Your Hospital's Logo Here

SPEECH, LANGUAGE & DYSPHAGIA ASSESSMENT

PATIENT IDENTIFICATION

DOB:	AGE:	GENDER: ☐ Male ☐ Female	DOA:	PHYSICIAN:

REASON FOR ADMISSION TO HOSPITAL:

REASON FOR SLP REFERRAL:

SIGNIFICANT MEDICAL HISTORY:

MENTAL STATUS:

ORIENTATION: ☐ Person ☐ Place ☐ Time ☐ Circumstance

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

ORIENTATION: ☐ 1 Step ☐ 2 Steps ☐ _____

GENERAL COMMENTS: _____

VISION / HEARING

HANDEDNESS: ☐ Right ☐ Left

PRE-MORBID SKILLS / DEFICITS:

SPEECH / LANGUAGE:

SWALLOWING:

ASSESSMENT; Findings Include:

PLAN / REFERRAL:

DISCHARGE PLANS (as of this Report Date):

SIGNATURE:	TITLE:	TEL:	DATE: