

**LSUHSC DEPARTMENT OF COMMUNICATION
DISORDERS SPEECH-LANGUAGE PATHOLOGY:
CLINICAL HANDBOOK** (Updated September 2017)

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I. Overview of the LSUHSC graduate program

A. *Departmental Mission*

The Department of Communication Disorders, School of Allied Health Professions, Louisiana State University Health Sciences Center, New Orleans has the following missions:

1. To offer an academic and clinical education program to students pursuing a Master of Communication Disorders (M.C.D.) degree in the area of Speech/Language Pathology and a Doctor of Audiology (Au.D.) degree in the area Audiology
2. To conduct research in the areas of audiology and speech/language pathology and
3. To provide clinical services in audiology and speech/language pathology.

The information in this clinic handbook includes policies and procedures related to clinical education in speech-language pathology. Each student enrolled in the speech-language pathology program is responsible for the information contained herein.

B. Sources of Information

For information regarding the academic program, professional organizations and Licensure, refer to the sources given as follows:

1. LSUHSC Academic Catalog: <http://catalog.lsuhs.edu>
 - a. General School Information; facility, fees, calendar
 - b. Scholastic requirements, dismissals, withdrawals
 - c. Student Academic Appeals
 - d. Communication Disorders; curriculum, grades, probation, course description and faculty

2. LSUHSC Department of Communication Disorders' Webpage: www.alliedhealth.lsuhs.edu/CommunicationDisorders
 - a. Current Curriculum
 - b. LSUHSC Academic Misconduct Policy
 - c. Harassment Prevention
 - d. NSSLHA Membership

3. ASHA Website: www.asha.org
 - a. Standards for Certification in Speech-Language Pathology (ASHA Certification Handbook: <http://www.asha.org/Certification/AboutCertificationGenInfo.htm>)
 - b. National Examination in Speech-Language Pathology and Audiology
 - c. Process to Complete Certification
 - d. ASHA Code of Ethics
 - e. Application Form (and more)

5. LBESPA Website: www.lbespa.org

6. LSUHSC Speech-Language Pathology Clinic Handbook:
www.alliedhealth.lsuhs.edu/CommunicationDisorders/SpeechLanguagePathologyClinicHandbook.pdf
 - a. General Clinic Policies
 - b. Clinic Practicum
 - c. Appendices

II. General in-house clinic policies

PLEASE BE AWARE THAT A LACK OF PROFESSIONAL RESPONSIBILITY RELATED TO ANY OF THE FOLLOWING ISSUES WILL RESULT IN A LOWERING OF PRACTICUM GRADES. IN ADDITION, IF THESE PROBLEMS ARE PERSISTENT, DISMISSAL FROM THE PROGRAM WILL RESULT. A VIOLATION OF THE ASHA CODE OF ETHICS MAY RESULT IN IMMEDIATE DISMISSAL FROM THE PROGRAM.

A. Timeliness

1. The student will be prompt in meeting patients for evaluation and treatment sessions, staffings, supervisory meetings, and special conferences.
2. To increase clinician punctuality for Speech-Language Clinic, five minutes have been allowed between sessions for cleanup of the room and/or preparation for the next patient. Appointments will not be canceled without a supervisor's approval or approval by the clinic coordinator.
3. When a patient is late, the student will wait half the period and check with his/he supervisor before leaving.
4. If a patient fails to meet three consecutive appointments without notification, or if attendance is poor, the student should inform his/her supervisor and a decision will be made about continuation of therapy.

B. Illness

In case of illness, it is the student's responsibility to:

1. Notify his/her supervisor directly (if not available, the clinic coordinator, or if not available, another faculty member).
2. Follow the supervisor's instruction, which may include calling the patient/parent, so keep client's phone numbers with you.
3. Make arrangements to make up for absences with supervisor approval.
4. For **evaluations**, see section D. Diagnostics: Illness procedures.

C. Dress Code

Speech-Language Pathology Students are required to wear attire which conforms to the image of the professional speech-language pathologist. The Health Sciences Center, and specifically the SLP Program, is a patient-care setting where patients, other professionals, and the general public form an impression of us which is based on our appearance and conduct. Being neatly dressed and well-groomed is exemplary of professional behavior and is required at all times. Safety and comfort concerns for both the patient and clinician also drive the need for dress modifications in the professional setting.

Clinical attire – Speech-language pathology students should wear appropriate clinical attire for all school related clinical activities. These include, but are not limited to, clinical observations, both at the LSUHSC Speech and Language Clinic and during class visits to different clinical settings, clinical practicum at LSUHSC’s Speech, Language and Hearing Clinic and all speech, language and hearing screenings. Students may be required to adhere to clinic dress code for departmental functions that are not considered clinical; however, SLP student representation is warranted (i.e. COMD Open House, SAHP Family Day)

Minimally appropriate clinical attire consists of the LSUHSC-NO SLP program polo shirt and black uniform pants. Specific information regarding purchase of uniforms will be available at student orientation. Shoes should be clean walking/running shoes with neutral colors (i.e. black, gray, white). All clinical attire MUST be CLEAN and PRESSED. When completing an external clinical practicum, the students are responsible for contacting their clinical instructors in advance for any other dress requirements that clinic might have (e.g., lab coats, neckties, scrubs, etc.). Any specific clinic dress code requirements supersede the LSUHSC SLP Program clinic dress code while at that facility.

The consequences for not wearing appropriate clinical attire may result in the student being sent home, having their clinic grade lowered and/or not having the patient contact time, for that day, counted towards their minimal clinical clock hours for graduation. Clinical supervisors will notify Clinical Coordinator of dress code violations.

Hair- Hairstyles should be neat, well-groomed, and of a conservative color to present a professional appearance. Men must be clean-shaven; or if a beard/mustache is worn, they must be clean and neatly trimmed.

Fingernails- Fingernails should be kept clean and well groomed. Polish is permitted, but should be unchipped, in colors that blend with the clinic attire. Neon or fluorescent colors, nail decals and nail jewelry are not permitted.

Jewelry- Jewelry should be simple, not excessive and should not interfere with the patient’s care. No more than one earring per ear is permitted. Dangling earrings are not allowed for safety reasons; however, simple post earrings are acceptable. No other visible body piercing permitted.

Tattoos/Body art- Students may not exhibit tattoos while wearing clinical attire.

LSUHSC-NO ID- must be worn at all times during clinical situations.

The consequences for not coming into clinical areas in the appropriate attire can be any or all of those listed below:

1. Being sent home
2. Having your clinic grade lowered
3. Forfeiture of certain remote site placement

D. Attendance

1. Required

- a. Screenings: All students are required to participate in speech-language and hearing screenings as assigned. This is part of your professional training and a responsibility which may extend beyond your need for obtaining minimums in clock hours.
- b. Supervisory Meetings: All students enrolled in clinical practicum for treatment or for evaluations are required to attend weekly meetings, as requested by their supervisors. For diagnostics/evaluations, this may include both pre-Diagnostic and post-Diagnostic meetings.
- c. Special Events: Special events are occasionally scheduled, in which student participation is mandatory. This may include guest speakers, faculty presentations, departmental meetings, professional conferences or other workshops. Students will be informed in advance if their participation is optional or mandatory. (i.e, Research Day, Job Fair, Professional Development Series, etc.)
- d. Clinic Clean-up: All students are scheduled for clinic clean-up. Schedules will be posted and it is up to students to complete responsibilities as part of their clinic practicum grade.
- e. All students may be required to attend LSHA and the ASHA conferences when they are held in New Orleans.

2. Optional

All students are encouraged to attend professional meetings at the local, state or national level and may be required to attend specific events (see Special Events above). Financial assistance is often available from departmental funds or through NSSLHA for interested students. The Louisiana Speech- Language-Hearing Association typically meets in June. The American Speech-Language-Hearing Association typically meets in November. The American Academy of Audiology meets in April.

E. Departmental Resources

1. Department telephones and telephone messages/E-mail

- a. The Department has several phone lines for outside calls and interdepartmental calls. Phones are available in the designated area. Phone conversations should be kept to a minimum so incoming call may be transferred. The phones are for professional use. When a personal call is necessary, the length of the call should be kept to a minimum.
- b. If a long distance call is necessary for client contact, the office personnel/clerical staff/supervisor will place the call.
- c. Messages taken by the office personnel/clerical staff will be placed in the faculty mailbox or e-mailed to the faculty member or student. Students are responsible for checking their mailboxes and E-mail daily for messages.

2. Photocopier

- a. There is a photocopier located in the lobby of the sixth floor. Students are required to personally copy any materials for their own educational purpose.
- b. **Exceptions:**
The photocopier in the front office and the large photocopier in the 9th floor Xerox Room are both off limits to students. Students are **NOT** authorized to make copies without a faculty's request and/or approval.

3. Materials and Forms

- a. Clinic Forms are located on the p: drive, including case history, oral mechanism, and hearing screening forms. Protocols for diagnostic tests are located in the Speech Materials Room or supervisor's office. There is a Speech Materials Room Inventory list: posted in the Student Computer Room and on the bulletin board outside of the Speech Materials Room.
- b. Checkout Procedures for Speech-Language Materials

The door to the Therapy/Diagnostic Materials Room should always be closed. Materials must be signed in and out per the following procedures:

- i. *Before checking out any material*, make sure they have not been placed on reserve.
- ii. Therapy Materials:
 - a. Materials must be returned each day because of heavy use. Please sign them out in the materials log book, located at the top of the file cabinets. Materials are not to be left in therapy room cabinets overnight. Someone else may need them for therapy or an evaluation.
 - b. Inventories are located on the Material's room bulletin board and in the computer room. They inform you of available materials and help you locate them.
- iii. Diagnostic Tests:
 - a. Diagnostic materials are inside cabinets in the Materials Room. *Sign out the test* in the diagnostic log book located on the top of the *file cabinets in the materials room*. Complete tests include all examiner and stimulus manuals, test objects, and forms. Specify what you take on the log.
 - b. Sign the test back in when you return it to the materials room. If you want to keep part of the test to score, please sign that portion out and check the remainder back in.
 - c. *Overnight checkout* starts at 5:00 p.m. and materials must be turned back in by 8:00 a.m. On Fridays, overnight check-out begins at 2:00 p.m. and the test must be turned back in by 8:00 a.m. on Monday morning.
 - d. Test forms are located in the filing cabinets in the materials room. Use only one test form for each test administration. Please inform the

faculty member in charge of materials in writing when there are 10 or less forms in the file.

- e. Exceptions: If a student is unable to check-out or return diagnostic materials as specified above due to an off-site placement, they may request special permission from the faculty in charge of materials. Check reserve forms first.

F. Infection Control Procedures

1. Objectives

- a. To identify and incorporate use of universal precautions for controlling infectious diseases in routine patient care.
- b. To increase awareness of type of disease and the means of transmission. Below are routine steps and procedures that should be used in the clinic. When particular persons are responsible for the implementation of the procedures, this is indicated in parentheses.

2. Procedures

a. Annually

- i. Physical Examination for clearance of communicable diseases.
- ii. Consultation with personal physician regarding required vaccines and immunizations.
- iii. It is the student's responsibility to provide documentation of updated immunizations to Student Health and the Clinical Coordinator.

b. Weekly

- i. Clinicians will disinfect toys in reception area per instructions.

c. Daily

- i. Student clinicians must disinfect the tables in the Speech treatment rooms with germicidal wipes after each treatment or diagnostic session.
- ii. If a patient mouths, drools or coughs on toys or test materials, clean immediately following the Treatment or Diagnostic session per instructions. Return to Diagnostic test kit immediately.
- iii. When using equipment with microphones, such as the Speech Viewer, Visi-pitch, headset microphone, etc., clinician disinfects microphone, table and equipment surfaces.
- iv. Custodial staff removes garbage in all treatment rooms.
- v. Hand Washing
 - 1. Wash hands before and after every patient contact.
 - 2. Wash hands immediately within the session if you have contacted any of your own or the patient's bodily fluids.

3. Refer to the posted instructions for specific procedures.
- vi. Wear Gloves on Both Hands for
 1. Performing Oral Mechanism examination
 2. Oral Motor Therapy
 3. Dysphagia/Feeding Therapy
 4. Diaper Changing should be performed by the family. There is a diaper changing station in the bathroom located on A Hall.

G. Clinic Clean-up

1. It is the responsibility of each individual using the clinic facilities to do the following:
 - a. Check out and return materials/equipment to the appropriate locations.
 - b. Leave the clinic rooms in order. Return all tables and chairs to original room immediately following session. Request vacuuming if needed.
 - c. Inform the staff or designated faculty of missing items or, items that need to be reordered.
 - d. Clinic clean-up schedule will be disseminated each semester. Students are to report to Materials Room on Fridays, as scheduled, and follow written instructions.
 - e. Notify supervisor of any impaired equipment.
2. Failure to fulfill clinic clean-up responsibilities will be reflected in student professionalism ratings in determining final grade.

H. Emergency Procedures

1. Medical Emergencies or Accidents

Students should inform a faculty member immediately and have the front desk call Campus Police (38999) or (911) if it is a life threatening emergency. If possible, a student, staff or faculty member should remain with the person in need of assistance, until Campus Police arrives. If the student witnesses the accident, they should remain available to fill out an accident report.

2. Fire Procedures

WHEN FIRE OR SMOKE IS DISCOVERED

If flames or smoke are seen, pull the nearest Fire Alarm. In all buildings, the fire alarm pull stations are located by the fire exits. In all buildings, floor plans giving the location of the fire extinguisher and stairwell fire evacuation routes are mounted on the wall of

each floor. You are urged to view these floor plans and become familiar with the one for your work location.

ALERT OTHERS

- a. Call University Police (568-8999) and give the following information:
 - i. Location of fire or smoke in the building and room number.
 - ii. Your name and telephone extension you are calling from.
 - iii. Close all doors to help contain the fire, if possible.
 - iv. Evacuate using stairs - Do not use elevators.

WHEN THE FIRE ALARM IS SOUNDED

- a. Personnel must evacuate the building by way of stairwells. Do not use elevators.
- b. All buildings at LSUHSC have organized fire evacuation teams consisting of a Floor Captain and an alternate Floor Captain for each floor of the building. Some floors with multiple Departments may have a Floor Captain for each Departmental area.
- c. University Policy regarding employees, patients and visitors with disabilities.
- d. Employees with disabilities shall notify University Police and Floor Captains of their work location(s), medical condition and any special requirements.
- e. Patients and visitors with disabilities should notify University Police upon entering the facility and advise of their location.
- f. Patients and visitors with disabilities should notify the University Police as they exit the building.
- g. Mobility impaired personnel, students and patients are to be placed in a secure location in the building fire exit stairwells; they should be registered with the University Police on the first floor of the Nursing/Allied Health Building. Floor leaders are to report the location and condition of mobility impaired personnel, students and patients to the University Police.
- h. Floor Captains are responsible for evacuating all occupants from their assigned areas and reporting any problems (people who will not leave, etc.) to the University Police.
- i. Faculty and staff report to the building exterior. Await further instructions from the University Police.

DO NOT RETURN TO THE BUILDING UNTIL THE ALL CLEAR SIGNAL HAS BEEN GIVEN BY THE UNIVERSITY POLICE.

I. Confidentiality

This Department abides by the Code of Ethics of the American Speech/Language/Hearing Association; the Health Information Portability Privacy Act (HIPPA) and the Louisiana Board of Examiners for Speech- Language Pathologists and Audiologists (LBESPA). All information shared by a patient is considered confidential.

1. Information obtained from an evaluation and/or treatment session cannot be released to others without authorization of the patient/parents. The *Authorization for Release of Medical Record Information* form must be signed and completed with names of persons to whom we may send or receive information. Students should check at the time of the evaluation to ensure it is accurate completion.
2. In addition make sure that the *Consent to Photography, Videotape, Audiotape* form is signed prior to taking pictures or recordings which may be used for teaching purposes. If patients/family do not agree to its use for teaching purposes, check if you may record for purposes of collecting data only.
3. Patient confidentiality must be observed at all times. Patients are not to be discussed outside the diagnostic or management room in which you are working, particularly not in public places or social situations. Even in discussions with your supervisor, it is best to be in a private room and not in the hallway or a public area.
4. **Password Protection of Files:** All patient reports (files) must be password protected. This applies to the files you are working on and all files submitted to supervisors. As this is a matter of professional ethics and patients' rights to confidentiality and privacy, there will be significant consequences such as lowering of clinic grade for submitting a file without password protection. Save all patient reports to the **p: drive only**. Students may NOT email reports to supervisor or store reports to flash drive/hard drive on computer.

5. Redaction

Another method of separating identifiers and health information is redaction. Redaction is the process of obscuring or removing information from a document or record. It is a difficult and painstaking process to do correctly on existing documents and records.

ALL instances of the information (e.g. name) and indirect references (e.g. mother's name) to the information must be identified and redacted.

The redaction method must render the redacted information unrecoverable.

Physical Redaction

Physical redaction is applied to paper records and analog recordings. Methods include:

- a. Excising (cutting) the printed or recorded information with a knife or scissors.
- b. Erasing magnetically information from recordings.
- c. Obscuring information with a special redaction marker.

When excising, be sure to collect all the cuttings and ensure they are destroyed by shredding or incinerating. When blacking out sections of paper documents ensure that information has been completely obscured.

- a. Use a marker especially designed for redaction.
- b. Shine bright light on and through the paper to ensure that the underlying information cannot be viewed.
- c. It may be necessary to blacken both sides of the paper or photocopy the blackened page and substitute the photocopy to ensure the underlying information cannot be viewed.

Digital redaction

Digital redaction is extremely difficult to perform correctly. Most computer programs are designed to preserve information, not destroy it. The majority of computer programs used for editing text do not have a redaction function.

This requires the individual performing the digital redaction to have an in-depth knowledge of information is stored in a computer. Adobe Acrobat (not Acrobat Reader) version 9 and later has an effective redaction function. It is a two-step process:

- a. First, mark all the information in the document to be redacted.
- b. Tell the program to redact the information. The program will warn you that the selected information is about to be destroyed and will become unrecoverable. You will need to confirm that is what you want before the information is actually redacted.

Digital Redaction Methods That DON'T WORK

- a. Highlight Function
 1. Using the highlight function and selecting the color black produces a document that has the same appearance as a redacted document.
 2. However, the information underneath the "highlight" has not been destroyed.
 3. To view the redacted information, simply select the whole document and highlight it in yellow.
- b. Track Changes- Some people choose to simply delete information from their documents and save the altered version. This is effective unless the "Track Changes" function is turned ON. When Track Changes is active. The deleted information is preserved and can be viewed, even though it is redlined.
- c. Password protecting a document – Most methods for password protecting a document are extremely weak and easily cracked. There are many free utilities available for this purpose.
 1. A search for "free Adobe password remover" produces over a million results.

2. A search for “free Microsoft Office password cracker” produces over eight (8) million results.

How to Check Digital Redaction

- a. Search the document for the redacted information. If the search function can find it, it has not been redacted.
- b. Select all the information in the document and highlight in a pastel color like yellow or light green. Does the redacted information become readable?
- c. Copy the redacted information from the document and paste it as plain text into a blank Word document. Does the redacted information become readable?
- d. Ensure “Track Changes” is turned OFF.

REMEMBER

- a. In order for redaction to be effective, the redacted information must be unrecoverable.
- b. ALL instances of identifiers in the document must be redacted for the document. If one instance of an identifier (e.g. the patient’s name, DOB, etc.) is missed, the document is considered identified information.
- c. For digital documents, use the search function to identify all instances of identifiers.
- d. For paper documents search the document from beginning to end and then from end to beginning. Get help from co-workers and fellow students in reviewing documents for identifiers.

J. Medical Records

A. Permanent Medical Records Chart

1. Organization of Chart

- a. Every patient who receives clinical services will have a permanent chart or file located in medical records. Fasteners are located on each side of the folder. With the folder opened, the left-hand side (without tab) contains clerical information related to both evaluation and management. A fixed order for both sides is maintained.
 - i. The order for the **left** side (clerical) is arranged in the following order from bottom to top:
 1. Information for billing purposes, such as insurance forms, fee reduction & Medicare Notification form
 2. Release or authorization form (to exchange information)
 3. Consent to Photograph or tape

4. Attendance form
5. Clinic Log Form(s)

ii. The order for the **right** side of the folder is:

1. The intake form
2. Case history
3. Test protocols used in evaluation.
4. Treatment plans, progress reports, IEP's, or staffing information.
5. Evaluation reports.
6. Letters.

iii. Note: Letters from the agencies, recall letters and subsequent reports will be placed in the folder according to the time sequence. All items will be punched and correctly located in the folder by the secretarial staff.

2. Access to patient records must be secure and monitored. All patient records are locked in cabinets that are stored in the front office. Access to this area is off limits to unauthorized personnel.

3. Check-out Procedures:

a. **The following procedures (rules) must be followed.**

- i. To obtain a patient's records: You will enter the records #, your name, the date, and time into a "check-out marker" when you are issued the records.
- ii. Records must be returned prior to close of business that day. At no time are records permitted to be viewed outside of the specified areas on the 9th floor or to be taken off of the 9th floor.

4. A log note should be made any time you have made contact with the client. **Sign it** with your first initial

and last name/supervisor's initials (e.g., **J. Smith/AL**)

- a. To confirm the appointment prior to the evaluation
- b. To confirm therapy schedule prior to the first session
- c. To note completion of evaluation or partial completion of an evaluation
- d. To note that client canceled or no showed, use red ink pen
- e. To note client or family conference or consultation
- f. To note client or family training instruction or education

5. Attendance Form

- a. Fill out an attendance record form each session and keep in your working folder. At the end of the semester, file it in your client's permanent medical records chart.

III. Clinic practicum

A. Observations

1. Clock Hour Requirements

- a. The student must complete at least 25 clock hours of supervised observation.
- b. Students will be allowed to participate in clinic practicum only after all of the 25 hours of required observation have been satisfied.
- c. Observation hours may be transferred from another program, providing the transferring program verifies, on University letterhead, that the observation meet ASHA Certification Standards. The transferring University also must supply the full name and AHSA certification number of the individual furnishing the documentation

2. Procedure for Observations

- a. Sign up on schedules posted by faculty's office and follow requirements posted, such as need to obtain prior approval from the supervisor, number of students that may observe a session, etc.
- b. Review the information contained in the client's medical record chart prior to the scheduled observation.
- c. Consult with the clinician prior to the observation to confirm information regarding patient status & obtain lesson plan for the session. You will be taking data along with the student clinician for each targeted objective.
- d. At the time of the appointment, shadow the clinician throughout the chart check-out & patient check-in process.
- e. Observe via observation room/classroom or from directly within the therapy room, if need be (Discuss with student clinician/supervisor prior to session).
- f. Observe the entire clinical session.
- g. Adhere to the clinic dress code while conducting observations.
- h. Demonstrate ethical and responsible behavior. Do not talk, make comments, laugh or express judgments, whether positive or negative, through verbal or nonverbal behaviors.
- i. Remember that all patient information is confidential. Do not discuss client with individuals other than the clinician or supervisor. Do not answer questions from or give advice to family members or clients. Relay that you are only observing. Refer to the individual by their initials in your report.
- j. Be discrete, holding comments until after the observation has been completed and the client has left the floor. In audiological evaluations, there are no two-way mirrors. **In speech-language sessions, family members may be present.**
- k. Observation Report: After each observation, the student will complete a report using the formats provided in the Appendix.
 - i. Reports must be submitted to the supervisor within **96 hours** (four calendar days)

of the observation. Observation hours for reports submitted after 96 hours cannot be counted.

- ii. The student must make and retain a copy of each observation report. The completed observation report is to be placed in the supervisor's mail box in the receptionist's area. The supervisor will read the observation report and return it to the student with edits/comments.
 - iii. The student must maintain a record of all observations completed on the *Observation Tracking Sheet*. This record must include the supervisor's name, the client's initials, the client's file number, the date of the observation, the length of the observation, and the type of clinic activity observed (e.g., child language treatment, audiological evaluation). It is the student's responsibility to keep all completed observation reports and maintain an accurate record of them on the *Observation Tracking Sheet*.
 - iv. Upon receipt of a graded observation report, the student must obtain the supervisor's initial on the Tracking Sheet to verify completion of the observation.
 - v. At the end of the summer semester, the student must turn in all observation reports attached to the *Observation Tracking Sheet* to the Clinical Practicum Coordinator. This is the only documentation of compliance with ASHA's observation requirements. The student will be required to do additional observations for any reports which are lost or misplaced.
- I. Pre-recorded Sessions: There are pre-recorded sessions available for speech-language observations.
- i. P: Drive – Go to Speech-Language Pathology; Reports Under Review; Faculty Member's Name
 - ii. Email supervisor
 - iii. Master Clinician Network (MCN): masterclinician.org

Reports for prerecorded session observations must follow the same format as described in the Appendix. Use the date you observed as the date of the session. Observation reports are to be submitted to the supervisor designated on the video or Mrs. Willis if using MCN.

- m. Off-site Observations: Will be approved on a case by case basis. We cannot arrange these for you.
- i. SLP you observe must have Certificate of Clinical Competence (CCC).
 - ii. Ask SLP to sign your *Observation Tracking Sheet* & record her ASHA #
 - iii. Complete summary of observation and submit to Mrs. Brouillette within 96 hours.

3. Procedures for Submitting Undergraduate Clinical and Observation Hours

1. Turn in your official verification from your undergraduate university to the Clinical Coordinator by placing it in the Signed Clock Hour sheet folder in the clock hour sheet mailbox or as part of your first semester's ICD class.
2. Input the hours into CALIPSO. Use the clinical coordinator, Molly Brouillette, as the supervisor. Make sure to denote the hours as undergraduate in CALISPO.
3. Use the month of your undergraduate graduation as the completion month and the date of your undergraduate graduation as the day for the hours. For the site, choose Undergraduate Hours from the list of choices.
4. Once they are input into CALIPSO and submitted for approval, The Clinical Coordinator will approve them and they will be in the CALISPO system. The Clinical Coordinator must have the signed verification sheet from your undergraduate university in order to verify the hours and to have the supervising SLP's signature on file.

B. Clinical Assignments

1. General

- a. Following clinical advising with Clinical Coordinator, clinical assignments are made on the basis of academic course work completed, clinical experience, the student's clinical practicum needs, the requirements of the clinical practicum site, and student availability and preference.
- b. Clinical assignments are made before the beginning of the semester. The student will receive a copy of the clinic assignment which designates the primary supervisor, additional supervisor(s), the site and type of clinical activity to which the student has been assigned, and the day and/or time of clinic. Clinic practicum activities at both LSUHSC and off-sites begin on the first day of classes. It is the student's responsibility to contact the clinic practicum supervisor(s) prior to the first day of classes.
- c. It is the student's responsibility to monitor clock hours throughout the semester. Any problems with scheduling or with client attendance should be discussed first with the clinic supervisor. Changes in the assigned number and type of clock hours to be earned weekly may not be made without the approval of both the clinic supervisor involved and the Clinic Practicum Coordinator.
- d. Concerns re: clinical matters should be discussed with clinical supervisor first, and if additional assistance is needed, the student may discuss concerns with the Clinical Coordinator.

2. Student Responsibilities

- a. Clinic will begin and end in accordance with the academic calendar. Students should be available for departmental activities and to complete departmental responsibilities from the first day of class through the last day of exam week.
- b. It is the responsibility of the student to check with his/her clinic supervisor PRIOR TO THE START OF THE SEMESTER to determine dates for initial staffing and the beginning of clinical practicum. Failure to do so may result in lowering of clinical practicum grade. After receiving assignments, the student assumes responsibility for client contacts (except the scheduling of evaluations)
- c. Mandatory Clinical Staffing will be held at the beginning of each semester to provide student training opportunities which may include: documentation review, observation, treatment planning, and review of client specific disorders.

3. Remote Sites

- a. The student will be assigned to at least three clinical settings either within the organizational structure of LSUHSC or affiliated with LSUHSC. All clinic practicum will be supervised by individuals holding ASHA certification and a Louisiana license in speech-language pathology.
- b. Evaluation of the student's performance in off-site clinical practicum will be conducted in a manner consistent with LSUHSC grading policies and procedures. All off-site clinic practicum activities will be coordinated and monitored by the Clinic Practicum Coordinator.
- c. Clinic Practicum sites, either within the organizational structure of, or affiliated with LSUHSC include: Children's Hospital of New Orleans, University Medical Center, Chabert Medical Center, NorthOaks Healthsystem, St. Charles General Hospital, Trinity Neurological Rehabilitation, Gulfport Memorial, East Jefferson General Hospital, Jefferson Parish Public School System, St. Tammany Parish School System, LSUHSC Department of ENT, Medical Center of Louisiana, New Orleans Speech and Hearing Center, Ochsner Clinics, Slidell Memorial Hospital, Terrebonne General Medical Center, Thibodeaux Regional, Touro Infirmary, Tulane Medical Center, West Jefferson Hospital, Waldon Healthcare, Greenbriar, Heritage Manor, Chateau Living Center, Ormond Skilled Nursing Facility, and Additional Private Practices and School Systems.

4. Procedures to Modify Clinic Practicum Responsibilities

- a. To request a reduction/increase in the number of clock hours per week

- i. The student must submit a written request to modify clinic practicum responsibilities (i.e., decrease in number of clock hours per week to which the student has been assigned).
- ii. The written request must be submitted to:
 - i. The clinic practicum supervisor
 - ii. The clinic practicum coordinator
 - iii. The student's academic advisor
- iii. The student must meet with the clinic practicum supervisor, the clinic practicum coordinator, and the academic advisor to discuss the request. The meeting and documentation of specific implications of the student's change in clinic practicum responsibilities should be forwarded to the review committee with a copy to the student's file.
- iv. The Program Director and/or Department Head will examine the student's request and approve or deny the request within 5 working days. The Clinical Coordinator will provide the student with written notification of the committee's decision and recommendations.

C. Treatment: Speech-language

A. Client Preparation

1. Read the client's permanent folder, making particular note of the information needed to initiate treatment, including recent evaluation, treatment plans, progress summaries, SOAP notes, goals, objectives and recommendations.
2. Attend Mandatory Clinical Staffing
3. Set appointment with your clinic supervisor(s) for your first meeting, to discuss the client and confirm a therapy schedule. **Read** clinical agenda items/requirements for each semester and refer to your supervisor's Syllabus or Requirements and Expectations Handout for specific *Beginning of Clinic responsibilities*.

B. Telephone Contact

1. Make initial phone contact, during which the student introduces him/herself to the patient or parent and confirms day and time for therapy. The date for the initial therapy session should also be stated. Send a confirmation letter per supervisor's instructions.

2. Telephone contact with clients should be made for the following reasons, unless otherwise designated by the clinical supervisor:
 - a. To alert the client about approved schedule changes (illness, emergencies, holidays, professional meetings).
 - b. To return client's call if requested.
 - c. If a client No Shows, discuss with your supervisor if calling your client is advised.

C. First Week of Treatment Sessions

1. When your client arrives, they “sign in” at the front office. Student clinicians then complete the sign-in log with supervisor initials, type of therapy etc. This is **critical** for billing purposes.
2. At the first or second session, discuss the fire exit procedures with your client or their family in case of an emergency. Provide client with procedural handout. Procedures are under Emergency Procedures in this manual.

D. Program Planning

A comprehensive treatment program includes information regarding incoming status, client goals and objectives, training procedures, probe criteria, reinforcement, dismissal criteria and follow-up procedures. The program plan changes as the client proceeds through treatment. The supervising faculty will advise the student through the case management process. Part of this process is the development of semester goals and objectives, broken down into a hierarchy of tasks, which then are incorporated into weekly lesson plans. The Treatment Plan and SOAP notes provide initial status information and state the goals and objectives for the client. Lesson plans, progress notes, data and probes will be ongoing. Progress will be noted in progress notes, progress summaries and/or discharge summaries.

E. Treatment Documentation

1. A *Treatment Plan or Hierarchy of Goals and Objectives* must be completed for all pediatric clients. Consult your supervisor for specifics regarding type of document and timelines. For adult clients your supervisor will inform you whether to follow the Treatment Plan or *SOAP Note* format. The purpose of the plan is to provide information regarding the client's initial status and to determine the client's semester goals. The plan should be submitted in behavioral terms. The completed Treatment Plan should be placed in the client's medical record chart after being signed by those present at the goal's conference
2. Examples of format for documentation will be provided by each individual supervisor. Types of Patient/Client documentation include:
 - a. *SOAP Note*

The SOAP note typically serves the purpose of both a treatment plan and a progress note in a hospital, rehabilitation center and nursing home setting. The SOAP format, which represents "Subjective-Objective-Assessment-Plan" is commonly used in hospital based speech-language pathology programs and is used for most of the adult clinic. Include information in each area as follows:

- i. Subjective: Provide background information, medical information, initial diagnosis
- ii. Objective: State objectives of treatment sessions
- iii. Assessment: Note progress toward objectives, update status and current diagnosis, impressions
- iv. Plan: Recommendations for continued treatment, change in objectives, education

b. Treatment Plan Conference Outline

c. Lesson Plan

- i. Specific deadlines for submission of lesson plans will be communicated to the student by the individual supervisor. Following each session, results should be formulated and submitted to the supervisor, along with the next weeks plan.
- ii. A lesson plan is the clinician's plan for what specific client behaviors are being targeted for the week and what procedures and activities are planned to accomplish this. It also serves as written communication between the student clinician and his/her supervisor about the planned session. The lesson plan should contain the following:
 1. Identifying information
 2. Specific objectives for the session. Goals and short term objectives may be included.
 3. Reinforcement schedule
 4. Antecedents and materials
 5. Consequences, cueing or correction procedures
 6. Results (added after the session)

d. Hierarchy of Goals and Objectives

This is a breakdown of semester goals and objectives into small steps, starting with the current level of the client and advancing to your final goal. Clinical Probes may also be noted as part of your hierarchy. The hierarchy will help you set reasonable semester goals and keep therapy moving toward your final goal. This will assist clinicians in writing their weekly lesson plans and should be discussed with their supervisor.

e. Data & Clinical Probes

All students will be required to develop their own data taking or recording

procedures, upon which to base their program decisions. Clinical probes are conducted to determine if the target response has generalized.

- f. Progress Summary/Treatment Plan
The Progress Summary provides a statement regarding client progress toward their target goals and objectives, procedures used in the treatment process and recommendations for the next semester. Reports should be written in terms that the client or family can understand.
 - g. Final Summary
A Final Summary summarizes progress for the semester and makes recommendations for the following semester of treatment.
 - h. Discharge Summary:
When a client is being discharged, the student writes a Discharge Summary, which summarizes the entire treatment course.
3. Treatment: Conferencing
- A. Initial Conference: Once a treatment plan is established, the clinician will conduct a conference with the client/family to review the proposed plan of care for the semester.
 - B. Final Conference: Upon completion of the Final (Progress/Discharge) Summary, the clinician will conduct a conference with the client/family to share progress and recommendations.
4. Treatment: End of the Semester Duties
- A. All clinic responsibilities must be completed before the end of the semester. These responsibilities include completing any make up therapy sessions, returning all borrowed clinic materials, completing log notations, signing all reports, funding paperwork and completing supervisor evaluations. It may include additional responsibilities as outlined by the supervisor, including an exit conference between student and supervisor.
 - B. All clinic reports must be in final form and approved by the clinic supervisor by the last day of exam week. Each day a report is late; the clinic practicum grade will be reduced by a letter grade. Any exception to this must be approved by the clinic supervisor in advance.
 - C. A grade of **I** (Incomplete) indicates that the student has not completed academic/clinic responsibilities for an **unavoidable** reason that is **acceptable** to the instructor. A student may not “choose” a grade of **I**.

D. Clinic: Diagnostics/Evaluations

1. Assignments

- A. Diagnostic appointments are scheduled by the clinical supervisors. Supervisors should keep the clinic coordinator informed of any special student needs and of any diagnostic schedule changes. Once an evaluation has been scheduled, the student should then review the case history and any other incoming information in order to make a diagnostic plan.
- B. Prior to the scheduled evaluation, the student should meet with his/her supervisor to review the case, to decide on appropriate interview questions, evaluation procedures, and if further information is needed from the client. Scheduled evaluations are not to be changed at the discretion of the student clinician. Any necessary changes in the appointment schedule can only be made by the Clinic Supervisor. Allotted time for evaluations varies from 1 to 3 hours.
- C. Confirmation Phone Call
 - a. A script for a Confirmation Phone Call can be found in the appendix of this handbook.
 - b. Students are to call and confirm appointments the day before the evaluation, using the clinic phones. In some instances supervisors may request that you call clients earlier. Discuss the need to call the client or parent with your supervisor at the pre-Dx planning meeting.
 - c. Students may refer to the Phone Call section of the Outline for Parent Interview. Students may need to call the client/family prior to and in addition to the confirmation call to clarify incoming information, to inform of need to interview, to outline procedures for the evaluation, etc.
 - d. Check to see if patient is scheduled for both AUD and SLP. If the patient is scheduled for both AUD and SLP, the discipline with the earliest appointment makes the confirmation call. The student who makes the call must immediately inform the student from the other discipline of the results (i.e., if confirmed, left message, NA etc).
 - e. Student should use the Confirmation Call script included in General Appendix.
 - f. If the patient is not home but has an answering machine, the student should leave a message indicating that the patient should call the clinic at 504-568-4348. If the patient is not home and has no answering machine the student must keep trying to contact the patient and should note times of calls made.
 - g. Students must notify their supervisor immediately if patient cancels.
 - h. When a patient calls in the clinic office the staff should notify the supervisor if there is a cancellation.
 - i. The staff should e-mail the supervisor if the patient calls into the clinic office confirming or canceling the appointment.

- j. If a student must call patients from a home/cell phone, use *67 to block your number. Remember NEVER to give your name, home phone number or other identifying information when making these confirmation calls. Only identify yourself as a representative of the LSUHSC Speech and Hearing Clinic.

D. Illness

- a. The student must contact the supervisor immediately.
- b. The student must phone the patient and cancel the appointment if that is the supervisor's directive.
(Note: Inform supervisor if this is a double discipline appointment, canceling only your half.)
- c. Therefore all students should have the client's home/work phone number with them prior to an evaluation, in case of illness.
- d. After the student contacts the patient **or** if the student cannot contact the client s/he must again call the supervisor with that information.
- e. Re-scheduling clients will be coordinated with the clinical supervisor.

E. Greeting Client

- a. Students are to greet their client in the reception area and complete the sign-in log before the evaluation. If clients are late, students can wait in the student area and the front office will call them over the intercom when the client arrives.
- b. Students should introduce themselves and their supervisor and briefly explain the routine for the evaluation. Additional protocol may be discussed during your supervisory meetings.
- c. *Students should* check the registration information and/or the patient's medical chart to insure that both the *Authorization for Release of Information* and the *Consent to Photograph and Videotape* have been completed and signed. If family/client does not wish for photographs or tapes to be used for teaching purposes, ask permission to use audio or videotapes for data collection only.
- d. Medicare clients must also be instructed to sign a form for *Notification of Possible Denial of Payment by Medicare for Non-covered Services* when it is known or suspected that services will not be paid by Medicare.

F. Client Conference/Counseling

- a. After the testing portion of the evaluation is completed, the student clinician will meet with the supervisor to discuss test results and observations. Following this preparation, a client/family conference will be held where test results will be interpreted, recommendations made, and questions answered.

An outline of this type conference can be found in the appendix of this handbook.

- b. Again make sure that the *Authorization for Release of Information* is filled out accurately if they wish for an outside agency to receive a copy of the report.
- c. For those evaluations that are scheduled for more than one sessions or when deemed necessary by the supervisor, parent conferences may be scheduled at an additional time. In this case, the student should meet with the supervisor to review test results and plan the conference session.

G. Concluding the Evaluation

- a. Make a notation on the log that the evaluation or the first half of an evaluation was completed. Make a log notation, documenting client conference to share test results and recommendations. If training or educational instruction was included, document this also.

H. Filing of Test Forms

- a. All test information will be labeled with the client's name, file number, examiner's name and date of evaluation before being placed in the client's folder following the evaluation. Information concerning the general organization of the permanent folder may be found under the Organization of the Chart. All test forms, audiograms, language samples, etc., must remain in the client's folder and are not to be removed from the folder or the clinic to write the reports.
- b. The student must note test results on a separate sheet (not a 2nd form) in order to write their report.

I. Diagnostic or Evaluation Documentation and Routing

- a. Refer to *Procedures for Routing and Saving Clinical Documentation* below.
- b. For Examples of formats for diagnostic reports, see individual clinic supervisor.
- c. Rough drafts of evaluation reports should password protected and saved on the p: drive.
- d. Student should email supervisors upon placement of reports on p: drive.
- e. The supervisor will read the rough draft, make any corrections, and save it to the P: drive for the student to modify. The report may require more than one editing process.

J. Diagnostic Protocols

- a. Diagnostic protocols provide the students with general guidelines to facilitate planning for most types of evaluations conducted in this clinic. These are designed to outline areas recommended for inclusion in your

clinical reports under Documentation, however students should consult with individual supervisors regarding specific format. Protocols are provided in the Appendices for a variety of communication disorders.

K. Case Staffing

1. Purpose: Pre and/or post-diagnostic patient staffings and client management staffings are conducted as part of Quality Assurance procedures and to improve client management by obtaining professional input through presentation, interaction, and discussion on topics which include the following:
 - a. Clients with unusual and/or complex disorders
 - b. Clients who pose a problem to clinicians/supervisors;
 - c. Diagnostic and/or therapy techniques which have proven effective/ineffective with a client.
 - d. Schedule: The scheduling of case staffings varies from semester to semester and involves clients for both evaluations and treatment. The format for speech-language presentations will vary, depending upon the background of the students and will be specified in the Issues and Methods in COMD class.

IV. Procedures for Routing and Saving Clinical Documentation

- a. All documents with personal identifying information must be password protected when saved. All clinical documentation is routed and saved on the P: drive of the LSU School of Allied Health Network. Clinical documents should not be saved on personal computers or jump drives. Use of email for client's protected health information is prohibited.
- b. Steps to save send a document to a supervisor for review:
 1. Go to the P: drive on your computer
 2. Open the *Speech_Language_Pathology* Folder
 3. Open the *Reports_under_review* Folder
 4. Open your Folder
 5. Save the report in this Folder
 6. Inform your supervisor that you have saved the report on the P:drive via email
 7. Check back to see changes made by your supervisor
 8. The supervisor will read the rough draft in the P: drive, make corrections and save it back into the P; drive. The report may require more than one editing process.

9. The supervisor will inform the student when the draft is ready to print and indicate the number of originals needed. The supervisor will send the document to the *Reports_to_be_printed* Folder on the P: drive. To convert reports for final printing: (a) change to single space insert page headers, (b) include page #s (Refer to Report Format),(c) on first page allow room at the top (2") for letterhead, (d) , (e) check page alignment & use hard page end as needed, (f) signatures should not stand alone on a page (must be included with some text),and (g) headings must be followed by text on the same page. See individual supervisor for printing instructions which may include informing the front office staff to print the document.
 10. The front office staff will print your document and place it in your supervisor's box for signatures. Once the document has been printed, and as needed mailed and/or distributed, the front office staff will send the document to the *Archived_reports* Folder in the P: drive.
 11. Proof the final copy and consult with the supervisor regarding setting up a conference to discuss the plan with the client/family if necessary. The report is typically signed at this conference.
 12. Client documentation is to be saved per supervisor's instruction on the p: drive.
- c. Patient Satisfaction Surveys
1. Surveys are located in the clinic waiting room. All clients are encouraged to complete the surveys as part of our clinic's quality assurance

V. Grading Policy for Students in Clinical Practicum

- A. Observations:
Each observation report are due within 72 hours of observation and will be read by the supervising faculty member. Reports may require revision/resubmission.
- B. Clinical Practicum:
1. Session Evaluation Forms: May be used to provide feedback to the student, along with verbal feedback provided during supervisory meetings. Forms are provided for evaluation of treatment sessions, diagnostic sessions and written skills.
 2. Midterm and Final Evaluations: Mid-term and final clinical evaluation are completed within the CALIPSO system.
 3. Students are assigned to a level (Beginning, Intermediate, or Advanced) based on their clock hours obtained and the primary supervisor's recommendation. At midterm and at the end of the semester, all supervisors will provide the primary

supervisor with a grade reflecting the student's performance. The primary supervisor will combine these ratings to determine the overall grade.

4. All clinic reports must be in final form and approved by the clinic supervisor by the last day of exam week. Each day that a report is late, the clinic practicum grade will be reduced by a letter grade. Any exception to this must be approved by the clinic supervisor in advance.
5. If a student receives a grade of "D" or "F" in clinical practicum, *none* of the practicum hours earned that semester will count toward LSUHSC or ASHA requirements.
6. A grade of "I" (incomplete) indicates that the student has not completed academic/clinic responsibilities for an unavoidable reason.

C. Student Experiencing Clinic Difficulty - Procedures

The primary goal of the procedure outlined below is to ensure that the student will receive individualized instruction for optimum student training.

Step 1. The primary supervisor/advisor should monitor the total clinical performance of assigned students on a weekly basis. Any student suspected of experiencing difficulty in Clinical Practicum should receive a written evaluation indicating the level of performance at midterm or earlier if possible. Clinical Difficulty is defined as obtaining a grade of C or below in either diagnostics or treatment. Thus, it is possible for a student to obtain an overall grade of B and still be in Clinical Difficulty.

Step 2. The supervisor, primary supervisor/advisor and Coordinator of Clinic Practicum will meet immediately following notification of the student. The Coordinator will inform the faculty of the student's Clinical Difficulty, so that faculty will not assign additional responsibilities for that student.

Step 3. The Coordinator of Clinic Practicum, the supervisor under whom the student obtained a grade of C or below and the student will meet to discuss the student's clinical performance within seven days following notification of the student. A remediation plan will be developed which will include: specific behavioral objectives reflecting skills that need to be developed will be outlined, along with recommended remediation strategies. Arrangements will be made for team supervision, if determined appropriate. Satisfactory performance toward accomplishment of these specific objectives in conjunction with acceptable overall performance, as delineated by a grade of A or B, in each area (diagnostics and treatment) will be expected by the end of the semester, to avoid being put on Clinic Probation for the following semester. Upon satisfactory completion of the remediation plan, completion of the remediation is documented and file in the student's folder.

Step 4. If the student earns a final grade of C or below in either the diagnostics or treatment portion of their grade, the student is put on Probationary status, for next term. The supervisor will send a letter to the student and the Chair of the Review Committee, notifying them of the student's Clinic Probationary status. The letter should advise the student that Probationary status is only for one semester, and should the student obtain a grade of C or below (in area of deficiency) a second semester, then the student must appeal to the Review Committee to remain in the program. In addition the student must earn a grade of B or higher in the area of deficiency before being placed off- site for practicum.

Step 5. If the student's midterm grade is a C or lower during the Probationary term, complete steps 1-3 above. If the student earns a grade of C or below at the end of the semester, the student would need to appeal to the Review Committee to continue in the program.

VI. Evaluation of Clinical Supervisor

At the end of each semester, students are required to complete an evaluation of their supervisor. These forms will be sent via e-mail through the Course Evaluation System utilized by the School of Allied Health Professions. Students are strongly urged to complete these important evaluation which remains anonymous and confidential. Evaluations of off-site supervisors is completed via CALIPSO.

VII. Recording Clinical Hours

The student must maintain a record of all clock hours earned in clinic practicum. Except for rare instances when a supervisor is not in the CALISPO system, students should track their clock hours and submit the hours for approval through the CALIPSO system. CALIPSO can be accessed via the following link:
<https://www.calipsoclient.com/lshsc/account>.

To register as a student in CALIPSO:

1. Before registering, have available the PIN provided by your Clinical Coordinator via e:mail.
2. Go to <https://www.calipsoclient.com/lshsc/account/login>
3. Click on the "Student" registration link located below the login button.
4. Complete the requested information, being sure to enter your "school" e-mail address, and record your password in a secure location. Click "Register Account."

5. Please note: PIN numbers are valid for 45 days. Contact your Clinical Coordinator for a new PIN if 45 days has lapsed since receiving the registration e-mail.

To login to CALIPSO:

1. To login, go to <https://www.calipsoclient.com/lshsc/account/login> and login to CALIPSO using your school e-mail and password that you created for yourself during the registration process (step one.)
2. Upon logging in for the first time, you will be prompted to pay the student fee and to provide consent for the release of information to clinical practicum sites.

To Enter Clock Hours in CALIPSO:

1. Click on the "Clockhours" link located on the lobby page or the "Student Information" link then "Clockhours."
2. Click on the "Daily clockhours" link located within the blue stripe.
3. Click on the "Add new daily clockhour" link.
4. Complete the requested information and click "save."
5. Record clock hours and click "save" located at the bottom of the screen. You will receive a "Clockhour saved" message.
6. Repeat above steps to enter additional clock hours gained under a different supervisor or in a different clinical setting.
7. To view/edit daily clock hours, click on the "Daily clockhours" link located within the blue stripe.
8. Select the record you wish to view (posted by supervisor, semester, course, and setting) from the drop-down menu and click "Show."
9. Select the desired entry by clicking on the link displaying the entry date located along the top of the chart. Make desired changes and click save.
10. Please note: Supervisors are not notified and are not required to approve daily clock hour submissions.

To Submit Clock Hours to Clinic Supervisor for Approval:

1. Click on the "Daily clockhours" link located within the blue stripe.
2. Select the record you wish to view (posted by supervisor, semester, and course) from the drop-down menu and click "Show."
3. Check the box (located beside the entry date) for all dates you wish to submit for approval then click "Save selected clockhours to semester clockhour form." Clock hours logged for the dates selected will be consolidated into one record for supervisor approval. The designated supervisor will receive an automatically generated e-mail requesting approval of the clock hour record.
4. Please note: Daily entries cannot be edited once approved. However, if you delete the entry from the "Clockhour list" link prior to approval, daily hours may be resubmitted.

5. View consolidated clock hour entries by clicking “Clockhours list” located within the blue stripe.

Procedures for Submitting Clocks hours for Screenings (Supervised by SLPs not in the CALIPSO System)

1. Bring an “old type” off-site clock hour sheet to the screening with you. These are located in the student computer area in the file cabinets.
2. Have the Certified Speech-Language Pathologist supervising you sign off on your hours. Make sure you get his/her ASHA number on your clock hour sheet.
3. Make a copy of your clock hour sheet.
4. Turn in the original in the front office by placing it in the Signed Clock Hour sheet folder in the clock hour sheet mailbox.
5. Input the hours into CALIPSO. Use the clinical coordinator, Theresa Nicholls, as the supervisor and LSUHSC as the site.
6. In the comments section of the clock hour sheet on CALIPSO. Please type. These hours were supervised and signed off on by (the SLP’s full Name), ASHA # (000000000). *Example: These hours were supervised and signed off on by Sally Doright, M.C.D., CCC-SLP, ASHA # 1234567.*
7. Once they are input into CALIPSO and submitted for approval, The Clinical Coordinator will approve them and they will be in the CALISPO system. The Clinical Coordinator must have the signed clock hour sheet in order to verify the hours and to have the supervising SLP’s signature and ASHA number on file.

Procedures for Submitting Undergraduate Clinical and Observation Hours

1. Turn in your official verification from your undergraduate university to the Clinical Coordinator by placing it in the Signed Clock Hour sheet folder in the clock hour sheet mailbox or as part of your first semester’s ICD class.
2. Input the hours into CALIPSO. Use the clinical coordinator, Theresa Nicholls, as the supervisor. Make sure to denote the hours as undergraduate in CALISPO.
3. Use the month of your undergraduate graduation as the completion month and the date of your undergraduate graduation as the day for the hours. For the site, choose Undergraduate Hours from the list of choices.
4. Once they are input into CALIPSO and submitted for approval, The Clinical Coordinator will approve them and they will be in the CALISPO system. The Clinical Coordinator must have the signed verification sheet from your undergraduate university in order to verify the hours and to have the supervising SLP’s signature on file.

VIII. Complaints, Comments and Concerns

- A. Complaints, Comments and Concerns box is located in the mailbox area of the student work area. This box is monitored on a regular basis by the Department Head for speech-language pathology and audiology.

- B. There are specific procedures for complaints related to the Standards for Accreditation of Entry-Level Graduate Education Programs in Audiology and Speech Language Pathology. These can be found on- line at:
http://www.asha.org/academic/accreditation/accredmanual/section8.htm#Complaints_programs.

- C. Complaints should be sent to:

Chair, Council on Academic Accreditation in Audiology and Speech-Language Pathology
American Speech-Language-Hearing Association,
2200 Research Boulevard, #310
Rockville, MD 20850

APPENDICES

Confirmation Phone Call Scripts

No. 1: For Patient

"Hello Mr./ Ms./ Mrs. "

"This is the LSU Health Sciences Center Speech and Hearing Clinic calling to remind you of your appointment for a (hearing test and/or a speech-language evaluation) tomorrow. (give day of the week)at (give the time). Will you be able to keep this appointment?"
If the answer is "Yes", end with "Thank-you, we will be looking forward to seeing you (tomorrow).

If the answer is "No", instruct them to call **568-4337** to reschedule.

Always end with a "thank you." If leaving a recorded message add: "If you are unable to keep this appointment, please call **568-4348** to cancel and reschedule. Thank-you."

No. 2 For Parent of Patient

"Hello Mr./ Ms./ Mrs. "

"This is the LSU Health Sciences Center Speech and Hearing Clinic calling to remind you of your (daughter/son's) appointment for a (hearing test and/or a speech-language evaluation) tomorrow. (give day of the week) at (give the time). Will you be able to keep this appointment?"

If the answer is "Yes", end with "Thank-you, we will be looking forward to seeing your tomorrow (or day)" If the answer is "No", instruct them to call **568-4337** to reschedule.

Always end with a "thank you." If leaving a recorded message add: "If you are unable to keep this appointment, please call **568-4348** to cancel and reschedule. Thank-you."

Answer Machine Phone Script

To confirm an evaluation:

Hello, this is the LSU Health Sciences Center Speech and Hearing Clinic calling to confirm an appointment for someone in this household tomorrow (give day of the week) at (give time of day). If you are unable to keep this appointment, please call 568-4348 to cancel and reschedule. Thank You.

To set up therapy time for an established client at LSUHSC:

Hello, this _____ from the LSU Health Sciences Center Speech and Hearing Clinic calling to set up appointment times for this semester. Please give me a call at _____. Thank You.

Do not give your name, home phone number or any other identifying information when making reminder calls for diagnostics.

Remember, NEVER, NEVER give your name, home phone number or other identifying information when making these reminder calls. Only identify yourself as a representative of LSUHSC Speech & Hearing Clinic.

Templates for Observation Reports

Observation Form for Speech-Language Treatment

Observer _____ Clinician _____
Client _____
Date of Observation _____ Starting Time of Session _____ Ending Time
of Session _____
Supervisor _____ ASHA # (if off-site) _____
Site _____
Length of Observation _____
Date Report Submitted _____

4. What type and severity of communication disorder did the client exhibit?
5. What were the behavioral objectives being targeted?
6. How did the clinician greet the client? Their caregiver? Significant other?
7. How was the session structured?
8. What was the room arrangement/seating arrangement?
9. What types of materials and activities were used?
10. What types of cues were used (visual, tactile, verbal)? Explain
11. What types of reinforcers were used and on what schedule?
12. How were undesirable behaviors addressed (if any)?
13. How were responses charted?
14. How did the clinician close the session and dismiss the client?
15. Were planned and executed procedures congruent? If not, explain.
16. If you were the clinician, what changes might you make for the next session?

Professional Organizations and Licensure

1. ASHA: American Speech-Language Hearing Association. NSSLHA: National Student Speech-Language Association. Refer to ASHA Membership and Certification handbook for information regarding Certificate of Clinical Competence (CCC) Clinical Fellowship and National Examinations in Speech-Language Pathology and Audiology (NESPA).

For additional information:

ASHA

10801 Rockville Pike

Rockville, Maryland 20852

Action Line: (800) 638-6868

www.asha.org

LSHA: Louisiana Speech and Hearing Association

For membership or information:

LSHA

8550 United Plaza Blvd.

Suite 1001

Baton Rouge, Louisiana

70809 (504) 922-4600

www.lsha.org

LBESPA: Louisiana Board of Examiners for Speech Pathology and Audiology

Licensure is mandatory in Louisiana for both professions.

LBESPA

18550 Highland Road, Suite B

Baton Rouge, LA 70809.

(225)756.3480, (225)756.3472 (fax)

www.lbespa.org

For Teacher Certification contact:

Louisiana State Board of Elementary and Secondary Education

(BESE)

P. O. Box 94064 Capitol Station Baton Rouge, Louisiana 70804-9064

OR

626 N. 4th Street Baton Rouge, Louisiana 70810 (504) 342-584

General Diagnostic Outline

Evaluation

1. Case History
2. Observation
3. Interview with client and/or family

Standardized Assessment

Additional Procedures

(Contributing Factors)

Documentation

1. Background Information
2. Results and Interpretation
3. Impressions to include: severity of communication disorders, possible etiology, prognosis for improvement.
4. Recommendations to include: type of service, frequency and estimated duration (if treatment is being recommended), follow-up and additional referrals as appropriate
5. Follow-up
6. Counseling/Training

Diagnostic Protocol: APHASIA ASSESSMENT

Evaluation

1. Case History
2. Review of Medical Chart: Obtain file from medical records given written release
Read chart and record (or copy)
pertinent information
 - a. etiology of current dx
 - b. related procedures performed
 - c. past medical history
 - d. medications
 - e. previous speech/language/dysphagia evaluations or notes
 - f. psych history
 - g. other information as pertinent
3. Interview with client, and significant other and/or family to include:
 - a. Personal identifying information
 - i. social history (to include education, employment, family life, roles and structure)
 - ii. concerns, hobbies etc.) -medical history (in patient/family's description-as they understand it)
 - iii. current medications
 - iv. changes in communication/swallowing since incident
 - v. current breakdowns/problem areas at home with regard to communication and participation in activities of daily living
 - vi. patient/family goals for speech/language/cognition/swallowing
 - vii. address any concerns that arise during this portion of the session

Standardized Assessment

1. Formal and Informal Assessment:
 - a. use of both standardized and informal assessment tools will vary on a case by case basis based on specific patient functioning but must include:
 - b. Language Assessment: to include assessment of Auditory Comprehension, Verbal Expression, Reading Comprehension, Written Expression
 - c. Speech Assessment: to include assessment of pitch, intensity, articulation, prosody, resonance, and respiration.
 - d. Cognitive Assessment: to include assessment of orientation, attention, perception, memory, auditory processing, reasoning, problem solving, executive functions.
 - e. Cranial Nerve Examination: to include assessment of strength, range of motion, symmetry, and speed of motion for labial, lingual, facial, mandibular, velopharyngeal regions.
 - f. Swallowing Assessment: to include assessment of swallowing mechanism as warranted by bedside swallow examination or video fluoroscopy.

Additional Procedures: Hearing screening or review of hearing status

Documentation

1. Background Information
2. Results and Interpretation
3. Impressions to include etiology, severity of communication disorder, functional communication status, and prognosis for improvement.
4. Recommendations to include type of service, frequency, estimated duration of treatment, long-term objectives, if treatment is being recommended, as well as any referrals that are being made.
5. Patient and family involvement in treatment planning and acceptance of the completed treatment plan.
6. Indicate follow-up as appropriate
7. Counseling/Training

Diagnostic Protocol: AUDITORY PROCESSING EVALUATION

Evaluation

1. Case History
2. Behavioral Observation of client and when appropriate interacting with family members
3. Interview with client and/or family

Standardized Assessment:

1. Auditory Processing Battery to include assessment of hearing acuity; perceptual processing (auditory attention, auditory figure-ground, discrimination of speech sounds, auditory synthesis, segmentation, syllabication and memory); cognitive-semantic processing and linguistic processing.
2. Informal Assessment: Interaction measurements obtained through dialogue in various settings.

Documentation

1. Background Information
2. Results and Interpretation
3. Impressions to include etiology, severity of communication disorder, functional communication status, and prognosis for improvement.
4. Recommendations to include type of service, frequency, estimated duration of treatment, long-term objectives, if treatment is being recommended, as well as any referrals that are being made.
5. Patient and family involvement in treatment planning and acceptance of the completed treatment
6. Indicate follow-up as appropriate
7. Counseling/Training

Diagnostic Protocol: AUGMENTATIVE AND ALTERNATIVE COMMUNICATION EVALUATION

Evaluation

1. Description of Problem Define specific needs(s) as stated by person referring, the consumer, and family or other caregivers at the time of the assessment.
2. Obtain and review comprehensive history (medical, educational, therapeutic, vocational, and developmental as needed).
3. Interview (questionnaires, telephone) as many team members as possible (e.g., from educational, residential, vocational domains) to obtain a feel for communicative needs according to environment.
4. Pay special attention to what has been tried, what is working, what is not working
5. Gather data on potential funding sources and resources for equipment and training
6. Hearing Screening A complete hearing evaluation is usually completed before the AAC evaluation. Often, clients have not received valid assessments in the past. A hearing screening is completed if there is no reliable assessment on record, or scheduled.
7. Visual Assessment This portion of the assessment is conducted jointly with the occupational therapist and who uses all pertinent background information from other vision specialists.
8. Visual specialists may be called in to address needs of clients with significant visual impairment.
9. Look at the client's ability
 - a. to scan visual fields to locate and identify items varying in terms of size, orientation, and distance (and we try to determine interfering factors, such as field cuts, or motor patterns that interfere with functional vision)
 - b. to use systematic scanning for simple displays (vertical, horizontal, and diagonal)
 - c. to use systematic scanning for electronically assisted scanning (circular, row-column, block-row- column)
 - d. to cross visual midline
10. Experiment with
 - a. the size and configuration of the visual array to be used

- b. the size, color, and other properties of candidate symbols (e.g., letters, pictures, objects, tangible symbols) characteristics of dynamic displays
 - c. characteristics of information on a computer monitor in terms of size, color, definition, background, complexity, etc.
- 11. Motor Speech Assessment Oral mechanism / function exam
- 12. Neuromotor exam and/or articulation screening
- 13. Measure of intelligibility
- 14. Dysphagia screening: interview, observe or obtain consult, provided the client is already taking food by mouth with doctor's approval
- 15. Prognosis for speech
- 16. Gross Motor Assessment Obtain consultation from Physical Therapist to interpret records and current situation for SLP
- 17. Fine Motor Assessment Obtain consultation, team assessment or separate assessment by Occupational Therapist, as scheduling allows to include:
 - a. considerations of physical access to AAC high/low technology computers, and environment control
 - b. positioning needs across functional environments Cognitive/Developmental Level for AAC The data reported here are used to document support for the client's ability to use or not use particular types of AAC systems, and to establish entry points for the various modalities under consideration. We are not exceeding professional scope of practice.
 - c. Behavioral observations
 - d. Early intervention assessment tools of development (e.g., A-SICD, CSBS & Rossetti)
 - e. Formal tools (TONI, etc.)
- 18. Literacy may be assessed formally or informally Behavior and Sensory Processing
- 19. The data reported here are used to document client characteristics that influence the choice of materials and training that will be needed for AAC.
 - a. Document the following: SSIBs, stereotypies
 - b. ability to attend to information of various complexity and format -sensory preferences for input
 - c. susceptibility to over stimulation
 - d. tactile defensiveness -characteristics secondary to Autism (PDD, etc.), head injury, stroke, and other neurological impairment
 - e. prompting strategies and reinforcers are addressed -response to trial therapy addressed (ease/speed of learning, frustration level) Language Assessment
- 20. Receptive Language Use published materials or clinician-constructed materials with alternative response format as needed to assess comprehension of spoken language
- 21. Use published materials or clinician-constructed materials with alternative response format as needed to assess comprehension of written language Expressive Language
- 22. This section is further broken down from unaided to most aided modalities. The purpose of the section is to address the complexity of language attainable in each modality (motor speech, intelligibility was addressed above). The traditional domains

of pragmatics, semantics, syntax, morphology, and phonology are addressed within the relevant categories to the greatest extent possible given the consumer's familiarity with a response format.

- a. Expressive language:
 - Unaided modalities:
 - Speech
 - Gestural communication
 - functional use of head movements
 - use of conventional gestures
 - use of home or conventional sign language
 - Written communication
 - use of print to communicate (e.g., hand writing)
 - Expressive language: Aided modalities (non-electronic):
 - use of pictures on communication displays (manual, gaze)
 - use of letters/words on communication displays
 - typing
- b. Expressive language: Aided modalities (electronic):
 - use of AAC devices (digitized and synthesized speech) to express ideas
 - use of encoding systems pertinent to the systems
 - use of computer with a word processor (standard, taking, etc.)
- c. Environmental Control Needs Assessment
 - Interview
 - Schedule home-based assessment with an OT

Documentation

1. STATEMENT OF PROBLEM
2. BACKGROUND INFORMATION RESULTS AND INTERPRETATION
3. IMPRESSIONS: Summarize findings and provide rationale for the recommendations
4. COUNSELING
 - i. Case managers, family, consumer, other caregivers or service providers participate in a discussion of findings, recommendations for equipment, implementation and training.
 - ii. Establish an initial plan, through discussion. Make it clear that the plan is only a first approximation, and that follow-up will be needed.
 - iii. establish responsibilities for all participants in the implementation plan before they leave the session.
 - iv. Address participants' concerns. If there is some hesitation about a particular component, provide rationale, honor their preferences and work with them.
 - v. Use catalogs or actual equipment to illustrate products. Address funding issues.
5. RECOMMENDATIONS
 - i. Specify equipment, training and implementation.
Indicate follow-up as appropriate
 - ii. Reflect both the assessment team's preferences and the preferences expressed by the family, should there be a significant disagreement.

Diagnostic Protocol: DYSPHAGIA ASSESSMENT (Clinical/Bedside)

Evaluation

1. Case History/Medical Chart Review Behavioral Observation
 - a. Make note of level of alertness, ability to follow multi-step directives, speech intelligibility, attention/distraction, dentition, and excess secretions
2. Interview with patient and/or family

Standard Assessment:

1. To include examination of the oral mechanism, including cranial nerve assessment, assessment of respiration, and reflexes including laryngeal reflexes.
2. If appropriate, administer ice chips or food (solids and liquid). Observe timing of oral transit and pharyngeal swallow, presence of cough, and vocal quality following swallows.

Additional Procedures: Hearing Screening or review hearing status

Documentation

1. Background Information
2. Results and Interpretation
3. Impressions to include severity of swallowing disorder, possible etiology, prognosis for improvement
4. Recommendations to include type of service, frequency and estimated duration, if treatment is being recommended and additional referrals as appropriate (such as additional, objective testing). Indicate follow-up as appropriate Counseling/Training

Diagnostic Protocol: FLUENCY DIAGNOSTIC PROTOCOL

Evaluation

1. Case History
2. Behavioral Observation
 - a. Child-observe interactions with parent/other persons in the waiting room. Listen to speech patterns when escorting to the test room.
 - b. Adult-observe interactions with persons in the waiting room. Listen to speech patterns in informal conversation while escorting to the test room.
3. Interview with patient and/or family Glean information about when speech difficulties started, when speech is better, when speech is worse, and how the client feels about the problem.

Standardized Assessment

1. Child-Standardized language test to assess receptive/expressive language in the areas of syntax, morphology, semantics, pragmatics, and phonology.
2. Complete a formal measure of speech fluency. (This should include speech produced at different levels of speech demand including imitation, spontaneous speech, answering questions, monologue, conversation, and reading.
3. Adult- Language test not necessary.

4. Complete formal measure of speech fluency to include different levels of speech demand identified for child assessment.
5. Informal Assessment:
6. Language sample-Representative sample of the client's conversation abilities when talking about a neutral topic and an emotional topic to be able to calculate the percentage of disfluent speech in conversation.

Additional Assessment Procedures: An oral mechanism examination, hearing screening if complete audiological has not been performed. If audiological has been completed, review the results.

Documentation

1. Background Information
2. Results and Interpretation
3. Impressions to include etiology, severity of communication disorder, functional communication status, and prognosis for improvement.
4. Recommendations to include type of service, frequency, estimated duration of treatment, long-term objectives, if treatment is being recommended, as well as any referrals that are being made.
5. Patient and family involvement in treatment planning and acceptance of the completed treatment plan.
6. Indicate follow-up as appropriate
7. Counseling/Training

Diagnostic Protocol: LANGUAGE: CHILD/ADOLESCENT

Evaluation

1. Case History Behavioral Observation
2. Establish rapport and elicit spontaneous speech sample for analysis of pragmatic, syntactic, semantic language areas.
3. Interview with client and/or family
4. Obtain detailed information about academic history, school performance, previous efforts to deal with difficulties, and perceptions about the problem(s).
5. Standardized language test of receptive and expressive language skills in the areas of morphology, syntax, semantics, pragmatics, and phonology.
6. Standardized test of reading/writing abilities.
7. Standardized test of learning aptitude. The tests should be normed for the appropriate age group and population.
8. Informal measures will include analysis of the language sample. Areas to be analyzed will include pragmatics, semantics, syntax, and morphology. Sample will be screened to rule out fluency, articulation, and/or voice problems.
9. Additional Assessment Procedures: Evaluation of oral mechanism, Evaluation of hearing or review of hearing status

Documentation

1. Background Information
2. Behavioral Observation

3. Results and Interpretation
4. Impressions (Severity, Etiology, Prognosis)
5. Recommendations
6. Indicate follow-up as appropriate
7. Counseling/Training

Diagnostic Protocol: LANGUAGE ASSESSMENT: Pre-K

Evaluation

1. Case History
2. Behavioral Observation of client and when appropriate interacting with family members
3. Interview with patient and/or family

Standardized Assessment

1. Language Battery: -to include assessment of receptive and expressive language skills in the areas of syntax, morphology, semantics, pragmatics and phonology
2. If seeking services through the public schools, then follow requirements of 1508 evaluation
3. Informal Assessment:
4. Communication sample
 - a. obtained to elicit representative sample of client's spoken language abilities in areas of syntax, morphology, semantics, pragmatics and phonology, and to rule out fluency, articulation, or voice problems.
 - b. speech screening of articulation, voice, fluency
 - c. oral mechanism examination

Additional Procedures: Hearing Screening or review of hearing status. If 0-4 (has not entered school), determine need to screen gross and fine motor, social, Interactional, play, adaptive and cognitive skills.

Documentation

1. Background Information
2. Results and Interpretation Impressions to include severity of communication disorder, possible etiology, prognosis for improvement.
3. Recommendations to include type of service, frequency, estimated duration, and programmatic recommendations if treatment is being recommended and additional referrals as appropriate.
4. Indicate follow-up as appropriate Counseling/Training

Diagnostic Protocol: LARYNGECTOMY PROTOCOL

Evaluation

1. Case History/Medical Chart Review to include surgery data and radiation therapy if available
2. Interview with client and/or family

Standard Assessment:

1. Oral mechanism examination
2. include instruction on oral cancer prevention

3. Cognitive Screening as pertains to use of artificial larynx, esophageal speech, tracheoesophageal prosthesis
4. Assessment with artificial larynges
5. Assessment of esophageal speech
6. Preliminary evaluation of candidacy for tracheoesophageal speech

Additional Procedures:

- Hearing Screening or review hearing status
- Patient/Family Education -view American Cancer Society videotape, emergency procedures, new voice clubs, donation from American Cancer Society to patient

Documentation

1. Background Information - include pertinent medical information such as date of surgery, size of tumor, radiation treatment Results and Interpretation
2. Impressions to include diagnostic statement; should not predict esophageal speech outcome. Recommendations to include type of therapy (individual/group), frequency, estimated duration and additional referrals as appropriate.
3. Indicate follow-up as appropriate
Counseling/Training
-with patient and family of results and equipment use

Diagnostic Protocol: MOTOR SPEECH DISORDERS ASSESSMENT

Evaluation:

1. Case History/Medical Chart Review
2. Behavioral Observation Interview with patient and/or family

Standard Assessment:

1. Examination of the speech mechanism during non-speech activities
2. Assessment of perceptual speech characteristics
3. Intelligibility assessment
4. Acoustic and physiologic measures

Additional Procedures: Hearing Screening or review hearing status

Documentation:

1. Background Information Results and Interpretation Impressions to include severity of communication disorder, possible etiology, prognosis for improvement.
2. Recommendations to include type of service, frequency and estimated duration, if treatment is being recommended and additional referrals as appropriate.
3. Indicate follow-up as appropriate Counseling/Training

Diagnostic Protocol: OROFACIAL ANOMALIES/VELOPHARYNGEAL INCOMPETENCY

Evaluation

1. Case History review of pertinent data to include:
 - a. hearing, speech and language development
 - b. surgical history if any
 - c. current status
2. Behavioral Observations

- a. observe interaction with parent, and listen to child's speech
- b. Interview with patient and/or family, confirm information from case history; add data if appropriate

Standardized Assessment: The Iowa Breath Pressure Test from the Templin-Darley Tests of Articulation

Non-Standardized Assessment:

1. Bracketts Speech Sample.
2. Oral Manometric Testing.
3. Stomatognathic Examination to include information regarding facies, mandible, maxilla, dental occlusion and hygiene, palatal and velar anatomy and physiology, pharyngeal depth, tonsils (if present), etc.

Additional Procedures: Audiological screening or evaluation

Documentation

1. Background Information
2. Behavioral Observation
3. Results and Interpretation
4. Diagnostic Impressions
5. Recommendations
6. Indicate follow-up as appropriate
7. Counseling/Training

Diagnostic Protocol: SPEECH AND LANGUAGE SCREENING

Clinical Process

1. Standardized and non-standardized methods are used to screen speech and language.
2. Clients who fail the screening are referred to a speech-language pathologist for further assessment.

Documentation

1. Documentation includes a statement of identifying information, results limited as to whether the person passed or failed the screening, and recommendations including the need for rescreening, assessment, or referral.

Diagnostic Protocol: SPEECH SOUND PRODUCTION DISORDERS IN CHILDREN

Evaluation:

1. Case History Behavioral Observation
 - a. Establish rapport and elicit spontaneous speech sample for analysis
 - b. Estimate intelligibility
 - c. Develop hypotheses regarding speech sound production and associated skills
2. Interview with patient and/or family developmental (general), speech and language, medical, educational and social history

Assessment:

1. Speech sample
 - a. single-word elicitation tasks

- b. reading tasks (if age-appropriate)
- c. directed (or free-form) conversational tasks
- 2. Intelligibility
 - a. Stimulability
 - b. Consistency
 - c. Assessment of phonetic contextual effects

Additional Assessment Procedures:

1. Evaluate integrity of oral structures and functions
2. Evaluate hearing sensitivity and discrimination
3. Screen other speech and language skills
4. Screen cognitive functioning (if appropriate)

Analysis:

1. Sound-by-sound analysis (if few errors)
2. Relational analysis procedures:
 - a. place-voice-manner analysis
 - b. distinctive feature analysis
 - c. natural phonology (phonological process) analysis
3. Independent analysis procedures
 - a. generative phonology analysis
 - b. nonlinear phonology analysis

Documentation

1. Background Information
2. Behavioral Observation
3. Results and Interpretation Impressions
-severity etiology (if apparent) Prognosis
2. Recommendations -programmatic recommendations -referrals for additional assessment - recommended treatment goal priorities and procedures
3. Indicate follow-up as appropriate
Counseling/Training

Diagnostic Protocol: VOICE DISORDERS ASSESSMENT

Evaluation

1. Case History/Medical Chart Review , Include endoscopic/stroboscopic results if available
2. Interview with patient and/or family

Assessment:

1. Oral peripheral mechanism examination
2. Audio/Video-taped protocol
3. Assessment of perceptual voice characteristics
4. Acoustic and physiologic measures

Additional Procedures: Hearing Screening or review hearing status

Documentation

1. Background Information Results and Interpretation Impressions to include severity of communication disorder, possible etiology, prognosis for improvement
2. Recommendations to include type of service, frequency and estimated duration, if treatment is being recommended and additional referrals as appropriate.
3. Indicate follow-up as appropriate Counseling/Training

Worksheet for Minimum Clinical Requirements in Speech-Language Pathology

Can be completed during practical component of course, interactive video, Alternative Clinical Education (Such as Simucase), or clinical practicum experience

Student: _____ Graduation Date: _____

Articulation	
Completed a minimum of 3 adult articulation evaluation hours (no more than 50% coming from screening and/or ACE) and/or practical sessions during academic coursework or Interactive video	
Completed a minimum of 5 child articulation evaluation hours (no more than 50% coming from screening and/or ACE) and/or practical sessions during academic coursework or Interactive video	
Completed a minimum of 5 adult articulation treatment hours and/or practical sessions during academic coursework or Interactive video	
Completed a minimum of 10 child articulation treatment hours and/or practical sessions during academic coursework or Interactive video	
Fluency	
Completed at least 1 fluency evaluation/case study or practical sessions during academic coursework or Interactive video	
Completed 5 fluency treatment hours/case study or practical sessions during academic coursework or Interactive video	
Voice	
Completed 1 voice diagnostics/case study or practical sessions during academic coursework or Interactive video	
Completed 3 hours of voice treatment/case study or practical sessions during academic coursework or Interactive video	
Language	
Completed a minimum of 5 adult language evaluation hours (no more than 50% coming from screening and/or ACE) and/or practical sessions during academic coursework or Interactive video	
Completed a minimum of 10 child language evaluation hours (no more than 25% coming from screening and/or ACE) and/or practical sessions during academic coursework or Interactive video	
Completed a minimum of 10 adult language treatment hours and/or practical sessions during academic coursework or Interactive video	
Completed a minimum of 15 child language treatment hours and/or practical sessions during academic coursework or Interactive video	
Hearing	
Completed a screening competency evaluation	
Completed a minimum of 8 hours of hearing screens	
Completed 5 hours of Aural Rehab treatment hours/Case Study or practical sessions during academic coursework or Interactive video	
Swallowing	
Completed 5 hours of swallowing diagnostics and/or participated in at least two Modified Barium Swallow Studies, FEES or Clinical Evaluations of Swallow and/or practical sessions during academic coursework or Interactive video	
Completed 5 Hours of swallowing treatment hours and/or practical sessions during academic coursework and/or Interactive video.	
Cognitive Aspects	
Completed one cognitive evaluation/Case Study and/or practical sessions during academic coursework or Interactive video	
Completed 5 hours of cognitive treatment/Case Study or practical sessions during academic coursework or Interactive video	
Social Aspects	
Completed at least one social aspect evaluation/Case Study or practical sessions during academic coursework or Interactive video	
Completed 5 hours of social aspect treatment/Case Study or practical sessions during academic coursework or Interactive video	
Communication Modalities	
Completed at least 1 AAC Evaluation/Case Study and demonstrated ability to determine appropriate AAC system to be used with a client through practical sessions during clinic, academic coursework or ACE	
Observation Hours	
Completed twenty-five hours in clinical observation.	
Total Patient Contact Hours	
Completed 400 clock hours of supervised clinical experience in the practice of speech-language pathology Including a minimum of 375 hours in direct client/patient contact.	

Off-site Clock Hour Summary Worksheet (For SLPs Not in CALIPSO System)

Student Clinician _____ Supervisor's Name _____ Supervisor's ASHA Number _____

Month _____ Year _____ Clinical Practicum Site _____ Clock Hour Key: .25 = 15 minutes, .50 = 30 minutes, .75 = 45 minutes, 1.0 = 1 hour

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total	
Child (Evaluation)																																	
Articulation																																	
Fluency																																	
Voice																																	
Dysphagia																																	
Language																																	
Cognition																																	
Comm. Modalities																																	
Social Aspects																																	
Language Screen																																	
Speech Screen																																	
Hearing Screen																																	
Child (Treatment)																																	
Articulation																																	
Fluency																																	
Voice																																	
Dysphagia																																	
Language																																	
Cognition																																	
Comm. Modalities																																	
Social Aspects																																	
Aural Rehab																																	
Adult (Evaluation)																																	
Articulation																																	
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Dysphagia																																	
Language																																	
Cognition																																	
Comm. Modalities																																	
Social Aspects																																	
Language Screen																																	
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Hearing Screen																																	
Adult (Treatment)																																	
Articulation																																	
Fluency																																	
Voice																																	
Dysphagia																																	
Language																																	
Cognition																																	
Comm. Modalities																																	
Social Aspects																																	
Aural Rehab																																	

Supervisor's Signature _____

Monthly Total _____

Clinic Practicum Registration Form for Speech-Language Pathology

Student: _____

Semester: _____

Graduation: _____

Undergraduate Hours Earned (Provide Type and Number):			
---	--	--	--

Observation Hours Completed

Graduate Hours Earned	Articulation	Fluency	Voice	Language	Hearing	Swallowing	Cognitive Aspects	Social Aspects	Comm. Mod.
<i>Evaluation: Child</i>									
<i>Treatment: Child</i>									
<i>Evaluation: Adult</i>									
<i>Treatment: Adult</i>									
<i>Screening: Adult/Child</i>									

Total Graduate Contact Hours Earned		Total Contact Hours Needed to Graduate <small>(375 minus total graduate hours earned and up to 50 of your undergraduate hours earned)</small>	
--	--	---	--

List all past supervisors and sites and number of hours earned to date:		

Courses Completed:

Key	C = Graduate Level courses completed	S =courses scheduled for upcoming semester	E = equivalent undergrad level courses
	5100 Survey of Communication	6201 Anat & Physiol of Spch & Hearing	6464 Sem Lang Disorders
	5132 Speech Science	6204 Motor Speech & Related Disorders	6466 Sem Spch Disorders
	5134 Clinical Linguistics	6210 Fluency Disorders	6468 Sem Basic Human Comm Proc.
	5136 Clinical Phonetics & Phonology	6212 Voice & Related Disorders	6702 Clinic Practicum
	5201 Intro. to Audiology	6214 Diagnosis & Eval in SLP	6704 Clinic Practicum
	5203 Management of Hearing	6216 Augmentative Communication	6706 Clinic Practicum
	5204 Language Disorders of Children	6218 Dysphagia	6708 Clinic Practicum
	5208 Aphasia & Related Disorders	6220 Cleft Palate	5490 Issues in Communication Disorders
	5206 Articulation & Phonological	6222 Language Assessment &	5492 Issues in Communication Disorders
	6230 Infant/Geriatrics	6228 Medical Aspects in SLP	5494 Issues in Communication Disorders
	6100 Research in Communication	6300 Multicultural Aspects of Comm Dis	5496 Issues in Communication Disorders
	6130 Neuroscience	6462 Sem SLP: Intro to Diagnostics	5498 Issues in Communication Disorders

Outline for Parent/Patient Conference

[Format or order may vary. Discuss with supervising faculty first] I. Purpose evaluation, addressing referral concern]

II. Give a general statement regarding the client's performance during the evaluation session

III. Review results

- A. General overview of functioning and/or results of cognitive screening
- B. Language Performance (Do not list test names and scores. Instead tell what aspects of language were assessed, how you did it, how the client performed, and what that means).
 - 1. Receptive Language
 - a. Explain what receptive language is
 - b. If you gave several receptive tests, indicate consistency in performance or explain why inconsistencies occurred
 - 2. Expressive Language
 - a. Same as (a) above
 - b. Same as (b) above
 - c. Summarize impressions of informal analysis/discourse
 - 3. Pragmatic performance
 - a. Semantic
 - b. Syntactic
 - c. Morphological
- C. Articulation and oral motor skills
 - a. Explain what it is
 - b. Relate to intelligibility
- D. Voice and Fluency (if indicated)
- E. Impressions--Pull information together
- F. Recommendations

Outline for Parent/Patient Interview

[Format or order may vary. Discuss with supervising faculty first]

Interview (This begins when you go to pick up the client from the waiting room)

1. Introduction of self, team member, and supervisor
2. Review of what is to occur and what you want parent to do
3. Gathering information
 - a. Give rationale for why you are going to ask questions
 - b. Use open-ended questions
 - c. Have examples prepared to illustrate what you mean
 - d. Do not use professional jargon
 - e. Give time for client to respond
 - f. Give neutral responses when client gives negative information
 - g. If your question is similar to one already answered on case history, take the client/ parent from that point. For example, Say, "You stated that X has ear infections, how often do they occur." Instead of "Does X ever have ear infections?"
 - h. Follow up on information that the client gives you
 - i. Even if you have not prepared a specific question for that information.
 - j. If you have prepared a question to get that information but it is farther down on your list, ask it now
 - k. When you have finished asking your questions, you may
 - l. Ask the client/parent if they have any questions you have not answered and/or
 - m. If it is not already clear, ask what they want to find out from the evaluation
 - n. Close the interview and briefly review what happens next
 - o. Watch rate of speech and use appropriate eye contact.

Progress Note: SOAP Format

[Format or order may vary. Discuss with supervising faculty first]

SOAP notes should cover the following:

1. **Heading:** Consistent with other LSUHSC report formats
2. **Subjective:** (may include)
 - a. Patient name and current status (e.g., "Patient continues to present with...")
 - b. Statement regarding attendance or overall response to Tx.
 - c. Any personal/medical issue that is influencing performance (e.g., change in medication, etc.).
 - d. Statements expressed by patient reflecting primary complaints or concerns (e.g., "my words don't come out right," "my voice is too deep," "my throat hurts when I try to talk" etc.). -State family/patient involvement.
3. **Objective:**
 - a. Indicate present focus of treatment (e.g., "Therapy continues to emphasize/address..."). -State specific short term goals that are measurable:
 - b. Example: (1) Patient will generate simple sentences from a picture stimulus set of 20 with 80% accuracy. (2) Patient will initiate 5 conversational exchanges within a 30 minute therapy session in response to everyday activity pictures. (3) etc...
4. **Assessment:**
 - a. May provide a narrative summary of progress in response to STG stated in objective section (e.g., Over past Tx. period patient has continued to evidence slow steady gains in...) -OR State progress in response to each itemized goal
 - b. Example (1) Patient averaged 70% accuracy. (2) Patient initiated 3 exchanges within 30 minutes. (3) etc.
5. **Plan:**
 - a. Description of treatment program indicating any changes (e.g., "Continue on present program and schedule for group Tx). -Include any referrals to be made (e.g., refer to Vocational). -Mention shift in focus of goals (e.g., begin training with communication book, or log of speaking behavior, etc.).
6. **Signatures:** Faculty & Student, using format consistent with other LSUHSC reports

Progress Note Example: SOAP Format

[Format or order may vary. Discuss with supervising faculty first]

November 23, 1999

Dr. XYZ
LSU Lions Clinic 2020
Gravier Street
New Orleans, Louisiana 70112-2234

Re: Patient X DOB: 0-0-00

Age: 81 years

Address: 0000 St Charles Ave

New Orleans, LA 70000

Telephone: (337) 662-5251

Dates of Therapy: 11/9, 11/11, 11/23/00

Referral Source: Dr. XYZ

Clinician: Name

Supervisor: Faculty Name

Diagnosis: ICD-9: 784.49

File #: 5555

S: Patient X, an 81 year old male, was seen at the LSUHSC Speech-Language-Hearing Clinic for a voice evaluation on November 2, 1999, due to concerns regarding recent changes in his vocal quality. Patient X was referred to this clinic by his physician, Dr. XYZ, after a diagnosis of erythema of the larynx and presbylarynges. It was reported that Patient X participated in several potentially vocally abusive behaviors, including excessive coughing and throat clearing, and consumption of caffeinated and alcoholic beverages. He also stated that he smoked cigarettes until 20 years ago when he received a diagnosis of emphysema. Patient X presented with a hoarse, breathy vocal quality with reduced volume and prosody. Mean phonation time and average fundamental frequency were below normal limits, and perturbation measures were abnormally high. Phonatory competence was reduced in comparison to his normal exhalation pattern. Pitch range was found to be within normal limits.

O: Patient X was seen at this clinic for three sessions in order to learn a vocal exercise regimen that he can continue independently at home. The long term goal was a functional, clearer vocal quality in all settings. In order to address this, the first short term goal was to complete patient education on vocal health and hygiene. The clinician presented information regarding his vocal pathology and provided a handout which discussed techniques to maintain proper vocal health and hygiene. The second short term goal was to increase vocal function. To achieve this, Patient X was taught a series of four vocal function exercises which include warm-up, stretching, contraction, and adductory power exercises. For the warm-up exercise, Patient X was initially able to sustain phonation of /i/ for a range of 11-15 seconds, with an average of 13.5 seconds. On the final session, he had improved to a range of 18-24

seconds, with an average of 20.2 seconds. For the stretching exercise, Patient X was required to glide from the lowest to highest possible notes on the word “knoll”. On this exercise, he produced a pitch range of 86-382 Hz initially and improved to a range of 52-607 Hz. For the contraction exercise, Patient X was required to glide from the highest to lowest possible notes on the word “knoll”. On this exercise, he produced a pitch range of 138-90 Hz initially and improved to a range of 572-51 Hz. For the adductory power exercises, five pitches were chosen within a comfortable range at which to sustain phonation on the word “knoll.” These pitches were B, C, C#, D, and E below middle C. On this exercise, Patient X was initially able to sustain phonation for a range of 9-15 seconds, with an average of 13 seconds. On the last session, he improved to a range of 12-15 seconds, with an average of 13.8 seconds. Patient X was able to perform all exercises at a level sufficient for independent performance.

A: Patient X continued to present with a hoarse, breathy vocal quality with reduced volume and prosody. These characteristics were consistent with the diagnosis of presbylarynges. Prognosis for improvement and follow-through were good due to progress made to date, his willingness to participate in treatment, his ability to complete the exercise regimen, and his indication that he will continue the exercises at home.

P: It was recommended that Patient X continue with these vocal function exercises at his home. These exercises should be completed twice daily. Instructions for completing the exercises were recorded on an audio cassette, complete with vocal models, and will be mailed to Patient X for his use in home practice. A follow-up phone call will be made in approximately one month to monitor progress of Patient X’s vocal quality.

Faculty Name, Ph.D., CCC-SLP
Assistant Professor Speech-Language Pathology

Great Student, BA
Graduate Student Speech-Language Pathology

Progress Summary LSUHSC Clinic Format

[Format or order may vary. Discuss with supervising faculty first]

Date

Name: (Patient/Parent/Referral) Address:

Re: Client

Date of Therapy:

(Beg-End of Sem) DOB:

Clinician:

Age:

Supervisor: Parents:

Diagnosis: Telephone:

File #:

Attendance:

Sessions/week ____

Length of Session ____

of sessions: ____ attended ____ canceled ____ no shows

PROGRESS SUMMARY

Therapy Procedures and Results

Post-therapy data was collected on (date) and (date) . Goal 1. (Same as Treatment Plan)

Objective a: Achieved (date) / Not achieved/Not initiated (State the objective as written on the treatment plan.)

Describe procedures used to implement the goal. Provide any pertinent information which would help others understand how you implemented your goal, including elicitation strategies, materials, facilitating techniques, and any modification in goals. Discuss the client's progress, including results of post-therapy data and goal completion or lack of it.

Impressions

Briefly give your impressions of the client's progress or lack of it as it relates both to your specific goals and your client's communication skills in general.

Example: (Name) demonstrated minimal/good/significant progress improving his articulation skills this semester. He has incorporated use of final sounds into conversational speech and now produces "strident" (air) sounds at a word level. Although his intelligibility has improved, speech errors are still noticeable and he is difficult to understand even with careful listening.

Recommendations

Write your recommendation regarding the need for continued services or dismissal. If to continue, give specific recommendations regarding goals. Make any other appropriate recommendations regarding referrals etc.

Document the final conference held with client/parent.

Example:

Progress and the following recommendations were shared with (Name) at a conference held on (date). It is recommended that:

1. (Name) continue to receive individual speech-language therapy.
2. Goals include to increase...

Patient/Parent

Date

Supervisor's Name

Title

Speech-Language Pathology

Graduate Student Clinician

Speech-Language Pathology

Progress Summary Example: LSUHSC Clinic Format

[Format or order may vary. Discuss with supervising faculty first]

Mr. and Mrs. D. Fasching
789 Bourbon Street
New Orleans, Louisiana 70116

Re: Bacchus Fasching
8/31-12/2/93
DOB: 2/15/89
Age: 4:1 years
Parents: M/M Fasching
Telephone: (504) 123-4567

Dates of Therapy:

Clinician: Gras
Supervisor: Tuesday
Diagnosis: ICD-9: 315.3
File #: 0000

Attendance:
Sessions/week: 2
sessions attended: 26, 1 canceled, 2 no shows

Length: 55 minutes

PROGRESS SUMMARY

Therapy Procedures and Results

Post-therapy data was collected on 11/18/93 and 11/23/93.

Goal 1. To increase verbal communication for behavioral regulation and social interaction.

Objective a: Achieved 10/5/93

Given a verbal and nonverbal model during low structured activities and snack, Bacchus will verbally communicate (i.e., words or word approximations) to express communicative functions of requesting object, requesting action and protesting at least 10 times for two consecutive 55 minute sessions.

Objective b: Achieved 11/7/93

Given a verbal and nonverbal model, Bacchus will verbally communicate to express the communicative functions of greeting, calling, requesting social routine, requesting permission and showing off at least 10 times for two consecutive 55 minute sessions.

Objective c: Achieved 11/23/93

Given interactive play activities with the clinician and provided need to communicate, Bacchus will verbally communicate for behavioral regulation and social interaction at least 10 times during a fifty minute session.

The environment was engineered to create the need for communication. For example, the clinician placed toys in clear jars with the lids tightly closed, creating the need to request help. The clinician also offered undesired toys to promote a protest. Regarding behavioral regulation, Bacchus initially did not communicate to protest but occasionally produced word approximations to request objects. When the clinician modeled an appropriate verbal protest and waited for imitation, Bacchus usually attempted to play with something else. Communication for social interaction progressed more slowly at first. In the beginning stages of both objectives *a* and *b*, the clinician paired a verbal model with a nonverbal mode of communication and gradually models were phased out. By the end of the semester Bacchus verbally communicated to protest, to request objects, to request actions, to greet, to call, to request a social routine, and to request permission, but not to show off. Post-therapy data showed an increase from four verbal communications to an average of 12 per session.

Goal 2. To increase comprehension of routine directions.

Objective a: Achieved 10/23/93

During snack Bacchus will follow two different one-step directions given within a routine and accompanied by gestural cues with 100% accuracy for two consecutive sessions.

Objective b: Achieved 11/15/93

During a 55 minute session of low structured activities and snack, Bacchus will follow five different one-step directions within a routine and accompanied by gestural cues with 80% accuracy for two consecutive sessions.

Objective c: Not achieved

During a 55 minute session of low structured activities and snack, Bacchus will follow a selected set of five different one-step directions within a routine involving familiar objects with 80% success for two consecutive sessions.

This goal was initiated during snack time because Bacchus was highly motivated to comply during this activity. Directions were gradually presented throughout the session, usually during transitions between activities. Each time a new direction was added, it was accompanied by gestural cues and occasionally by physical prompts. The cues were faded when no longer needed. Bacchus demonstrated an increased ability to follow one-step directions, from two different directions given with gestures at the start of the semester, to seven different one-step directions at the end of the semester. Because he only followed four of the targeted directions without gestures, this goal was not met.

Impressions

Bacchus demonstrated good progress in his ability to communicate this semester. He exhibited an increase in both nonverbal and verbal communication to express a variety of

communication functions. Bacchus revealed an increased ability to use communication to behaviorally regulate his environment and to engage in social interaction. He also demonstrated an increase in ability to understand and follow simple one- step directions within a known routine. In addition, the clinician has observed an increased desire to communicate verbally and to interact with the clinician. Parents have reported a similar increase in his verbal communication at home.

Recommendations

Progress and the following recommendations were shared with Mr. and Mrs. Fasching at a conference held on 12/2/93. It is recommended that:

1. Bacchus continue to receive individual speech-language therapy at LSUHSC Speech-Language-Hearing Clinic.
2. Goals include development of functional communication by increasing his use of single words across pragmatic and semantic categories and by improving his comprehension of language.

Patient/Parent Date Other

Date

Name

Title

Speech-Language Pathology

Name

Graduate Student Clinician

Speech-Language Pathology

Speech-Language Evaluation Report LSUHSC Clinic Format

[Format or order may vary. Discuss with supervising faculty first]

Person to Whom Report is going

Name Address City, State, Zip Code

Re:

Name

Date of Evaluation:

DOB:

Length of Evaluation:

Age:

Referral Source:

Parents: (or responsible party's name) Clinician(s):

Address:

Telephone:

Supervisor:

Diagnosis: ICD-10:

File #: _____

Speech and Language Evaluation Report

_____ was seen for a speech and language or an audiological evaluation at LSU Health Sciences Center Speech-Language-Hearing Clinic. State complaint and/or reason for referral if that information is available. The following information is based upon case history and examination results obtained at that time.

Background Information/History

Give pertinent history information. This includes all pertinent facts from other reports (Medical, psychological, education) and all pertinent information obtained from parents or relatives during the interview and from the case history. Do not include background information in the examination part of the report. In most cases, the source of information should be clearly indicated. Try to include only verifiable pertinent information.

Evaluation

*Additional subheadings may be appropriate and requested
by the supervisor*

The purpose of the evaluation will dictate the content and format. For specifics, follow your supervisor's guidelines and examples. Summarize significant observations and test results. Include interpretation of results and statements regarding reliability of test results. All communication evaluations should include at least a statement regarding

receptive and expressive language, articulation/phonology, voice, resonance and fluency. Additional areas may be warranted, including functional level, play skills, academics, etc.

Impressions

Clearly state nature and severity of speech-language and/or hearing problem. Inferences and information pertaining to probable etiology(ies) and prognosis should be indicated. Do not give any information which was not cited previously. Do not state other types of diagnosis outside of our scope of practice. We do not diagnose brain damage, mental retardation, emotional maladjustment, etc. The purpose is to determine speech-language and/or hearing disorders.

Recommendations

A conference was held to discuss results and the following recommendations with Name(s) on date .

1. Recommendations for therapy or reevaluation and follow-up. If reevaluation is recommended, indicate the month and year it should take place. If therapy is recommended, length and frequency should be indicated.
2. Recommendations for referrals. When applicable, referrals to medical specialists should be made through the referring physician, rather than directly to the specialist.
3. State recommendations for remediation of the problem that are given to patient or parents at time of evaluation.

Supervisor's Name
Speech Pathology Speech-Language Pathology

Name
Graduate Student Clinician
Speech-Language Pathology

Treatment Plan LSUHSC Clinic Format

[Format or order may vary. Discuss with supervising faculty first]

Name: For whom the report is written

(Patient/Parent/Referral Source) Address:

Re: Client

Dates of Therapy: (To date)

DOB:

Clinician:

Age:

Supervisor:

Parents: (If applicable)

Diagnosis:

(Code #)

Telephone:

File #:

Sessions/week:

Length: (Of each session)

TREATMENT PLAN

Background Information

Provide a brief history of communication services to date. You may be able to build from the previous semester's description. Include the original evaluation date and results, previous therapy, past semester goals, progress made toward goals, goals not completed, and recommendations from the previous clinician.

Example: (Name) was initially evaluated at (place) on (date). Results of that evaluation stated. It was recommended that s/he be enrolled in speech-language therapy to improve . (Name) has been seen for speech-language therapy twice a week at LSU Health Sciences Center Speech-Language-Hearing Clinic for semesters. Last semester's goals included (summarize goals and note progress or need to continue).

Initial Status

Summarize the client's behavior at the beginning of the semester, including the pre-therapy performance, on- task behavior if remarkable and assessment data. This information provides the rationale for proposed goals.

Goals and Objectives

State goals and at least three objectives for each goal, which should be targeted for completion by end of semester. Write objectives behaviorally and specifically enough that you can determine immediately if objective is being passed or not. Objectives should include 1. condition, 2. client's target behavior and 3. criteria.

Example: Goals and objectives for the semester are as follows:

- Goal 1. To increase articulation by incorporating final sounds into spontaneous speech.
- a. Given picture cards and a request to name them, (Name) will produce targeted final sounds (t,m,n,k,b) in words with 90% accuracy for two consecutive sessions.

- b. Using previously practiced picture cards in game activities, (Name) will produce targeted final sounds in phrases and sentences with 90% accuracy for two consecutive sessions.
- c. Given low structured play activities, (Name) will produce all final sounds within his repertoire in spontaneous speech with 80% success for at least 3 consecutive sessions.

Treatment Plan Example LSUHSC Clinic Format

[Format or order may vary. Discuss with supervising faculty first]

Mr. and Mrs. D. Fasching
789 Bourbon Street
New Orleans, LA 70116

Re: Bacchus Fasching
DOB: 2/15/89
Clinician: Gras
Age: 4:1 years
Supervisor: Tuesday Parents: M/M Fasching
Diagnosis: ICD-9: 315.3
File #: 0000
Sessions/week: 2 Length: 55 minutes

Dates of Therapy: 8/31-9/22/93

Telephone: 123-4567

TREATMENT PLAN

Background Information

Bacchus was initially evaluated at Children's Hospital on February 29, 1992. Results of that evaluation stated that Bacchus exhibited a severe receptive and expressive language delay with poor speech intelligibility. It was recommended that he be enrolled in speech-language therapy to expand his receptive and expressive language skills and to seek additional services through Child Search. Bacchus was seen Spring semester for speech-language therapy twice a week at LSU Health Sciences Center Speech-Language-Hearing Clinic. Goals included increasing imitative and interactional skills, expression of speech acts through either nonverbal or verbal modes and the ability to follow directions. Although improvement was made toward his receptive and expressive language goals, they were not achieved and it was recommended to continue on both. However, Bacchus improved his interactional skills, meeting his goals to increase eye gaze and imitation of play skills.

Initial Status

Baseline measures were collected on 8/31/93 and 9/5/93. Initial measures were taken during organized play activities and snack. Within a 55 minute session, Bacchus appropriately maintained eye contact with clinician for two to four seconds on four different occasions. In order to request that the clinician perform some desired action, Bacchus vocalized accompanied by a gesture on an average of four times during a single session. In addition, Bacchus inconsistently vocalized when objects were withheld. He followed two different one-step directions out of six opportunities. During a 10 minute snack period, Bacchus verbally requested items six times, using two different one-word approximations ("cracker" and

"drink"). Besides some jargon- like singing, these two word approximations were the only verbal attempts at communication observed during initial measurement.

Treatment Plan Patient Name Patient File #

Therapy Goals and Objectives

Goals and objectives for the semester are as follows:

Goal 1. To increase verbalization for behavioral regulation and social interaction.

- a. Given a verbal model and the need to communicate during structured activities and snack, Bacchus will express (i.e., words or word approximations) communicative functions of requesting object, requesting action and protesting at least 5 times during a 10-15 minute activity for 2 of 3 sessions.
- b. Given a verbal model, Bacchus will to express communicative functions of greeting, calling, requesting social routine, and showing off at least 5 times during 10-15 minute activities for 2 of 3 sessions.
- c. Given interactive play activities with the clinician and provided the need to communicate, Bacchus will verbally communicate for behavioral regulation and social interaction at least 10 times during a 55 minute session.

Goal 2. To increase comprehension of routine directions.

- a. During snack Bacchus will follow two different one-step directions given within a routine and accompanied by gestural cues with 100% accuracy for two consecutive sessions.
- b. During a 55 minute session of low structured activities and snack, Bacchus will follow five different one-step directions within a routine and accompanied by gestural cues with 80% accuracy for two consecutive sessions.

Signatures:

Patient/Parent

Date

Name

Title

Speech-Language Pathology

Name

Graduate Student Clinician

Speech-Language Pathology

Speech-Language Pathology Billing Codes

Diagnosis codes for speech-language pathology can be found on the American Speech-Language and Hearing Association's website. The link to this page is:

<http://www.asha.org/practice/reimbursement/coding/icd9SLP.htm>

Current Procedural Codes for speech-language pathology can be found on the American Speech-Language and Hearing Association's website. The link to this page is:

<http://www.asha.org/practice/reimbursement/coding/SLPCPT.htm>

Test User Qualification Codes

The American Psychological Association's Committee on Psychological Tests and Assessment (CPTA) has developed a **Statement on the Use of Secure Psychological Tests in the Education of Graduate and Undergraduate Psychology Students**. This document (available on-line at <http://www.apa.org/science/leadership/tests/test-security.aspx>) provides recommendations regarding (1) security of test materials, (2) testing demonstrations, (3) teaching students to administer and score tests, and (4) using tests in research. This document, in part, asserts:

Before students administer any kind of psychological test, they should have completed appropriate prerequisite coursework in tests and measurements, statistics, and psychometrics, and they should be thoroughly trained in the proper administration of the specific test being used.

It is true, however, that the skills necessary to administer, score, and interpret tests vary widely depending upon which test is being used. The **Test User Qualification Code** was established as a simple means of recognizing this diversity and to encourage self-policing among professionals to ensure ethical use of tests. Many test publishers now use this code to ensure those who purchase testing materials have adequate and appropriate training. The code differentiates among three levels of tests:

Level A: Tests or aids that can adequately be administered, scored, and interpreted with the aid of the manual and a *general* orientation. User has completed at least one course in measurement, guidance, or an appropriate related discipline or has equivalent supervised experience in test administration and interpretation. *Examples: GFW Test of Auditory Discrimination, informal scales*

Level B: Tests or aids that require *some* technical knowledge of test construction and use, and of supporting psychological and educational fields such as statistics, individual differences, psychology of adjustment, personnel psychology, and guidance. User has completed graduate training in measurement, guidance, individual psychological assessment, or special appraisal methods appropriate for a particular test. (In lieu of coursework, clinical supervisors could provide instruction in the use of these tests). *Examples: PPVT-III, EVT, GFTA, MTDDA, OWLS, TACL-R, TOLD-P:3, PLS-3, CELF-P, CELF-3, TWF, TONI, etc.*

Level C: Tests and aids that require *substantial* understanding of testing and supporting psychological fields, together with supervised experience in the use of these devices. User has completed a recognized graduate training program in psychology with appropriate coursework and supervised practical experience in the administration and interpretation of clinical assessment instruments. *Examples: PICA, EFA-3, Woodcock- Johnson Tests of Cognitive Ability - Revised, K-ABC*



Code of Ethics

American Speech-Language-Hearing Association. (2010). *Code of ethics* [Ethics]. Available from www.asha.org/policy.

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Preamble

The preservation of the highest standards of integrity and ethical principles is vital to the responsible discharge of obligations by speech-language pathologists, audiologists, and speech, language, and hearing scientists. This Code of Ethics sets forth the fundamental principles and rules considered essential to this purpose.

Every individual who is (a) a member of the American Speech-Language-Hearing Association, whether certified or not, (b) a nonmember holding the Certificate of Clinical Competence from the Association, (c) an applicant for membership or certification, or (d) a Clinical Fellow seeking to fulfill standards for certification shall abide by this Code of Ethics.

Any violation of the spirit and purpose of this Code shall be considered unethical. Failure to specify any particular responsibility or practice in this Code of Ethics shall not be construed as denial of the existence of such responsibilities or practices.

The fundamentals of ethical conduct are described by Principles of Ethics and by Rules of Ethics as they relate to the responsibility to persons served, the public, speech-language pathologists, audiologists, and speech, language, and hearing scientists, and to the conduct of research and scholarly activities.

Principles of Ethics, aspirational and inspirational in nature, form the underlying moral basis for the Code of Ethics. Individuals shall observe these principles as affirmative obligations under all conditions of professional activity.

Rules of Ethics are specific statements of minimally acceptable professional conduct or of prohibitions and are applicable to all individuals.

Principle of Ethics I

Individuals shall honor their responsibility to hold paramount the welfare of persons they serve professionally or who are participants in research and scholarly activities, and they shall treat animals involved in research in a humane manner.

Rules of Ethics

- A. Individuals shall provide all services competently.
- B. Individuals shall use every resource, including referral when appropriate, to ensure that high-quality service is provided.
- C. Individuals shall not discriminate in the delivery of professional services or the conduct of research and scholarly activities on the basis of race or ethnicity, gender, gender identity/gender expression, age, religion, national origin, sexual orientation, or disability.
- D. Individuals shall not misrepresent the credentials of assistants, technicians, support personnel, students, Clinical Fellows, or any others under their supervision, and they shall inform those they serve professionally of the name and professional credentials of persons providing services.
- E. Individuals who hold the Certificate of Clinical Competence shall not delegate tasks that require the unique skills, knowledge, and judgment that are within the scope of their profession to assistants, technicians, support personnel, or any nonprofessionals over whom they have supervisory responsibility.
- F. Individuals who hold the Certificate of Clinical Competence may delegate tasks related to provision of clinical services to assistants, technicians, support personnel, or any other persons only if those services are appropriately supervised, realizing that the responsibility for client welfare remains with the certified individual.

- G. Individuals who hold the Certificate of Clinical Competence may delegate tasks related to provision of clinical services that require the unique skills, knowledge, and judgment that are within the scope of practice of their profession to students only if those services are appropriately supervised. The responsibility for client welfare remains with the certified individual.
- H. Individuals shall fully inform the persons they serve of the nature and possible effects of services rendered and products dispensed, and they shall inform participants in research about the possible effects of their participation in research conducted.
- I. Individuals shall evaluate the effectiveness of services rendered and of products dispensed, and they shall provide services or dispense products only when benefit can reasonably be expected.
- J. Individuals shall not guarantee the results of any treatment or procedure, directly or by implication; however, they may make a reasonable statement of prognosis.
- K. Individuals shall not provide clinical services solely by correspondence.
- L. Individuals may practice by telecommunication (e.g., telehealth/e-health), where not prohibited by law.
- M. Individuals shall adequately maintain and appropriately secure records of professional services rendered, research and scholarly activities conducted, and products dispensed, and they shall allow access to these records only when authorized or when required by law.
- N. Individuals shall not reveal, without authorization, any professional or personal information about identified persons served professionally or identified participants involved in research and scholarly activities unless doing so is necessary to protect the welfare of the person or of the community or is otherwise required by law.
- O. Individuals shall not charge for services not rendered, nor shall they misrepresent services rendered, products dispensed, or research and scholarly activities conducted.
- P. Individuals shall enroll and include persons as participants in research or teaching demonstrations only if their participation is voluntary, without coercion, and with their informed consent.
- Q. Individuals whose professional services are adversely affected by substance abuse or other health-related conditions shall seek professional assistance and, where appropriate, withdraw from the affected areas of practice.
- R. Individuals shall not discontinue service to those they are serving without providing reasonable notice.

Principle of Ethics II

Individuals shall honor their responsibility to achieve and maintain the highest level of professional competence and performance.

Rules of Ethics

- A. Individuals shall engage in the provision of clinical services only when they hold the appropriate Certificate of Clinical Competence or when they are in the certification process and are supervised by an individual who holds the appropriate Certificate of Clinical Competence.
- B. Individuals shall engage in only those aspects of the professions that are within the scope of their professional practice and competence, considering their level of education, training, and experience.
- C. Individuals shall engage in lifelong learning to maintain and enhance professional competence and performance.
- D. Individuals shall not require or permit their professional staff to provide services or conduct research activities that exceed the staff member's competence, level of education, training, and experience.
- E. Individuals shall ensure that all equipment used to provide services or to conduct research and scholarly activities is in proper working order and is properly calibrated.

Principle of Ethics III

Individuals shall honor their responsibility to the public by promoting public understanding of the professions, by supporting the development of services designed to fulfill the unmet needs of the public, and by providing accurate information in all communications involving any aspect of the professions, including the dissemination of research findings and scholarly activities, and the promotion, marketing, and advertising of products and services.

Rules of Ethics

- A. Individuals shall not misrepresent their credentials, competence, education, training, experience, or scholarly or research contributions.
- B. Individuals shall not participate in professional activities that constitute a conflict of interest.

- C. Individuals shall refer those served professionally solely on the basis of the interest of those being referred and not on any personal interest, financial or otherwise.
- D. Individuals shall not misrepresent research, diagnostic information, services rendered, results of services rendered, products dispensed, or the effects of products dispensed.
- E. Individuals shall not defraud or engage in any scheme to defraud in connection with obtaining payment, reimbursement, or grants for services rendered, research conducted, or products dispensed.
- F. Individuals' statements to the public shall provide accurate information about the nature and management of communication disorders, about the professions, about professional services, about products for sale, and about research and scholarly activities.
- G. Individuals' statements to the public when advertising, announcing, and marketing their professional services; reporting research results; and promoting products shall adhere to professional standards and shall not contain misrepresentations.

Principle of Ethics IV

Individuals shall honor their responsibilities to the professions and their relationships with colleagues, students, and members of other professions and disciplines.

Rules of Ethics

- A. Individuals shall uphold the dignity and autonomy of the professions, maintain harmonious inter-professional and intra-professional relationships, and accept the professions' self-imposed standards.
- B. Individuals shall prohibit anyone under their supervision from engaging in any practice that violates the Code of Ethics.
- C. Individuals shall not engage in dishonesty, fraud, deceit, or misrepresentation.
- D. Individuals shall not engage in any form of unlawful harassment, including sexual harassment or power abuse.

- E. Individuals shall not engage in any other form of conduct that adversely reflects on the professions or on the individual's fitness to serve persons professionally.
- F. Individuals shall not engage in sexual activities with clients, students, or research participants over whom they exercise professional authority or power.
- G. Individuals shall assign credit only to those who have contributed to a publication, presentation, or product.
Credit shall be assigned in proportion to the contribution and only with the contributor's consent.
- H. Individuals shall reference the source when using other persons' ideas, research, presentations, or products in written, oral, or any other media presentation or summary.
- I. Individuals' statements to colleagues about professional services, research results, and products shall adhere to prevailing professional standards and shall contain no misrepresentations.
- J. Individuals shall not provide professional services without exercising independent professional judgment, regardless of referral source or prescription.
- K. Individuals shall not discriminate in their relationships with colleagues, students, and members of other professions and disciplines on the basis of race or ethnicity, gender, gender identity/gender expression, age, religion, national origin, sexual orientation, or disability.
- L. Individuals shall not file or encourage others to file complaints that disregard or ignore facts that would disprove the allegation, nor should the Code of Ethics be used for personal reprisal, as a means of addressing personal animosity, or as a vehicle for retaliation.
- M. Individuals who have reason to believe that the Code of Ethics has been violated shall inform the Board of Ethics.

N. Individuals shall comply fully with the policies of the Board of Ethics in its consideration and adjudication of complaints of violations of the Code of Ethics.