# SPEECH THERAPY REVISIT NOTE

**DATE OF SERVICE** _____/_____/_____

**TIME IN**_____ **TIME OUT**_____

**VITAL SIGNS:** Temp:_____ Pulse:_____ Regular / Irregular Resp.:_____ B/P:_____

Using $O_2$ at _____LPM via:_____

**PAIN:** Rating scale: 0 1 2 3 4 5 6 7 8 9 10
(0 No pain, 4 Mod pain, 8 Worst pain)

Current pain level:_____ **(subjective reporting)**

Pain quality:_____ (ache, sharp, etc.) Pain location:_____ Frequency:_____

**SOC DATE**_____/_____/_____

**Treatment Diagnosis/Problem Area(s):**

- ❑ Voice disorders
- ❑ Speech articulation disorders
- ❑ Dysphagia
- ❑ Language deficits
- ❑ Dysphonia
- ❑ Expressive aphasia
- ❑ Receptive aphasia
- ❑ Functional communication deficits
- ❑ Other: _____

## SPEECH THERAPY INTERVENTIONS/INSTRUCTIONS

- ❑ 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
- ❑ Pain Management
- ❑ Other: _____

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

| Functional Goal Area Focused On: | Performance/Progress toward Functional Task: | Barriers towards Independence: |
|---|---|---|
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| Adaptive Equipment Needs Identified and/or Trained on: | Patient/Caregiver/Family Response: |
|---|---|

**Comments:**_____

**Evaluation and Patient/Caregiver Response:**_____

CARE PLAN: ❑ Reviewed/Revised with Patient/Caregiver/Family

Revised: ❑ Yes ❑ No (specify)_____

APPROXIMATE NEXT VISIT DATE:_____/_____/_____

PLAN FOR NEXT VISIT: _____

DISCHARGE PLAN DISCUSSED WITH:

❑ Patient/Family ❑ Care Manager ❑ Physician

❑ Other:_____

CARE COORDINATION DISCUSSED WITH:

❑ Physician ❑ Nursing ❑ PT ❑ OT ❑ ST ❑ MSW ❑ Aide

❑ Other:_____

## SIGNATURES/DATES

**X** _____ _____/_____/_____

*Patient/Caregiver (if applicable)* *Date*

Complete **TIME OUT** (above) prior to signing below.

_____ _____/_____/_____

*Therapist (signature/title)* *Date*

PATIENT NAME – Last, First, Middle Initial | ID#