

SPEECH THERAPY EVALUATION

PATIENT NAME _____ AGENCY NUMBER _____

CLINICAL FINDINGS (CONTINUED)

| III. ORAL PERIPHERAL EXAM | | IV. ORAL MOTOR EXAM | |
|---------------------------|--|---------------------|----------------|
| LIPS | | LIPS ABDUCTED | ADDUCTED |
| MANDIBLE | | TONGUE ELEVATION | PROTRUSION |
| MAXILLA | | TONGUE RETRACTION | LATERALIZATION |
| TEETH | | VELUM ELEVATION | |
| OCCLUSION | | P-T-K FORWARD | BACKWARD |
| PALATE | | PHONEME CONTROL | |
| UVULA | | | |
| PHARYNX | | ASSISTIVE DEVICES | |

V. COMMUNICATION SKILLS

TELEPHONE/FAMILY/SOCIAL, ETC. _____

VI. ACTIVITIES OF DAILY LIVING

I U

- TELEPHONE USAGE
- SWALLOWING
- READING
- MAKING CHANGE
- CHEWING

I - INDEPENDENT
U - UNABLE TO PERFORM

I U

- FOLLOWING RECIPES
- TAKING MEDICATIONS
- OTHER
- OTHER (SPECIFY)

HEARING

- GOOD
- FAIR
- POOR
- AID

MENTAL STATUS

- ORIENTED X3
- INTERMITTENT CONFUSION
- DISORIENTATION
- COMA

ASSESSMENT

CARE PLAN

| Problem Number | PROBLEM | GOALS | PLAN | Date Resolved |
|----------------|---------|-------|------|---------------|
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DISCHARGE PLANS

PLAN OF CARE REVIEW (Date & Initial)

| | | | |
|--|----------|----------|----------|
| | 1. _____ | 3. _____ | 5. _____ |
| | 2. _____ | 4. _____ | 6. _____ |

SIGNATURE _____ DATE _____