

SPEECH THERAPY PROGRESS STATUS

Treatment Diagnosis:	Onset Date:	Admission Date:	SOC Date:
Discharge Outcome/Setting/Long-Term Goal:		Frequency/Duration:	
ST Goal(s)/Justification to Continue Therapy/Treatment: 1) 2) 3) 4)			
Precautions:		Barriers:	

TREATMENT MODALITIES	INITIAL EVAL DATE:	DATE:	DATE:	DATE:	DATE:	DATE:
Dysphagia Treatment Oral Phase CPT:						
Pharyngeal Phase CPT:						
Diet Level CPT:						
Auditory Comprehension CPT:						
Verbal Expression CPT:						
Non-Verbal Communication CPT:						
Cognition Orientation Attention Problem-Solving Memory CPT:						
CPT:						
CPT:						
Teaching:	<input type="checkbox"/> Pt <input type="checkbox"/> CG	<input type="checkbox"/> Pt <input type="checkbox"/> CG	<input type="checkbox"/> Pt <input type="checkbox"/> CG	<input type="checkbox"/> Pt <input type="checkbox"/> CG	<input type="checkbox"/> Pt <input type="checkbox"/> CG	<input type="checkbox"/> Pt <input type="checkbox"/> CG
Progress Note						
Physician Orders						
THERAPIST SIGNATURES/ DATES	Signature/Title	Signature/Title	Signature/Title	Signature/Title	Signature/Title	Signature/Title
	Date	Date	Date	Date	Date	Date

NAME-Last	First	Middle	Attending Physician	Record No.	Room/Bed
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SPEECH THERAPY PROGRESS NOTES

ADDITIONAL COMMENTS/NOTES – INCLUDE DATE AND SIGNATURE/TITLE

www.BriggsHealthcare.com
©SAMPLE
(800) 247-2343

NAME-Last

First

Middle

Attending Physician

Record No.

Room/Bed