

Speech Language Pathology Sample Reports © 2011

Includes:

- *Plan of Care*
- *Initial Evaluation/ Examination (full-length compliant)*
- *Progress/Treatment Note*
- *Missed Visit Report*
- *Progress/Treatment Note*
- *Physician's Communication*
- *Discharge Summary*



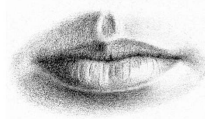
Documentation the Right Way



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Speech Language Pathology

Initial Evaluation

Page 1 of 3

Patient Name: HENDERSON, BEATRICE	Date: 1/20/2011 02:40 PM
Medical Record #: H123490	DOB: 1/26/1939
Account #: 747842390	SOC Date: 1/20/2011
Provider: Action Rehabilitation Services	
Provider #: 17238940	
Treating Clinician: Sally Smith, MA, CCC-SLP	

Patient Information

Address: 7890 Middle Avenue	Physician: Greg House
	Physician #: NPI# 45679
City, State, Zip: Nashville, Tennessee 37215-4818	
Occupation: Clerical	# of Approved Visits: 0
Gender: Female	Medicaid #: NA
Contact Person: George Henderson	Medicare #: 17182304

Rehabilitation Information / History

	Onset Date	Code	Description
Primary Diagnosis:	12/29/2010	434.11	CEREBRAL EMBOLISM WITH CEREBRAL INFARCTION
Other Diagnosis:	12/29/2010	787.21	DYSPHAGIA, ORAL PHASE
Prior Functional Status: Communication appropriate and efficient in all situations			
Safety Measures: Adhere to dietary restrictions			
Recent Speech\Language Therapy: Acute hospital setting - within last sixty days			
Rehabilitative Prognosis: Good rehab potential to reach the established goals			
Mental Status: Patient responsive to therapy stimuli			
Special Needs: Glasses			
Concerns that led Patient to SLP: Difficulty swallowing food or liquid			
Ambulatory Status: Independent			
History is Significant for: Diabetes			
Patient / Caregiver is aware of and understands his/her diagnosis and prognosis:			Yes
There is need for further functional assessment by another discipline:			No
History Comment: Beatrice suffered a sudden onset of right sided weakness and slurred speech on 12/29/2011. Beatrice admitted to Vanderbilt Hospital. Slurred speech symptoms resolved over the course of her hospital stay. Modified barium swallow study (MBS) on 12/30/2011 revealed mild oral phase dysphagia with no signs or symptoms of aspiration. Patient placed on soft diet with regular liquids and reportedly tolerated this diet well.			
Assessment Method: CLINICAL SWALLOW EVALUATION			

Functional Measures

Eating - Swallowing

Initial Level: LEVEL 4 - Swallowing disorder does not prevent eating to meet nutritional needs, although general supervision is required to ensure use of compensatory techniques.

Goal: LEVEL 7 - Swallowing is normal in all situations. by 2/20/2011

Goals

Functional Characteristics Compensatory techniques and monitoring required during meals to ensure safety.

Patient Name: HENDERSON, BEATRICE **Date:** 1/20/2011 02:40 PM
Medical Record #: H123490 **DOB:** 1/26/1939
Account #: 747842390 **SOC Date:** 1/20/2011
Provider: Action Rehabilitation Services
Provider #: 17238940
Treating Clinician: Sally Smith, MA, CCC-SLP

and Analysis:**Physical Findings****Oral Motor**

Oral motor structure/function is normal in all aspects: No

Facial Appearance:

Right Sided Weakness

Strength Reduced in:

Lips - Right; Tongue - Right

Range of Motion Reduced for:

Lips - Right

Rate of Movement Reduced for:

Lips; Tongue

Is Drooling Present: No

Oral Motor Comments:

Right facial, tongue and lingual symptoms are mild.

Swallowing Exam

Swallowing Function Exam is normal in all aspects: No

Liquid Consistency Tested:

Small Cup Sip

Cup--Consecutive small swallows/sips

Regular Liquid

Testing Variables:

Patient fed self appropriately

Clinical Findings:

ORAL PHASE: Benefitted from extra swallows

ORAL PHASE: No anterior spillage

Food Consistency Tested:

Cookie

Regular

Testing Variables:

Patient fed self appropriately

Clinical Findings:

ORAL PHASE: Benefitted from alternating foods with liquids

Swallowing Comments (Food):

Patient tolerated regular foods if cut into small bites.

Impressions / Recommendations**Diagnostic Impressions:**

Patient presents with mild oral phase dysphagia and mild right facial weakness. Patient compensates for this weakness by using small bites and alternating liquids and solids. Patient self feeds but requires reminders to follow these compensatory strategies. Patient benefits from chopped meats to ensure that bites are of sufficiently small size.

Diagnostic Recommendations:

Upgrade to regular diet with chopped meats. Continue regular liquids.


Interventions (CPT Code)

Patient Name: HENDERSON, BEATRICE **Date:** 1/20/2011 02:40 PM
Medical Record #: H123490 **DOB:** 1/26/1939
Account #: 747842390 **SOC Date:** 1/20/2011
Provider: Action Rehabilitation Services
Provider #: 17238940
Treating Clinician: Sally Smith, MA, CCC-SLP

Evaluation - Oral & Pharyngeal Swallow Function 92610
Treatment - Swallowing dysfunction &/or Oral function, feeding 92526

Frequency of SLP: Two times weekly for 2 weeks, then decrease to 1 time every 2 weeks

Duration of SLP: 4 weeks

	1/20/2011 4:15:02 PM
Sally Smith, MA, CCC-SLP	Date/Time
State License #: TN # 0715	



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Speech Language Pathology **Progress / Treatment Note**

Page 1 of 1

Patient Name: HENDERSON, BEATRICE **Date:** 1/20/2011 04:15 PM
Medical Record #: H123490 **DOB:** 1/26/1939
Account #: 747842390 **SOC Date:** 1/20/2011
Provider: Action Rehabilitation Services
Provider #: 17238940
Treating Clinician: Sally Smith, MA, CCC-SLP

	Onset Date	Code	Description
Primary Diagnosis:	12/29/2010	434.11	CEREBRAL EMBOLISM WITH CEREBRAL INFARCTION
Other Diagnosis:	12/29/2010	787.21	DYSPHAGIA, ORAL PHASE

Time In: 10:30 AM **Time Out:** 11:00 AM

SLP Interventions and CPT Codes Consisted of:	CPT Code	Modifiers	Minutes	Units
Evaluation - Oral & Pharyngeal Swallow Function	92610		30	1
Total Minutes: 30 Total Timed Minutes: 0 Total Untimed Minutes: 30				
Total Units: 1 Total Timed Units: 0 Total Untimed Units: 1				

Intervention Comments:

Please refer to Initial Evaluation this date.

Current Plan:

Two times weekly for 2 weeks, then decrease to 1 time every 2 weeks

Discharge Planning was Discussed with Patient/Caregiver:

Yes

	1/20/2011 4:17:06 PM
Sally Smith, MA, CCC-SLP	Date/Time
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Speech Language Pathology

Missed Visit Report

Page 1 of 1

Patient Name: HENDERSON, BEATRICE **Date:** 1/27/2011 04:27 PM
Medical Record #: H123490 **DOB:** 1/26/1939
Account #: **SOC Date:** 1/20/2011
Provider: Action Rehabilitation Services
Provider #: 17238940
Treating Clinician: Sally Smith, MA, CCC-SLP


	Onset Date	Code	Description
Primary Diagnosis:	12/29/2010	434.11	CEREBRAL EMBOLISM WITH CEREBRAL INFARCTION
Other Diagnosis:	12/29/2010	787.21	DYSPHAGIA, ORAL PHASE

Patient did not receive therapy today for the following reason:

Patient was not feeling well enough to tolerate therapy today

Plan:

Continue with 2 times weekly therapy

	1/20/2011 4:28:26 PM
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Speech Language Pathology Progress / Treatment Note

Page 1 of 1

Patient Name: HENDERSON, BEATRICE **Date:** 1/25/2011 04:17 PM
Medical Record #: H123490 **DOB:** 1/26/1939
Account #: **SOC Date:** 1/20/2011
Provider: Action Rehabilitation Services
Provider #: 17238940
Treating Clinician: Sally Smith, MA, CCC-SLP

	Onset Date	Code	Description
Primary Diagnosis:	12/29/2010	434.11	CEREBRAL EMBOLISM WITH CEREBRAL INFARCTION
Other Diagnosis:	12/29/2010	787.21	DYSPHAGIA, ORAL PHASE
Time In: 11:00 AM		Time Out: 11:30 AM	

SLP Interventions and CPT Codes Consisted of:	CPT Code	Modifiers	Minutes	Units
Treatment - Swallowing dysfunction &/or Oral function, feeding	92526		30	1
Total Minutes: 30		Total Timed Minutes: 0		Total Untimed Minutes: 30
Total Units: 1		Total Timed Units: 0		Total Untimed Units: 1

Intervention Comments:

Patient reports that she has experienced no episodes of choking or coughing since diet upgrade.

Goals

Eating - Swallowing	Cueing	Accuracy
LEVEL 7 - Swallowing is normal in all situations. by 2/20/2011		
Swallowing Activities	Cueing	Accuracy
Training compensatory technique - Multiple swallows	in 1/2 tsp amount, with cueing	5/5 trials
Training compensatory technique - Bolus size control	bumpy texture, with cueing	5/5 trials
Training compensatory technique - Multiple swallows	bumpy texture, with cueing	5/5 trials

Specific Observations:

Dependence on cues - Decreased since last treatment

Specific Functional Changes:

Eating and swallowing - Improved since last treatment

Current Plan:

Two times weekly for 2 weeks, then decrease to 1 time every 2 weeks

Discharge Planning was Discussed with Patient/Caregiver:	Yes
Patient's response to Speech Interventions:	Good
Patient's progress toward established goals:	Good

<i>Sally Smith MA, CCC-SLP</i>	1/20/2011 4:24:46 PM
Sally Smith, MA, CCC-SLP	Date/Time
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Speech Language Pathology **Physician's Communication**

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Patient Name: HENDERSON, BEATRICE **Date:** 1/31/2011 04:25 PM
Medical Record #: H123490 **DOB:** 1/26/1939
Account #: **SOC Date:** 1/20/2011
Provider: Action Rehabilitation Services
Provider #: 17238940
Treating Clinician: Sally Smith, MA, CCC-SLP

	Onset Date	Code	Description
Primary Diagnosis:	12/29/2010	434.11	CEREBRAL EMBOLISM WITH CEREBRAL INFARCTION
Other Diagnosis:	12/29/2010	787.21	DYSPHAGIA, ORAL PHASE

Speech Language Pathology Comments: Patient is too ill to tolerate the current frequency of therapy.

Plan/Orders: Put therapy on hold for 1 week, then resume with established frequency

Additional Comments: Patient sick with flu. Will resume therapy at one time per week when patient has recovered.

Greg House	Date/Time
I certify the need for these services furnished under this plan of treatment while under my care.	

<i>Sally Smith MA, CCC-SLP</i>	1/20/2011 4:29:21 PM
Sally Smith, MA, CCC-SLP	Date
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Speech Language Pathology

Discharge Summary

Page 1 of 2

Patient Name: HENDERSON, BEATRICE	Date: 2/18/2011 04:29 PM
Medical Record #: H123490	DOB: 1/26/1939
Account #:	SOC Date: 1/20/2011
Provider: Action Rehabilitation Services	
Provider #: 17238940	
Treating Clinician: Sally Smith, MA, CCC-SLP	

Patient Information

Address: 7890 Middle Avenue	Physician: Greg House
	Physician #: NPI# 45679
City, State, Zip: Nashville, Tennessee 37215-4818	
Occupation: Clerical	# of Approved Visits: 0
Gender: Female	Medicaid #: NA
Contact Person: George Henderson	Medicare #: 17182304

Discharge Information

	Onset Date	Code	Description
Primary Diagnosis:	12/29/2010	434.11	CEREBRAL EMBOLISM WITH CEREBRAL INFARCTION
Other Diagnosis:	12/29/2010	787.21	DYSPHAGIA, ORAL PHASE

Patient / Caregiver was given proper notification of Discharge: Yes

No further Speech/Language Therapy intervention is indicated at this time in this setting: Yes

Patient's physician has been notified that patient has been discharged from Speech and Language Pathologist's care: Yes

Reasons for Discharge: Goals Met

Final Instructions to Patient: Patient to continue compensatory strategies of small bite size and multiple swallows. Patient on normal diet without supervision.

Functional Measures

Eating - Swallowing

Initial: LEVEL 4 - Swallowing disorder does not prevent eating to meet nutritional needs, although general supervision is required to ensure use of compensatory techniques.

Goal: LEVEL 7 - Swallowing is normal in all situations. by 2/20/2011

Final Level: LEVEL 7 - Swallowing is normal in all situations.

Goals

Functional Characteristics and Analysis: Patient utilizes compensatory techniques without monitoring or cuing. Patient presents with functional oral intake skills.

Physical Findings

Oral Motor

Oral motor structure/function is normal in all aspects: No

Facial Appearance:

Right Sided Weakness

Strength Reduced in:

Lips - Right; Tongue - Right

Range of Motion Reduced for:

Lips - Right

Patient Name: HENDERSON, BEATRICE
Medical Record #: H123490
Account #:
Provider: Action Rehabilitation Services
Provider #: 17238940

Date: 2/18/2011 04:29 PM
DOB: 1/26/1939
SOC Date: 1/20/2011

Treating Clinician: Sally Smith, MA, CCC-SLP

Rate of Movement Reduced for:

Lips; Tongue

Is Drooling Present:

No

Oral Motor Comments:

Right facial, tongue and lingual symptoms are mild.

Swallowing Exam

Swallowing Comments (Liquid):

Patient tolerating thin liquids without signs or symptoms of aspiration.


Swallowing Comments (Food):

Patient tolerated regular diet. Patient able to apply compensatory strategies of small bites and multiple swallows without supervision or cuing.

Interventions (CPT Code)

Evaluation - Oral & Pharyngeal Swallow Function 92610

Treatment - Swallowing dysfunction &/or Oral function, feeding 92526

	
Sally Smith, MA, CCC-SLP	2/18/2011 2:42:55 PM
State License #: TN # 0715	Date/Time