GUIDELINES FOR WRITING REPORTS

Report writing is a challenging and important part of the clinical experience. Students will write a variety of reports depending on the clinical practicum setting. Report writing skills develop over time with practice and experience. Graduate clinicians are expected to complete all paperwork according to the guidelines of the particular setting to which the student is assigned with guidance from the clinical educator.

Clinical writing tasks related to speech-language services in the Communication Disorders Clinic:

- Diagnostic report – written after each comprehensive evaluation. This report summarizes the evaluation results, interprets the data gathered, and makes specific recommendations regarding the need for and the focus of intervention.

- Audiology Reports – gives examples of both the standard report for clients and the format used with OSHA testing.

- Speech-Language Reports – gives examples of a full narrative report and a chart-style report. Each Clinical Educator may have certain requirements for a diagnostic report and will let the student clinician know which format to use.

- Intervention Plan – written at the beginning of the semester to describe the functional categories and outcomes, treatment methodology and rationale, treatment goals and criteria, initial status of the client, and the procedures for obtaining the goals. (An intervention plan format is given in this Appendix. However, each Clinical Educator may have certain requirements for an intervention plan and will let the student clinician know which format to use.)

- Progress/Summary report – completed at the end of the semester or when the client is discharged from treatment. This report may be completed on the same form as the intervention plan or using a separate report format. It describes a summary of the services received by the client and the progress made. It also suggests recommendations for future intervention or follow-up. (A progress report is included in Appendix A as a part of the intervention plan format is given in this Appendix. However, each Clinical Educator may have certain requirements for a progress/summary report and will let the student clinician know which format to use.)

- Lesson Plan – written for each treatment session. The lesson plan describes the objectives of each session, and the techniques to be used. Lesson plans are usually written using measurable clinical objectives. Each Clinical Educator may have certain requirements for lesson plans and will let the student clinician know which format to use.

- Progress Notes – written after each diagnostic or treatment session. The progress note identifies who was in the session, the objectives targeted, the data obtained, an analysis of the data, and future plans or recommendations. It is a legal document. Often progress notes are written in SOAP note format. Each Clinical Educator may have certain requirements for a progress note and will let the student clinician know which format to use.