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:_____

Demonstrates Rehab Potential: ❑ Poor ❑ Fair ❑ Good ❑ Excellent

Patient demonstrates potential for continued gains towards a greater level of functional independence and will benefit from continued Speech Therapy Services to address deficit areas impacting his/her function. Please see Speech Therapy Evaluation and Plan of Care for further detailed information regarding current functional level and areas of focus.

Plan developed by:_____ Date:_____

Professional signature/title

Speech Therapy Care Plan and Physician Orders

NOTE: To be used ONLY for Supplemental Orders to Plan of Care/485 for Therapy Services.
When patient under hospice POC, the IDT determines changes to the POC with the medical director and/or attending physician.

Recommended Plan, Outcomes, Frequency & Duration as above.

Verbal orders from physician by:_____ Date:_____

Professional signature/title

Physician signature:_____ Date:_____

Please sign and return promptly

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

PATIENT NAME – Last, First, Middle Initial	ID#