SPEECH AND LANGUAGE EVALUATION

CLIENT : RESP. PARTY : 
ADDRESS : INFORMANT : 
REFERRAL SOURCE : 
BIRTH DATE : EVALUATION DATE : 
PHONE : REPORT DATE :

All pages following the letterhead page should be headed as follows:

Client's Name  
Date of Evaluation  
Page <number>

REFERRAL AND COMPLAINT

This opening section should be composed of a brief, but concise statement relative to the referral source and the specific reason for the referral.

Example: (Client's name and age) was referred for complete speech and language evaluation by Dr. Charles F. Wilson who felt that (Client's Name) was difficult to understand. Dr. Wilson also reported the mother to be quite concerned about her son's speech and language development.

This statement should be paraphrased from a letter of referral if possible. It should also include a statement of the problem as perceived by the parents or informant.

Example: Mrs. Smith felt that even though Jimmy was difficult to understand, his speech was "essentially normal" and his teacher, who referred him, was overreacting.

HISTORY

The informant should be identified in the first sentence of this section. Pertinent historical information should be obtained from the case history form and supplemented through personal interview, previous reports, etc. Use a narrative format with paragraphs on: birth and medical; developmental; family, education, and social; client or parent reactions, and other concerns. These subsections need not be headed.
(Birth and Medical)

1. **Prenatal**: Mother's health, medications, length of pregnancy, labor complications; **Perinatal**: Birth complications, type of delivery, medications used, condition of baby at birth; **Postnatal**: (up to one month)

2. **Medical**: Significant illness, injury, hospitalization, history of ear infections, including type and number, allergies, etc. If there is no **significant** medical history, i.e., medical history pertinent to the disorder, then simply state that "medical history was unremarkable."

(Developmental)

1. **Motor**: Age crawl, sit, stand, walk, etc. General statement about client's motor coordination.

2. **Oral Motor**: Difficulty with suckle-swallow, difficulty with solid foods, loss of liquids through nose, history of choking.

3. **Dental**: Significant dental injuries, routine dental care, and anything unusual about dental development.

4. **Speech and Language**:
   
a. Early cry (Excessive, None, Variation).

b. Cooing, babbling, vocal play, etc. Should obtain approximate ages if possible.

c. Response to others' speech - when and how. Were there periods of no response? If so what were the circumstances?

d. First meaningful words - age and words if possible.

e. Paralanguage - did client utilize gestures in combination with speech?

f. Stringing words - age and how many. Get examples if possible.

g. Use of oral communication in home environment and school.
(Social)

**Social Interactions:** (Parents, siblings, peers, teachers, etc.) should also be discussed when appropriate.

(Educational)

If client is in pre-school or school.

Information should also reflect the client's present school placement and overall performance; i.e., did he or she enjoy school? Are there specific problems with separation from parents? What types of peer problems did or does the client have? Are there specific academic problems? Grades skipped or repeated.

(Family)

This section should give information on any speech or language disorders in other family members, at least back to maternal and paternal grandparents. Inclusion of this section is at the discretion of the clinical educator.

(Client's or parents' personal reactions to the speech problem)

1. Is the client aware of the problem?

2. Has the client displayed any significant emotional reaction to the problem?

3. Has the client been ostracized by his peers, siblings, etc.? If so, what were his or her reactions?

(Other concerns of parents and family)

Many times parents will have other concerns about their child, which will not come to the surface during a standard interview or through a formal case history. It is, therefore, very important to ask them if they have any other concerns.
EVALUATION

This section provides a general outline of areas of assessment and examination and is by no means a standard for all clients. Dependent upon the client, the order of examination and testing may vary. This may necessitate variation from the order of components below.

The clinician needs to report the type of testing that was done as well as the results of that testing. Organization is quite critical in this section. The report should contain subsections relating to the areas of behavior assessed, such as articulation and phonology, language, oral peripheral mechanisms, related non-verbal behaviors.

Examination of Oral Structure and Function:

If oral structures and function are within normal limits, simply state that. If not, be specific in describing the abnormality. Be sure to note any dental abnormality and whether it is potentially significant to, or an etiologic factor for the speech problem.

Audiometric Screening:

The major purpose of a hearing screening is to determine if further testing is warranted. This is not a threshold test and results do not reflect normal or abnormal hearing levels. Results should be stated in terms of pass or refer, with further recommendations if indicated.

Standard hearing screening for this Clinic should be at 20 dB HL for the frequencies 500, 1000, 2000, and 4000 Hz bilaterally by air conduction. Ambient noise may require increase in intensity, but it should not be increased beyond 25 dB HL.

Language:

Specific tests or procedures will vary according to the presenting problem. Which tests to utilize will be determined through consultation with the clinical educator. The diagnostic report should reflect the following order.

1. Receptive
   a. Exact names of tests and brief description
b. Test results

c. Interpretation of results.

2. Expressive

a. Exact names of tests and brief description

b. Test results

c. Interpretation of results.

Auditory Processing:

1. Exact names of tests and brief description

2. Results of tests

3. Interpretation of results

Articulation and Phonology:

1. Exact names of tests and brief description

2. Results of tests

3. Interpretation of results

Fluency:

1. Exact names of tests and brief description

2. Results of tests

3. Interpretation of results

Voice:

1. Pitch
2. Intensity

3. Quality

4. Flexibility
   a. Exact names of tests and instruments and brief description
   b. Results of tests
   c. Interpretation of results

CLINICAL IMPRESSIONS:

This section should be utilized to describe the client's response to the testing situation, his behavior around his parents and family, or other specific behavior problems exhibited during the diagnostic process.

Example: Throughout the examination the client was restless and did not cooperate with requests made by the clinician. He refused to separate from his mother and would only respond while seated in her lap. Several times during the session he gave vent to frustration with the tasks presented by tantruming.

DIAGNOSIS

Statement should include the primary diagnosis, severity of the problem, overall effect on client's communicative ability, secondary problems, as well as the etiology. You should not reiterate the detail that was given in the "Evaluation" section; rather, you must give the reader your overall impressions as they were derived from the data obtained during your evaluation.

Example: (client's name) presents with a severe phonological or articulation disorder secondary to fluctuating conductive hearing loss as a result of chronic otitis media from age one to three years. The client also presents with a moderately restricted lingual frenum, which may be a contributing factor for some of the noted articulatory deviations. Referral for further medical examination is pending.
PROGNOSIS

Prognostic statement should be based on one or more of the following: stimulability, hearing acuity, oral motor integrity, oral structures, intelligence, attending behavior, age, cooperation and interest of parents, interest of the client in elimination of the problem, awareness of the client, and severity of the problem.

Example: There are many positive indicators for Benjamin’s communication development. Benjamin’s parents are very concerned about and involved in his development. Early initiation of intervention is also a positive factor in communication development. Benjamin exhibits behaviors, which are autistic in nature and may have a negative impact on the prognosis. A complete prognosis will be contingent upon future assessment.

FINAL CONFERENCE

A brief description of the information presented to the parent or client, the manner in which the information was received, and an estimate of whether it was understood and accepted.

RECOMMENDATIONS

Should be specific to primary and secondary diagnosis, and should be listed and numbered sequentially.

Treatment:

The report should indicate if treatment is recommended or not. If recommended, state number of sessions per week to achieve maximum improvement. This should be based upon your impressions and not upon what would be physically and financially convenient for the client or family. The final outcome is usually based on a compromise.

Suggested treatment approach - based upon diagnosis and behavioral observations.

Recommended resources for treatment and family.

Recommendations for outside referral when necessary.
SIGNATURES

CLINICAL EDUCATOR'S NAME  CLINICIAN'S NAME
Speech-Language Pathologist  Graduate Clinician

Copies to:

Responsible party (parent, client, spouse, etc.)

Referral source, when authorized (Check release form for names and dates)

Outside referrals when necessary and authorized (Check release form for names and dates)