SPEECH THERAPY CARE PLAN

SOC DATE_____/_____/_____

Primary Diagnosis:____________________ **Onset Date:**_____/_____/_____

Treatment Diagnosis/Problem Areas:

❑ Speech articulation deficit ❑ Voice deficit ❑ Expressive aphasia ❑ Dysphonia ❑ Other:____________________
❑ Functional communication deficits ❑ Dysphagia ❑ Receptive aphasia ❑ Language ____________________

Analysis of Evaluation/Test Scores:____________________

Frequency and Duration:____________________

SPEECH THERAPY INTERVENTIONS

❑ Establish HEP: ❑ Given to Pt ❑ In Chart
❑ Patient/Family/Caregiver education
❑ Voice disorders
❑ Speech articulation disorders
❑ Dysphagia treatments
❑ Language disorders
❑ Aural rehabilitation
❑ Non-oral communication
❑ Alaryngeal speech skills
❑ Language processing
❑ Food texture recommendations
❑ Safe swallowing evaluation
❑ Speech dysphagia instruction program
❑ Teach/Develop communication system
❑ Other:____________________

GOALS/OUTCOMES: Patient/Therapist identified functional based goals (areas identified in evaluation)

Functional Goal Area Identified at Eval:	Functional Short Term Goal #1: Measurable and date by:_____/_____/_____	Functional Long Term Goal #1: Measurable and date by:_____/_____/_____
Functional Goal Area Identified at Eval:	Functional Short Term Goal #2: Measurable and date by:_____/_____/_____	Functional Long Term Goal #2: Measurable and date by:_____/_____/_____
Functional Goal Area Identified at Eval:	Functional Short Term Goal #3: Measurable and date by:_____/_____/_____	Functional Long Term Goal #3: Measurable and date by:_____/_____/_____
Functional Goal Area Identified at Eval:	Functional Short Term Goal #4: Measurable and date by:_____/_____/_____	Functional Long Term Goal #4: Measurable and date by:_____/_____/_____
Functional Goal Area Identified at Eval:	Functional Short Term Goal #5: Measurable and date by:_____/_____/_____	Functional Long Term Goal #5: Measurable and date by:_____/_____/_____

Adaptive equipment needs identified? ❑ Yes ❑ No If Yes (specify):____________________

Patient/Family/Caregiver aware and in agreement of POC? ❑ Yes ❑ No If No (specify):____________________

Discharge Plan: ❑ When goals are met ❑ Other (specify):____________________

Comments:____________________

Plan developed by:____________________ Date:__________
Professional signature/title

Notified IDG:____________________ Date:__________
Professional signature/title

Original - Physician Copy - Clinical Record (until signed original returned)

PATIENT NAME – Last, First, Middle Initial	ID#

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