Your Hospital's Logo Here

SPEECH, LANGUAGE & DYSPHAGIA ASSESSMENT

☐ *This Hospital* ☐ *Assisted Living*

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:

☐ Vision Functional ☐ Wearing Glasses ☐ Visual Problem

☐ Wearing Hearing Aid(s) ☐ Functional Hearing for face-to-face Conversation ☐ Hearing Loss

ORAL MOTOR FUNCTION:

HANDEDNESS: ☐ Right ☐ Left

PRE-MORBID SKILLS / DEFICITS:

SPEECH / LANGUAGE: ☐ Within Functional Limits

☐ See Page 2 for more details

SWALLOWING: ☐ No Dysphagia

Current Weight: _____ Albumin Level: _____

Chest X-Ray Results:

☐ See Page 2 for more details

ASSESSMENT; Findings Include: (*Continued on Page 2*)

PART OF THE MEDICAL RECORD

NAME:

ASSESSMENT; Findings Include: (*Continued from Page 1*)

RECOMMENDATIONS

- ☐ No service needs indicated while in Hospital
- ☐ No services recommended after discharge from Hospital
- ☐ Patient / Family Education Plans _____
- ☐ Swallow Function Study - Reason _____
- ☐ Other_____

DISCHARGE RECOMMENDATIONS

- ☐ Home
- ☐ Home with Speech, Language & Swallow Services
- ☐ Outpatient w/ Speech, Language & Swallow Services
- ☐ SKILLED REHAB / Sub Acute
- ☐ ACUTE REHAB / Comprehensive
- ☐ Long Term Care
- ☐ Other_____

TREATMENT PLAN:

NOTES / ADDITIONAL INFORMATION:

SIGNATURE:	TITLE:	TEL:	DATE:

PART OF THE MEDICAL RECORD