Your Hospital's Logo Here

SPEECH, LANGUAGE & DYSPHAGIA ASSESSMENT

PATIENT IDENTIFICATION

DOB:	AGE:	GENDER: ☐ Male ☐ Female	DOA:	PHYSICIAN:
ADMITTING Dx:				REASON FOR REFERRAL:

SIGNIFICANT MEDICAL HISTORY:

MRI / CT RESULTS:

LABS / ALBUMIN:

MEDICATIONS:

MENTAL STATUS:

ORIENTATION: ☐ Person ☐ Place ☐ Time ☐ Circumstance Contact Tel #: _____

LEVEL of ALERTNESS: ☐ Alert ☐ Lethargic ☐ Unresponsive ☐ Comments: _____

VISION / HEARING:

HANDEDNESS: ☐ Right ☐ Left

PRE-MORBID SKILLS / DEFICITS:

	WFL	IMPAIRED
ORAL MOTOR		
Facial / Labial		
Lingual		
Dentition		
SPEECH		
Speech Intelligibility		
Voice / Loudness		
Pitch / Rate		
Nasality / Resonance		
Respiration		
SWALLOW		
Oral		
Pharyngeal		
Esophageal		
Pain w/ Swallow		
Weight / Best Range		
Nutrition Status		
Current Diet		
Chest X-Ray		
Cervical Auscultation		

	WFL	IMPAIRED
EXPRESSIVE LANGUAGE		
Naming		
Fluency		
Repitition		
Writing		
RECEPTIVE LANGUAGE		
YES / NO Questions		
Follows Directions		
Follows Conversation		
Reading		
MEMORY & COGNITION		
Short Term Memory		
Long Term Memory		
Problem Solving		
Cognitive Screening Results		_____ / 30 Correct
Speech & Language Screening		_____ / 42 Correct

NAME: _____

ASSESSMENT / PRELIMINARY DIAGNOSIS: _____

RECOMMENDATIONS: _____

TREATMENT GOAL / PLAN WHILE IN HOSPITAL / OUT-PT Tx	FREQUENCY OF SVCS
1. Patient will ...	
2. Patient will ...	
3. Patient will ...	

PATIENT / FAMILY EDUCATION: ☐ YES ☐ NO EXPLAIN: _____

REFERRALS: _____

D/C RECOMMENDATIONS: _____

SPEECH & LANGUAGE PATHOLOGIST'S [1] Signature; [2] Title; [3] Tel; and [4] Date below:

SIGNATURE:	TITLE:	TEL:	DATE: