SPEECH THERAPY
COGNITIVE / COMMUNICATION EVALUATION

Name:	Unit/Room:	DOB:
Medical Dx:		Onset Date:
Treatment Dx:		MD Order Date:

Reason for Evaluation:	
Past Medical Hx/Diagnosis:	Prior Therapy: (recent)
Prior Level of Function: (pre problem)	Resident Goals:

SUBJECTIVE: (caregiver report, etc.)

OBJECTIVE / CURRENT LEVEL OF FUNCTION / TESTS AND MEASURES:

Observation:	
Communication / Hearing / Orientation:	
Personal Memory:	Following Directions:
Recall:	Visual Processing / Reading Comprehension:
Problem Solving:	Auditory Selection
Categories:	Immediate Memory/Comprehension:
Verbal Descriptions:	Word/Picture Recognition:

Speech Language Pathologist _____ Date _____

NAME: DOB:

ASSESSMENT

GOALS

SHORT TERM _____ WEEKS

1 Res will follow _____step directions with _____% accuracy.
2 Res will comprehend verbal communication with _____% accuracy.
3 Res will comprehend written communication with _____% accuracy.
4 Res will recall conversations and directions with _____% accuracy.
5 Res will improve personal memory skills to _____% accuracy.
6 Improve prob solving skills in ADL's to _____% accuracy
7 Improve word recall to _____% in pragmatic language
8 Improve expressive conversation to _____% accuracy

OTHER:

LONG TERM _____WEEKS

1 Res will follow _____step directions with _____% accuracy.
2 Res will comprehend verbal communication with _____% accuracy.
3 Res will comprehend written communication with _____% accuracy.
4 Res will recall conversations and directions with _____% accuracy.
5 Res will improve personal memory skills to _____% accuracy.
6 Improve prob solving skills in ADL's to _____% accuracy
7 Improve word recall to _____% in pragmatic language
8 Improve expressive conversation to _____% accuracy

OTHER:

SPEECH THERAPY PLAN OF CARE

☐ Speech Therapy for Cognitive and/or Communication Training
☐ Caregiver Training and/or
Resident/Family Education
☐ Other treatments: (list)

☐ Speech Therapy Not Indicated at This Time

Type:	Skilled Speech Therapy (PPS)	OR	Type: Skilled Speech Therapy (Non- PPS)
Frequency:	Minimum of _____ days/week		Frequency: _____x per week
	Target of _____ minutes per week		OR _____# of visits
Duration:	_____ weeks 4 wk max		Duration: _____ weeks
Cert Period:	_____ to _____ 30 day max		Cert Period: _____ to _____

Speech Language Pathologist **Date**

I certify the need for these services furnished under this plan of care for the above cert period.

Physician Signature / Date