edition (CELF-P2)* is a standardized assessment that assesses both expressive and receptive language skills through a variety of subtests. Each subtest yields a scaled score; the average range includes scaled scores between 7-13. Subtest and Index descriptions and scores are addressed below, and findings are summarized in the table below.

Sentence Structure

The Sentence Structure subtest of the *CELF-P2* assessed Matthew's understanding of spoken language at the sentence level. Matthew's scaled score was 5, which was considered a moderate delay. His strengths in the area of comprehension included understanding spatial concepts, passive verbs, and modifications. Areas of difficulty for Matthew included understanding infinitives, compound sentences, subordinate clauses, and indirect requests.

Word Structure

The Word Structure portion of the *CELF-P2* evaluated Matthew's ability to use appropriate morphology and pronouns. Matthew received a scaled score of 4, which was considered a moderate delay. His strengths in this area included using the present progressive (verb + -*ing*), plurals, and contractible copulas (e.g., It is big). Areas of difficulty for Matthew included using regular and irregular past tense, pronouns, and noun derivation.

Expressive Vocabulary

Matthew's scaled score for Expressive Vocabulary was 4, which was considered severely impaired for his age. The client was able to identify food, verbs, and items associated with communication. Matthew had difficulty with objects correlating to science, math, and parts of a whole item (e.g., branch).

Core Language Score

The Core Language Score measures the client's general language ability that quantifies a child's overall language performance. The Core Language Score is derived by adding the scaled scores from the Sentence Structure, Word Structure, and Expressive Vocabulary subtests and converting the sum to a standard score. The sum of the scaled scores of the subtest was 14 resulting in a standard score of 69 which indicated that Matthew's receptive and expressive language skills are moderately-to-severely delayed.

Table 3. (CELF-P2)

Subtests	**Raw Score**	**Scaled Score**	**Percentile**	**Severity**
Sentence Structure	11	5	5	Moderate
Word Structure	10	5	5	Moderate
Expressive Vocabulary	12	4	2	Severe

Table 4. (CELF-P2)

Composite	Sum of Subtests	Standard Score	Percentile	Severity
Core Language	14	69	2	Severe

The *Preschool Language Scale- Fifth Edition (PLS-5)* was used in the initial diagnostic to evaluate Matthew's receptive and expressive language. The results indicated that the client was moderately delayed. The re-evaluation using the *CELF-P2* displayed that the client presented with a moderate-to-severe delay. Although the *PLS-5* and the *CELF-P2* are both measures of a child's receptive and expressive language skills, progress should not be measured by comparing the results of the two assessments as each assessment assesses language differently, and each have different standardization groups. Additionally, as standardized tests compare clients to same age peers and much more language is expected as a child develops, it is not unusual for standardized severity levels to increase as a child ages. Matthew has made progress in his expressive language skills as measured by completion of his short-term objectives.

Oral Motor

An oral motor examination was conducted to evaluate the structure and function of the client's oral mechanisms. No abnormalities in structure or function were detected.

SUMMARY/DIAGNOSIS

Testing results indicated that Matthew made progress in articulation as indicated by comparing the initial evaluation and the re-evaluation. Matthew also met or partially met all of the short-term goals for the fall semester. The client's diagnosis of language altered from a moderate delay in the initial evaluation to a moderate-to-severe delay even though he made progress toward his short-term goals. The moderate-to-severe receptive and expressive language delay and a mild-to-moderate articulation disorder is negatively impacting Matthew's daily communication abilities. A hearing screening indicated normal hearing acuity at this time.

THERAPY PLAN RECOMMENDATIONS

Due to Matthew 's diagnosis of a moderate-to- severe receptive and expressive language delay and a mild-to-moderate articulation disorder, it was recommended that he continue to receive speech services twice a week for one year beginning in the spring of 20XX.

LONG TERM OBJECTIVES

Long Term Objective #1 - The client will improve his speech intelligibility by increasing his percentage of consonants correct to 90% on his annual articulation test.

Long Term Objective #2 - The client will demonstrate improved receptive and expressive language skills as measured by completion of 80% of his short-term objectives.

SHORT TERM OBJECTIVES

1. In order to improve the ability to communicate with others during an emergency, the client will accurately produce initial / s/ blends /sk, sl, sm, sn, sp, st/ at the spontaneous sentence level with minimal verbal cueing with 90% accuracy.
2. In order to express specific needs in medical situations, the client will accurately produce the final consonants /p, b, t, k, n, θ, l, f/ at the spontaneous sentence level given minimal visual and/or verbal cues with 90% accuracy.
3. To enhance the client's skilled speech and more effectively communicate wants and needs in all settings, the client will accurately produce third-person singular morphemes /z, əz/ in the spontaneous sentence with minimal visual cueing with 90% accuracy.
4. To address expressive language delays secondary to articulation errors due to chronic otitis media, the client will accurately produce the past tense morphemes /d, əd/ in a spontaneous sentence given minimal visual cueing with 90% accuracy.
5. In order to follow procedures related to safety both at home and in the community, the client will correctly understand and use the objective pronoun "her" and the subjective pronoun "she" in structured sentences in response to a verbal and/or visual prompt with 80% accuracy.
6. The parents will participate in the client's progress towards the semester objectives through attendance at therapy sessions and/or completion of a home program 70% of the time.
7. A yearly hearing screening and speech/language evaluation will be conducted.

PROGNOSIS

Due to Matthew's age, demonstrated progress in therapy, and strong familial support, the prognosis to reach the long-term objectives listed above within a year with skilled speech therapy services is considered good.

Attestation statement: I was present with the student clinician during the entire evaluation and actively participated. I discussed the evaluation with the student and agree with the findings and plan as documented in this evaluation report.
Referring Physician - Dr. Stephen Smith
Additional Recipients - Tom and Paula South
CC Tom and Paula South; Tom and Paula South
Report Attachments
GFTA-3 Sounds-in-Words- Current

Target	Initial Error	Medial Error	Final Error
t			-
k			-
p			-
b			-
θ	sθ		

ð		d	
ʧ		ʃ	ts
dʒ		pdʒ	
l		w	
j	l		
r	w	w	
kr	kw		
bl	bw		
br	bw	bw	
dr	dw		
gr	gw		
fr	fw		
pl	pw		
pr	pw		
sp	p		
sw	sfw		
tr	tw		

GFTA-3 Sounds-in-Sentences

Target	Initial Error	Medial Error	Final Error
t		-	-
m		-	
n			-
f	-, t		
θ	-	-	-
l			-
r	w		
bl	bw		
br	bw		
gr	gw		
dr	dw	-	
dz			d
pl	pw		

KEY: - omission

PATIENT PORTAL - box checked prior to finalization.