**Patient’s Last Name** | **First Name** | **MI** | **HICN**
---|---|---|---

**Provider Name**  
LifeCare of Florida

<table>
<thead>
<tr>
<th><strong>Provider No</strong></th>
<th><strong>Onset Date</strong></th>
<th><strong>SOC Date</strong></th>
</tr>
</thead>
</table>

**Primary Diagnosis(es)** | **Treatment Diagnosis(es)**
---|---

### Clinical Interview

**Relevant Background Information**

The Interview was completed With:  
- [ ] Patient
- [ ] Spouse
- [ ] Caregiver
- [ ] Other: ___________________________

Patient Age: _____ Years  
Primary Language(s) Spoken:  
- [ ] English
- [ ] Other: _________________________

Mental Status:  
- [ ] Alert
- [ ] Responsive
- [ ] Cooperative
- [ ] Confused
- [ ] Lethargic
- [ ] Impulsive
- [ ] Uncooperative
- [ ] Combative
- [ ] Unresponsive

Vision Status:  
- [ ] Intact
- [ ] Visual Field Cut
- [ ] Diplopia
- [ ] Other: _______________________

Hearing Status:  
- [ ] Intact
- [ ] Hearing Loss: ____________________

Functional Impairments that Affect Communication or Feeding:  
- [ ] Tremors
- [ ] Neglect
- [ ] Hemiplegia/Hemiparesis
- [ ] Other: __________________________

Augmentative Communication Devices:  
- [ ] None or 
- [ ] Describe: ________________________

The patient resides in:  
- [ ] Home
- [ ] Apartment/Condo
- [ ] ILF
- [ ] ALF
- [ ] Other: __________________________

The patient lives:  
- [ ] Alone or with 
- [ ] Spouse
- [ ] Family
- [ ] 24 Hour Care Giver
- [ ] Other: __________________________

Family/Support System (Describe): ___________________________________________________________

---

**Reason for Referral/ Symptom Onset**

**Prior Level of Function** *(Describe Diet, Communication, Speech & Voice Function)*

**Current Level of Function** *(Summary from SLP Evaluation)*

**Identified Risks**

Patient is at risk for:  
- [ ] Swallow Safety
- [ ] Malnutrition
- [ ] Dehydration
- [ ] Aspiration Pneumonia
- [ ] LOS
- [ ] Mortality

Patient has safety risks due to speech/language impairment(s) cognitive impairments which would place patient at risk in the following situations:  
- [ ] Reacting to an emergency
- [ ] Recovering from a fall/calling for help
- [ ] Being home alone
- [ ] Managing Medication
- [ ] Travelling in community
- [ ] Other: __________________________

**Rehabilitation History**

- [ ] No prior therapy (PT, OT, SLP) appears to have been provided in the past 12 months or
- [ ] The patient has received ___ PT ___ OT ___ SLP in the last 12 months for the ___ current or a ____ previous condition  
  - [ ] Describe: ______________________________________________________
- [ ] The patient is not currently receiving home health services
Medical History/ Medications (Describe all relevant medical conditions and the date of onset. Include psychosocial diagnosis(es) if present)

Precautions/ Contraindications (For a specific activity and/or intensity of rehabilitation services)

Speech/ Language Plan of Treatment

Treatment Plan: SLP Therapy _____ days/wk x _____ weeks for a treatment duration of _____ hours per visit

Initial Certification Period: From:______________ - To: ________________

Rehabilitation Potential: □ Guarded □ Fair □ Good □ Excellent

Long Term Goals (Number Each Goal):

Skilled Intervention to Include:
☐ 92526 Treatment of Swallow Dysfunction and/or Oral Function for Feeding
☐ 92507 Treatment of Speech, Language, Voice, Communication or Auditory Processing Disorder
☐ Other: ________________________________

Additional Recommendations:
☐ OT Evaluation ☐ PT Evaluation ☐ Social Services
☐ Adaptive Equipment: ____________________________________________
☐ Medical Follow-Up For: _________________________________________
☐ Other: _______________________________________________________

Professionals Establishing This Plan of Treatment

Therapist’s Name & Credentials (Please Print) Therapist’s Signature Date

X _______________________________ ____________

As of the date of this evaluation, I certify the pertinent medical history and the need for skilled services that have been completed in consultation with the evaluating therapist under this plan.

Physician’s Name (Please Print) Physician’s Signature Date

X _______________________________ ____________
<table>
<thead>
<tr>
<th>Patient's Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>HICN</th>
</tr>
</thead>
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<tr>
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</table>

<table>
<thead>
<tr>
<th>Primary Diagnosis(es)</th>
<th>Treatment Diagnosis(es)</th>
</tr>
</thead>
</table>

### Cognitive - Communication Assessment

**Assessed By:** ☐ Clinical Evaluation ☐ Tests/ Sub-Tests Administered:

**Current Cognitive Status:** ☐ WFL or ☐ Impaired *(Check all Areas)*

- ☐ Level of Arousal
- ☐ Attention Span
- ☐ Sequencing
- ☐ Problem Solving
- ☐ Orientation
- ☐ Memory ○ ST ○ LT
- ☐ Categorization
- ☐ Learning
- ☐ Recognition
- ☐ Initiation/Termination of Task
- ☐ Concept Formation
- ☐ Generalization

**Pertinent Findings/ Clinical Impression:**

---

### Voice Assessment

**Assessed By:** ☐ Clinical Evaluation ☐ Tests/ Sub-Tests Administered:

**Vocal Quality:** ________________________________

**Vocal Intensity:** ________________________________

**Sustained Phonation:** ________________________________

**Pertinent Findings/ Clinical Impression:**

---

### Nutrition / Diet

**History of Aspiration Pneumonia?** ☐ No ☐ Yes: ________________

**Current Diet:** ☐ Regular ☐ Pureed ☐ Thickened Liquids ☐ Tube Feeding

**Recent Weight Loss?** ☐ No ☐ Yes _________ Lbs

**Diet/ Nutritional Concerns:** ☐ None or ☐ Describe Below:

---

### Dysphagia Evaluation

**Upper Extremity Function:**

- **Hand Dominance:** ☐ Right ☐ Left
- **Management of Utensils:** ☐ Independent ☐ Impaired: ________________________________
- **Hand to Mouth:** ☐ Independent ☐ Impaired: ________________________________
- **Other Functional Impairments that Affect Feeding:** ☐ None OR ☐ Tremors ☐ Neglect ☐ Hemiplegia/Hemiparesis ☐ Other: ________________________________

**Posture/ Positioning:**

- **Head Control:** ☐ Good ☐ Fair ☐ Poor ☐ Comments: ________________________________
- **Trunk Control:** ☐ Good ☐ Fair ☐ Poor ☐ Comments: ________________________________
- **Mobility:** ☐ Good ☐ Fair ☐ Poor ☐ Comments: ________________________________
## Oral/Peripheral Examination:

<table>
<thead>
<tr>
<th>Structure</th>
<th>Function (ROM/Strength)</th>
<th>Affects Speech?</th>
<th>Affects Feeding?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lips</td>
<td>□ WNL □ Impaired</td>
<td>□ WNL □ Impaired</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>Jaw</td>
<td>□ WNL □ Impaired</td>
<td>□ WNL □ Impaired</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>Teeth</td>
<td>□ WNL □ Impaired</td>
<td>□ WNL □ Impaired</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>Tongue</td>
<td>□ WNL □ Impaired</td>
<td>□ WNL □ Impaired</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>Palate</td>
<td>□ WNL □ Impaired</td>
<td>□ WNL □ Impaired</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>Facial Symmetry</td>
<td>□ WNL □ Impaired</td>
<td>□ WNL □ Impaired</td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

## Dysfunctional Factors:

- **Drooling**: □ Yes □ No
- **Anterior Bolus Loss**: □ Yes □ No
- **Coughing Before Swallow**: □ Yes □ No
- **Coughing During Swallow**: □ Yes □ No
- **Coughing After Swallow**: □ Yes □ No
- **Watery Eyes**: □ Yes □ No
- **Change/Wet Vocal Quality**: □ Yes □ No

## Spoken Language Comprehension

**Assessed By:** □ Clinical Evaluation □ Tests/Sub-Tests Administered:

<table>
<thead>
<tr>
<th>Task</th>
<th>Response</th>
<th>Cueing</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Point to Single Item</td>
<td>_______%</td>
<td>______</td>
<td></td>
</tr>
<tr>
<td>Answer Yes/No Questions</td>
<td>_______%</td>
<td>______</td>
<td></td>
</tr>
<tr>
<td>Follow Commands</td>
<td>_______%</td>
<td>______</td>
<td></td>
</tr>
<tr>
<td>Understand Conversation</td>
<td>_______%</td>
<td>______</td>
<td></td>
</tr>
</tbody>
</table>

## Spoken Language Expression

**Assessed By:** □ Clinical Evaluation □ Tests/Sub-Tests Administered:

<table>
<thead>
<tr>
<th>Task</th>
<th>Response</th>
<th>Cueing</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Repetition</td>
<td></td>
<td>______</td>
<td></td>
</tr>
<tr>
<td>Words</td>
<td>_______%</td>
<td>______</td>
<td></td>
</tr>
<tr>
<td>Phrases</td>
<td>_______%</td>
<td>______</td>
<td></td>
</tr>
<tr>
<td>Sentences</td>
<td>_______%</td>
<td>______</td>
<td></td>
</tr>
<tr>
<td>Automated Speech Tasks</td>
<td>_______%</td>
<td>______</td>
<td></td>
</tr>
<tr>
<td>Word Fluency</td>
<td>_______%</td>
<td>______</td>
<td></td>
</tr>
<tr>
<td>Word Production</td>
<td>_______%</td>
<td>______</td>
<td></td>
</tr>
<tr>
<td>Narrative</td>
<td>_______%</td>
<td>______</td>
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</tr>
</tbody>
</table>
### Reading Comprehension

**Assessed By:**  [ ] Clinical Evaluation  [ ] Tests/ Sub-Tests Administered:  

<table>
<thead>
<tr>
<th>Task</th>
<th>Response</th>
<th>Cueing</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simple Written Items</td>
<td>_____ % Accuracy</td>
<td>_____</td>
<td></td>
</tr>
<tr>
<td>Written Language</td>
<td>_____ % Accuracy</td>
<td>_____</td>
<td></td>
</tr>
<tr>
<td>Functional Reading</td>
<td>_____ % Accuracy</td>
<td>_____</td>
<td></td>
</tr>
</tbody>
</table>

### Writing

**Assessed By:**  [ ] Clinical Evaluation  [ ] Tests/ Sub-Tests Administered:  

<table>
<thead>
<tr>
<th>Task</th>
<th>Response</th>
<th>Cueing</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copying</td>
<td>_____ % Accuracy</td>
<td>_____</td>
<td></td>
</tr>
<tr>
<td>Functional Writing</td>
<td>_____ % Accuracy</td>
<td>_____</td>
<td></td>
</tr>
<tr>
<td>Written Discourse</td>
<td>_____ % Accuracy</td>
<td>_____</td>
<td></td>
</tr>
</tbody>
</table>

### Additional Pertinent Findings

### Diagnostic Impression
The patient was seen today for an initial therapy evaluation. The Plan of Treatment was developed and skilled therapy will be initiated consistent with the plan of care.

Time Spent for Care: Time In: _________________ AM/PM  Time Out: _________________ AM/PM

Patient Certification:
I certify that I was seen by the therapist below and agree that the time spent for my care is correct. I understand and agree to the goals and plan of care developed. I certify that I am not receiving home health services at this time.

Patient/Authorized Representative (Please Print)  
Patient/Authorized Signature  
X______________________________

Provider:  
Therapist’s Name & Credentials (Please Print)  
Therapist’s Signature  
X______________________________