LSUHSC DEPARTMENT OF COMMUNICATION DISORDERS

SPEECH-LANGUAGE PATHOLOGY: CLINICAL HANDBOOK

(Updated June 2013)

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OVERVIEW OF THE LSUHSC GRADUATE PROGRAM

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.

Sources of Information

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

1. LSUHSC Academic Catalog: www.lsuhsc.edu/catalog

    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.lsuhsc.edu/CommunicationDisorders

    a. Current Curriculum
    b. LSUHSC Academic Misconduct Policy
    c. Harassment Prevention
    d. NSSLHA Membership

4. 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.lsuhsc.edu/CommunicationDisorders/SpeechLanguagePathologyClinicHandbook.pdf

a. General Clinic Policies
b. Clinic Practicum
c. Appendices

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.

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/her 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.

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.

Dress Code

The concept of appropriate dress in an academic training program, which also houses clinical treatment areas, is relative rather than absolute. When in the clinical training environment one should dress in a manner that lends credence to the patients' sense of confidence that you are competent in your ability to deal with their problems. For example: shorts, sun-dresses, tank tops, sports bras, revealing clothing (i.e., bare midriffs, cleavage, too-tight clothes, underwear showing), jeans and sweat pants or exercise attire, flip-flops and dirty sneakers or walking shoes, should not be worn when involved in clinic activities or in areas where clients are present. Because there are clinical treatment areas on floors seven, eight, and nine of the Allied Health Building and the administrative offices of the Dean and the Office of Student Affairs are on the sixth floor, neat attire is required at all times.

Appropriate clinical dress may include:

1. Neatly pressed polo shirts monogrammed with Speech-Language Pathology with khaki pants or slacks.

2. Shoes can include loafers, lace-ups, clean walking/running shoes, flats or pumps.
3. Suits, skirts and blouses with pumps or flats;
4. White lab jackets may be required by a supervisor, depending on the age and diagnosis of your client.

Appropriate clinical dress does not include:

1. Scrubs
2. Blue jeans, tank tops, bare mid-rifts, exposure of cleavage
3. Flip-flops, thong sandals. Some supervisors may ban any type of sandal or open toed shoes.
4. Visible body piercing and body art (simple post earrings are acceptable).

Should you be unsure about your dress, check with your clinical supervisor before you enter the clinic area to do treatment or diagnostics. If you are enrolled in the anatomy class, please be courteous and change from the clothes that you wore during the lab. Formaldehyde does not leave a pleasant smell and may be distracting for your clients.

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

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-Dx and post-Dx 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.
   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 are 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.

Clinical Resources

1. Department telephones and telephone messages/E-mail

   a. The Department has several lines for outside calls and local lines for interdepartmental calls. A phone is available in the student study 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 clerical staff will place the call.
   c. Messages taken by the office personnel 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 in the file cabinets in the Student Computer Room - Protocols for diagnostic tests are located in the Speech Materials Room. 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

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

      2. *Before checking out any material,* make sure they have not been placed on reserve.

      3. *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.

      4. *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 f*ile cabinets in t*he 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. For *evaluations*, it is recommended that you reserve the tests needed to prevent them from being checked out at the time of your evaluation. *To reserve a test:* Fill out a Request form and tape it to the test box. These forms are located in an envelope on the bulletin board by the materials room. Be sure no one else has requested the test for the same date/time as you.
e. 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.
f. 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.

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.
   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 Tx or Dx session per instructions. Return to Dx test kit immediately.
      iii. When using equipment with microphones, such as the Speech Viewer, Visi-pitch etc., clinician disinfects microphone, table and equipment surfaces.
      iv. Custodial staff removes garbage in all treatment rooms.

d. As Needed

i. 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.

ii. Wear Gloves on Both Hands for ……..

1. Performing Oral Mechanism examination
2. Oral Motor Therapy
3. Feeding Therapy
4. TEP (Tracheoesophageal Puncture) Procedures
5. Laryngectomy Therapy

3. Diaper Changing should be performed by the family.

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. Fill out an equipment malfunction report on any impaired equipment and give to your supervisor.

2. Failure to fulfill clinic clean-up responsibilities will be reflected in student professionalism ratings.

Emergency Procedures

Medical Emergencies or Accidents

Students should inform a faculty member immediately and have the front desk call Campus Police (34100) 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.

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
Call University Police (568-8999) and give the following information:

- Location of fire or smoke in the building and room number.
- Your name and telephone extension you are calling from.
- Close all doors to help contain the fire, if possible.
- Evacuate using stairs - Do not use elevators.

WHEN THE FIRE ALARM IS SOUNDED

1. Personnel must evacuate the building by way of stairwells. Do not use elevators.
2. 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.
3. University Policy regarding employees, patients and visitors with disabilities.
4. Employees with disabilities shall notify University Police and Floor Captains of their work location(s), medical condition and any special requirements.
5. Patients and visitors with disabilities should notify University Police upon entering the facility and advise of their location.
6. Patients and visitors with disabilities should notify the University Police as they exit the building.
7. 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.
8. 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.
9. 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.

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 its 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. Working folders for clients should be identified by initials or client number, but not by their name.

5. 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 for submitting a file without password protection.

Medical Records

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.

CLINIC PRACTICUM

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 their ASHA observation requirements 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
    d. If the student has not completed undergraduate degree requirements in Communication Disorders, the student will be required to participate in an Associate Clinician Phase prior to the initial clinic practicum enrollment.

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. Be available in the clinic area ten minutes before the scheduled session time.
    d. Consult with the clinician before beginning the observation so the clinician can confirm or correct information regarding the patient, the type of disorder, clinical techniques to be employed, etc.
    e. Demonstrate ethical and responsible behavior. Do not talk, make comments, laugh or express judgments, whether positive or negative, through verbal or nonverbal behaviors.
    f. 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.
    g. Observe the entire clinical session.
    h. Adhere to the clinic dress code while conducting observations.
    i. 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.
    j. Previously Recorded Observations: There are a limited number of recorded sessions available for speech-language observations. Reports for recorded observations must follow the same format as described elsewhere in this handbook. Put the date you observed as the date of the session. Observation reports are to be submitted to the supervisor designated on the video tape.
    k. Observation Report: After each observation, the student will complete a report using the formats provided in the Appendix.
        - 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.
        - The student must make and retain a copy of each observation report. he completed observation report is to be placed in the supervisor's mail box in the receptionist's area.

- The student must maintain a record of all observations completed. 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). The supervisor will read, grade and initial the observation report and return it immediately to the student.
- It is the student's responsibility to keep all completed observation reports and maintain an accurate record of them on the *Observation Tracking Sheet*. 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.
- The student must turn in all observation reports attached to the 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.

Clinical Assignments

1. General

   a. 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.

   b. Clinical assignments are made before the beginning of the semester. The student will receive a copy of the clinic schedule which designates the primary supervisor, additional supervisor(s), the site and type of clinical activity to which the student has been assigned, the number of clock hours per week the student is expected to earn, and, whenever possible, 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.

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)

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, LSU Interim hospital, 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, Additional Private Practices and School Systems.

4. <u>Procedures to Modify Clinic Practicum Responsibilities</u>

a. To request a reduction 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 academic review committee will examine the student's request and approve or deny the request within 5 working days. The chair of the academic review committee will provide the student with written notification of the committee's decision and recommendations.

b. To request an increase in the number of clock hours per week.

i. The student must submit a written request to increase clinic practicum responsibilities to the clinic practicum coordinator.

ii. If the student's request is in excess of the average number of hours per week for which students have been scheduled, the clinic practicum coordinator will present the

student's request to the speech faculty. If the request is approved by the review committee, clinic practicum hours will be added depending upon availability of supervision and/or clients.

iii. If the student's request is within the average number of hours per week for which students have been scheduled, clinical practicum hours will be added depending upon availability of supervision and clients.

Clinic: Treatment

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. Set appointment with your clinic supervisor(s) for your first meeting, to discuss the client and confirm a therapy schedule. **Read** and refer to your supervisor's Syllabus or Requirements and Expectations Handout for specific *Beginning of Clinic responsibilities.*

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.

Treatment Room Sign-up

Sign-up sheets are hung on the dry erase board on the outside of each door. Check with your supervisor, as to whether there are any room requirements (blackboard, size etc.). Unless you remove your name, it will be assumed that you will use it at the designated time the entire semester. If your therapy time and/or day changes, please correct the sheet.

First Week of Treatment Sessions

1. Turn in a lesson plan to your supervisor prior to the first session.

2. 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.
3. At the first or second session, discuss the fire exit procedures with your client or their family in case of an emergency. Procedures are under Emergency Procedures in this manual.

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.

Treatment Documentation

- 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

- Examples of format for of all of the following documents can be found in the Appendix of this handbook.

1. *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:
     a. Subjective: Provide background information, medical information, initial diagnosis
     b. Objective: State objectives of treatment sessions
     c. Assessment: Note progress toward objectives, update status and current diagnosis, impressions
     d. Plan: Recommendations for continued treatment, change in objectives, education

Treatment Plan Conference

2. *Lesson Plan*
   - 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.
   - 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 a

written communication between the student clinician and his/her supervisor about the planned session. The lesson plan should contain the following:

a) Identifying information
b) Specific objectives for the session. Goals and short term objectives may be included.
c) Reinforcement schedule
d) Antecedents and materials
e) Consequences, cueing or correction procedures
f) Results (added after the session)

3. *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.

4. *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.

5. *Progress Summary*
   - 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.

6. *Final Summary*
   - A Final Summary summarizes progress for the semester and makes recommendations for the following semester of treatment.

7. *Discharge Summary*:
   - When a client is being discharged, the student writes a Discharge Summary, which summarizes the entire treatment course.

<u>Treatment: Conferencing</u>

1. *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.

2. *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.

<u>Treatment: End of the Semester Duties</u>

- All clinic responsibilities must be completed before the end of the semester. These responsibilities include returning all borrowed clinic materials, completing log notations, signing all reports, and

completing supervisor evaluations. It may include additional responsibilities as outlined by the supervisor, including an exit conference.

- 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.

- 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.**

Clinic: Diagnostics/Evaluations

Assignments

- 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.

- Speech-Language students should check the results of the recent hearing screening or evaluation, which is scheduled prior to all speech-language evaluations. You may need to consult with the audiology student/faculty, if a written report is not available. If a speech-language student is conducting the hearing screening as part of their evaluation, follow these procedures:

    a. **Check with the Audiology Faculty** assigned to clinic at this time slot to ensure that coverage can be provided, **at least 24 hours prior** to the appointment.
    b. Fill out the audiological screening form, found in Audiology clinic.
    c. File the screening form in the client's medical records chart.
    d. When you write the Speech-Language Report, be sure to add the audiological results. If the client did not pass the screen, have the audiological results **edited by the Audiology Faculty.**

- 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 Coordinator. Allotted time for evaluations varies from 1 to 3 hours.

Confirmation Phone Call

- A script for a Confirmation Phone Call can be found in the appendix of this handbook.
- 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.
- 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.

- 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).
- Student should use the Confirmation Call script included in General Appendix.
- 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.
- Students must notify their supervisor immediately if patient cancels.
- When a patient calls in the clinic office the staff should notify the supervisor if there is a cancellation.
- The staff should e-mail the supervisor if the patient calls into the clinic office confirming or canceling the appointment.
- If a student must call patients from a home 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.

Illness

- The student must contact the supervisor immediately.
- 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.)
- Therefore all students should have the client's home/work phone number with them prior to an evaluation, in case of illness.
- After the student contacts the patient **or** if the student cannot contact the client s/he must again call the supervisor with that information.

Greeting Client

- 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.
- Students should introduce themselves and their supervisor and briefly explain the routine for the evaluation. Additional protocol may be discussed during your supervisory meetings.
- *Students shou*ld 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.
- 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.

Client Conference/Counseling

- 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.

- 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.
- 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.

Concluding the Evaluation

- All students should escort their client to the front desk for payment and ask the front office staff if all paperwork has been completed. Students should seek the supervising faculty if there are any concerns, such as payment issues.
- 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.

Filing of Test Forms

- 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.
- The student must note test results on a separate sheet (not a 2nd form) in order to write their report.

Diagnostic or Evaluation Documentation and Routing

- Refer to *Procedures for Routing and Saving Clinical Documentation* below.

- For Examples of formats for diagnostic reports, including cover letter, are provided as appendices in this handbook. Diagnostic documentation should follow one of these formats unless another format is recommended by the supervisor.

- Rough drafts of evaluation reports should be received by the supervisor within three days after the date of the evaluation. This rule is strictly enforced. The student dates when the first draft was turned in on the routing form.

- The rough draft should be neatly typed and **double spaced**. Rough drafts should include **cover letters** for any referral source or other agency for which a report is being sent.

- The top portion of the **routing form** should be completed, including the date of the evaluation and the mailing due date, which is 15 working days from the evaluation date. Late reports will result in a **lower clinic grade**. Reports are to be saved as: file #. Supervisor's 1st and last initials (1234.al)

- The supervisor will read the rough draft, make any corrections, and save it to the P: drive for the student to modify. The supervisor will date when routed back to the student. The report may require more than one editing process.

Diagnostic Protocols

- Diagnostic protocols provide the students with general guidelines to facilitate planning for most types of evaluations conducted in this clinic. They also outline areas recommended for inclusion in your clinical reports under Documentation. Protocols are provided in the Appendices for a variety of communication disorders.

Case Staffing

- 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.

- 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.

Procedures for Routing and Saving Clinical Documentation

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.

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 Clinical Supervisor's Folder
5. Save the report and a *Routing of Report* form 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

Routing of the reports and completing the Routing of Report Form:

1. Complete the top portion of the routing form, omitting the date of evaluation and mailing due date.
2. 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. Your supervisor will record on the

routing form each time an editing process is completed. You will note down the date of the final edit on the routing form.

3. When the supervisor checks/dates that the draft is ready to print and indicates the number of originals needed, the supervisor will send the document to the *Reprts_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. You can then inform the front office staff to print the document.
4. 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.
5. 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. The supervisor and student need to date and initial the routing form also.

Reports are to be saved as follows:

- Evaluation report: file #. Supervisor's 1st and last initials 1234.al
- Treatment plan: file #tp. Supervisor's 1st and last initials 1234fr.al
- Soap note: file #sn. Supervisor's 1st and last initials 1234sn.al
- Progress summary: file #ps. Supervisor's 1st and last initials 1234pd.al

Patient Satisfaction Surveys

- Surveys are located in the clinic waiting room. All clients are encouraged to complete the surveys as part of our clinic's quality assurance

Grading Policy for Students in Clinical Practicum

Observations

Each observation report is worth 10 points. The points will be given as follows:

- 4 points: Accurate information is given across all content areas
- 4 points: Critical and sufficient information is given within the content areas
- 2 points: Information is presented in a professional manner (i.e., correct spelling, grammar, etc.)

Clinical Practicum:

1. Session Evaluation Forms: Used to provide feedback to the student, along with verbal feedback provided during supervisory meetings. Forms are provided for evaluation of management 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. The diagnostic grade is double weighted.

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.

<u>Student Experiencing Clinic Difficulty - Procedures</u>

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. 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.

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.

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 this important evaluation which remains anonymous and confidential.

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/lsuhsc/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/lsuhsc/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/lsuhsc/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.

<u>To Submit Clock Hours to Clinic Supervisor for Approval</u>:

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.

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

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.

<u>Procedures for Submitting Undergraduate Clinical and Observation Hours</u>

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.

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 program directors for speech-language pathology and audiology.
- 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. 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

1. Observation Form for Audiology Observation

   Observer _____ Date _____ Supervisor _____ Patient # _____
   Total Time _____ Start _____ End _____
   Purpose of Evaluation:
   Pertinent History:
   Tests Administered and Equipment Used: Test Results:
   Recommendations:
   Impressions:

2. Observation Form for Speech-Language Evaluations

   Observer_____ Starting Time of Session_____
   Clinician_____ Client_____ Ending Time of Session_____
   Supervisor_____ Site_____
   Length of Observation_____
   Date of Observation_____ Date Report Submitted_____
   What is the presenting problem or reason for referral?
   Identify:
   Behavioral Observations:
   Behaviors Being Evaluated
   Formal and Informal Procedures Used to Measure Behaviors
   Reinforcement Procedures Used
   Behavior Reinforced WAS APPROPRIATE RAPPORT ESTABLISHED? WAS REINFORCEMENT EFFECTIVE?
   WERE EVALUATION PROCEDURES COMPLETED?
   If not, why not?
   Clinical Impressions:
   Comments

3. Observation Form for Speech-Language Treatment

   Observer_____ Starting Time of Session_____
   Clinician_____ Client_____ Ending Time of Session_____
   Supervisor_____ Site_____ Length of Observation_____
   Date of Observation_____ Date Report Submitted_____
   What is the nature of the problem? Type, severity, characteristics
   What are the semester goals for this client?
   What are the target behaviors for this session?(write as behavioral objective including target behavior, conditions and criteria)
   DESCRIBE: Elicitation Techniques Used Client Response Clinician's Use of Correction Techniques
   WHAT BEHAVIOR MANAGEMENT TECHNIQUES WERE USED? System and Schedule of Reinforcement Behaviors Being
   Reinforced (Include instructional behaviors, such as attending, completion of work, eye contact, if applicable.)
   Behavioral Observations:
   Were planned and executed procedures congruent?
   If not, why not?
   COMMENTS:

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

2. 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

3. LBESPA: Louisiana Board of Examiners for Speech Pathology and Audiology

LBESPA is Louisiana State Licensing Board for both Speech Pathologists and Audiologists. 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

4. For Teacher Certification contact:
Louisiana State Board of Elementary and Secondary Education (BESE)
P. O. Box 94064Capitol Station Baton Rouge, Louisiana 70804-9064
OR 626 N. 4th Street Baton Rouge, Louisiana 70810 (504) 342-5840

ROUTING OF REPORT

Student Instruction: Check which type of report: _____Evaluation Report ____Other Report.

For Other, complete left column only; For Evaluation also provide evaluation date and mailing due date.

Patient #: Date of Evaluation:

Patient last name: Mailing Due Date:

Supervisor:

Student:

Saved as: a:\

Student Instruction: Date each of the following as completed**.**

Student:	**Supervisor:**
1st Draft:	Edited:
2nd Draft:	Edited:
3rd Draft:	Edited:
4th Draft:	Edited:
	OK to Print:
	# of Originals
Proofed /Signed:	Signed:
	Staff:
Copy given to client:	Mailed:
	# Days to Process:
	Disk Backed up :
	Med Rec:
	Report Filed:

Cover Letter

Date

Mr. and Mrs. _____
Address
City, State, Zip

or

Referral Source Dr. G. ENT Address City, State, Zip

Re: John Client

Dear Mr. and Mrs. _____:

Thank-you for your client referral. A copy of our report for the speech and language evaluation conducted on 8/8/01 is enclosed. If you have any questions regarding results or recommendations, please do not hesitate to call me at 568-4348.

Sincerely,

Supervisor's Name and Credentials
Title Speech-Language Pathologist

DIAGNOSTIC PROTOCOLS

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, r 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

<u>Diagnostic Protocol: AUDITORY PROCESSING EVALUATION</u>

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 plan.
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 a reliable assessment on record, or scheduled.
7. Visual Assessment This portion of the assessment is conducted jointly with the occupational therapist and 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 variousmodalities 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.

<u>Diagnostic Protocol: DYSPHAGIA ASSESSMENT (Clinical/Bedside)</u>

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

<u>Diagnostic Protocol: FLUENCY DIAGNOSTIC PROTOCOL</u>

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

<u>Diagnostic Protocol: LANGUAGE: CHILD/ADOLESCENT</u>

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 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. Aassessment 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
   Behavioral Observation
   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

Discharge Summary Example: SOAP Format

Patient Y
Street
City, State, Zip

Date:

Re: Patient Y
DOB:
Age:

Dates of Therapy:
Referral Service:
Clinician:
Code: ICD-9.
File#:

Discharge Summary

Subjective:
Patient Y presented with persistent swallowing and voice problems which are the result of cervical fusion surgery on C3 and C4 performed on February 26, 1999. Swallowing difficulties improved after surgery, but have stabilized without full resolution since mid June. He continues to complain of food getting stuck in his throat, which he then expels. Foods most difficult for Patient Y include crackers, fruits, rice, and bread. He also has difficulty swallowing pills. Voice complaints include hoarseness after speaking for only 30-45 minutes. This effect usually occurs in the morning. He finds his voice becomes progressively softer throughout the day. Patient Y still experiences pain and discomfort from his surgery. He also commented on a constant burning sensation in his fingers when seen for his first therapy session. He was already scheduled for neurological testing to further explore this phenomenon.

Patient Y was seen for a voice and swallowing evaluation on August 11, 1999. The oral peripheral mechanism examination revealed that with the exception of bilateral tongue weakness, structures and function were within normal limits. Measures obtained with Computerized Speech Laboratory (CSL) instrumentation revealed a high frequency of 349 Hz and a low frequency of 116 Hz. Mean phonation time for /a/ was 4 seconds, 5 seconds, and 5 seconds on three trials. Further CSL analysis of sustained vowels revealed one to three voice breaks during a three second sample. Perturbation ranged from 0.533 to 11.46 over three trials. Patient Y's voice was characterized by soft intensity and slight hyponasality. Phrase length was normal.

Patient Y was given general instructions for completion of Vocal Function Exercises. It was also recommended that he attend two one-hour sessions of voice therapy for further instruction of vocal function exercises to provide a more consistently clear voice quality by strengthening and balancing the laryngeal musculature.

Objective:
Patient Y attended one-hour sessions on both September 28, 1999 and September 30, 1999. The primary goal for these sessions was to complete extensive training for Vocal Function Exercises, as outlined below. Patient Y was given written instructions for these exercises, complete with their rationale, to facilitate continued use of the exercises at home.

1. 1. Prolonging /i/ as long as possible
2. 2. Gliding from low to high on /o/.
3. 3. Gliding from high to low on /o/.
4. 4. Prolong /i/ on a high, low, and comfortable pitch for as long as possible.

Assessment

While performing vocal function exercises, the Visi Pitch recorded the highest frequency of 369Hz and the lowest frequency of 110 Hz which reveals an improved range compared to the initial evaluation. The greatest improvement was demonstrated in sustained phonation time which increased from an average of five seconds to an average of 13 seconds for /o/ on 15 trials. The longest prolongation was 18 seconds on /i/. No voice breaks were noted at any time during the treatment sessions.

During the recommended course of therapy Patient Y was amenable and diligent towards all treatment tasks both in the therapy session and at home. He expressed that he noticed improvement in his voice as a result of therapy. He reported that after speaking for approximately 45 minutes he felt sometimes felt vocally fatigued and rested his voice for about four hours after which he was able to speak for the rest of the day "almost perfect".

Plan:

Patient Y has agreed to continue the exercises twice a day independently and will be given a tape to facilitate his practice at home. Adjustments to frequency of the Vocal Function Exercises will be made on the basis of follow-up phone calls. Subsequent visits will be provided as needed.

Clinical Supervisor's Name	Student Clinician's Name
Title in Department	Graduate Student Clinician

Final Summary: SOAP Format

Report Title & Date: Speech/Language Final Summary 00/00/95

Subjective:

- Patient name, age, sex, gender, date of onset, etiology.
- Admit date, initial status.
- If appropriate, relevant background information.
- Discharge date, from what service (inpt./outpt.), reason.

Objective:

- Description of Service provided (e.g., " patient received daily individual treatment for a period of 6 weeks").
- Indicate whether patient was a consistent attender.
- Specify Long Term Goals stated in initial Evaluation Report in 'Plan' section.

Assessment (Include impressions):

- Describe overall response to treatment relative to LTG stated in objective section of report. -Describe functional progress (e.g., "Patient's reading comprehension improved from single word level to simple paragraphs").
- Provide comparison of evaluation and reevaluation findings if completed (include raw data, e.g., scores increased from 60th to 75th Percentile, fund. Frequency increased from 182 to 221 Hz. for habitual pitch, etc.).
- State which goals were met, if not why.
- Status at discharge (e.g., "Patient continues to present with serve aphasia at 4 month post onsetof L-CVA.")
- Relative strengths and weaknesses, psychosocial issues. -Prognostic statement regarding further treatment.

Plan:

- Indicate whether treatment is recommended.
- If no, provide reason (e.g., "goals met," etc.)
- If yes, recommended goal areas to be addressed, frequency, estimated length of further treatment.
- State patient/family involvement in the plan (e.g., "Recommendations were discussed with patient/family and they are in agreement...).
- State patient/family training or educational efforts

Signature:
Include line for Patient, student and supervisor to sign Include student and supervisor credentials

Worksheet for Minimum Clinical Requirements in Speech-Language Pathology

Student: _____ Graduation Date:_____

Articulation	
Completed a minimum of 5 adult articulation evaluation hours (no more than 50% came from screening)	
Completed a minimum of 5 child articulation evaluation hours (no more than 50% came from screening)	
Completed a minimum of 10 adult articulation treatment hours	
Completed a minimum of 10 child articulation treatment hours	
Fluency	
Completed at least 1 fluency evaluation, including a complete diagnostic battery and a report.	
Completed 10 fluency treatment hours and/or practical components during coursework (i.e. an intervention management plan)	
Voice	
Completed 5 hours of voice diagnostics and/or completed at least one comprehensive voice evaluation	
Completed 5 hours of voice treatment and/or practical sessions during academic coursework and/or Interactive video	
Language	
Completed a minimum of 10 adult language evaluation hours	
Completed a minimum of 10 child language evaluation hours (no more than 25% came from screening)	
Completed a minimum of 15 adult language treatment hours	
Completed a minimum of 15 child language treatment hours	
Hearing	
Completed a competency evaluation with an audiologist	
Completed a minimum of 10 hours of hearing screens	
Completed practical components during academic coursework and/or completed 5 hours of Aural Rehab. treatment hours	
Swallowing	
Completed 5 hours of swallowing diagnostics and/or participated in at least two Modified Barium Swallow Studies, FEES or Clinical Evaluations of Swallow.	
Completed 5 Hours of swallowing treatment hours and/or practical sessions during academic coursework and/or Interactive video.	
Cognitive Aspects	
Completed 6 hours of cognitive diagnostics and/or at least one complete cognitive evaluation.	
Completed 5 hours of cognitive treatment and/or practical sessions during academic coursework and/or Interactive video and/or as demonstrated by therapy and diagnostic SOAP notes	
Social Aspects	
Obtained through clinical experiences. Some Examples: Functional therapeutic activities, Behavior Management Plans, Discourse Analysis and Treatment	
Communication Modalities	
Completed at least 1 AAC Evaluation and/or demonstrated ability to determine appropriate AAC system to be used with a client through: practical sessions during academic coursework, Interactive video and/or clinical placement experiences	
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																																
Fluency																																
Voice																																
Dysphagia																																
Language																																
Cognition																																
Comm. Modalities																																
Social Aspects																																
Language Screen																																
Speech Screen																																
Hearing Screen																																
Adult (Treatment)																																
Articulation																																
Fluency																																
Voice																																
Dysphagia																																
Language																																
Cognition																																
Comm. Modalities																																
Social Aspects																																
Aural Rehab																																

Supervisor's Signature _____ Monthly Total _____

Observation Hours Tracking Sheet

Student:_____ Undergraduate Observation Hours_____

Date of Observation	Supervisor	Site	Client's Initial	C=Child A=Adult	Activity	Start/End Times	Length of Observation	Supervisor's Initials

Total: _____

Supervisor's Name and ASHA Number (If observation was completed at an off-site):_____

Off-site Supervisor's Signature _____

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.
Evaluation: *Child*									
Treatment: *Child*									
Evaluation: *Adult*									
Treatment: *Adult*									
Screening: *Adult/Child*									

Total Graduate Contact Hours Earned		**Total Contact Hours Needed to Graduate** (375 minus total graduate hours earned and up to 50 of your undergraduate hours earned)	

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 of 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

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.

Outline for Parent/Patient Phone Call for Information

(Also refer to General Appendix: Confirmation Phone Call)

Phone Call

1. Introduction
2. Confirmation of Appointment
3. Brief review of what will occur during the evaluation and the length of time
4. Solicit questions
5. Gather needed information
6. Close call

Progress Note: SOAP Format

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

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

Progress Note

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

Date

Name: (Patient/Parent/Referral) Address:

Re: Client
DOB:
Age:
Parents:
Telephone:

Date of Therapy: (Beg-End of Sem)
Clinician:
Supervisor:
Diagnosis:
File #:

Attendance:
Sessions/week ___
of sessions: ___ attended ___ canceled ___ no shows

Length of Session ___

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

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

Re:	Bacchus Fasching	Dates of Therapy: 8/31-12/2/93
DOB:	2/15/89	Clinician: Gras
Age:	4:1 years	Supervisor: Tuesday
Parents:	M/M Fasching	Diagnosis: ICD-9: 315.3
Telephone:	(504) 123-4567	File #: 0000

Attendance:
Sessions/week: 2 Length: 55 minutes
sessions attended: 26, 1 canceled, 2 no shows

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

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:_____ Supervisor:_____
Telephone:_____ Diagnosis: ICD-9:_____

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 o

Speech-Language Evaluation Report: SOAP Format

The documentation format for Evaluation reports should follow the same standard as the pediatric cases: however, they should include an additional section titled "Objective of Evaluation."

Please refer below for more specific information regarding the content of the report.

1. **Header:** Use departmental procedure for Letterhead printouts.

2. **Report Title & Date:** Speech-Language Evaluation OR Voice Evaluation 00/00/95

3. **Subjective (**Background & Interview**):** -Name, age, gender, onset date of etiology. -Referral source, reason for admission, admit date. -Evaluation date, indicate inpatient or outpatient. -Case History Information including: previous hospital course (i.e., acute/inpatient rehab), previous treatment, significant medical history. -Social/educational/work history. -State whether a family member was available during eval.

4. **Objective of Evaluation (**Purpose): -Describe the purpose of evaluation (e.g., "to assess type and severity of disorder"). -Indicate specific areas to be assessed by modality (e.g., auditory comprehension, verbal expression, screen cognitive communication, voice, etc.) or more general statements can be used (e.g., to complete speech/language evaluation, oral motor examination, etc.).

5. **Assessment (**Results & Impressions): -List names of specific tests administered (structured and unstructured) and tests used should relate back to areas mentioned in objective section of report. -Indicate results and include raw scores, percentiles, etc. -Indicate primary speech/language diagnosis (e.g., patient presents with moderate dysphonia secondary to vocal nodules which is characterized by, etc.). -Describe functional communication relative to strengths and weaknesses, stimulability, effective strategies. -Include a statement regarding motivation, awareness, and overall effect. -Provide a prognostic statement.

6. **Plan (**Recommendations)**:** -State whether treatment is recommended or not. If not, provide rationale. -If yes, state frequency, duration, anticipated length of therapy course. -Indicate long term functional goals, i.e., where you think, with treatment, patient will be functioning at time of his/her anticipated discharge date (short term goals are stated in progress notes and should reflect procedures used to meet long term goals). -Report patient/family involvement in goal setting. -Document patient/family training and educational efforts.

7. **Signature:** Include credentials and title (Supervisor & Student)

Treatment Plan LSUHSC Clinic Format

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

Date

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

Re: Bacchus Fasching
DOB: 2/15/89
Age: 4:1 years
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
Clinician: Gras
Supervisor: Tuesday

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.

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 interprofessional and intraprofessional 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.