Clinical Information Summary Sheet

There are six available versions of the Clinical Information Summary Sheets. There are three versions available for Physical and Occupational therapy; one is for reporting findings related to an **Orthopedic** condition, one is for **Neurologic** conditions, and one is for **Pediatric** cases. For pediatric patients presenting with an orthopedic condition, please use the CISS Orthopedic form. Athletic trainers will also use the **Orthopedic** form when treating and reporting on sports-related injury or condition. There are three versions for Speech Therapy clinical findings and include one for **Speech/Language/Cognitive** disorders, one for **Dysphagia**, and one for **Continuing Care** of ST services. The purpose of the Clinical Information Summary Sheet is to document the pertinent clinical findings that contribute to the formulation of the member's diagnosis and treatment plan. It is the standard tool you may use to communicate with the Peer Clinical Quality Evaluators (CQE) when submitting treatment/services for verification of Medical Necessity. This tool is a summary, does not constitute a complete or adequate record, and should not be used as your primary history and evaluation form.

The Clinical Information Summary Sheet may be used for:

1. Documenting findings from an initial evaluation, re-evaluations and/or assessments
2. Documenting a patient's clinical findings if they suffer a new injury/condition
3. Documenting a patient's clinical findings if continuing care is necessary or the Member is not progressing as expected

The following are general guidelines for completing the Clinical Information Summary Sheet.

Section I: Historical Information

In this section list each Chief Complaint, the date each complaint began (or if the date is unknown use a descriptor such as "gradual", "insidious", or "unknown"), the cause / mechanism of injury (how each complaint began), and the Stage and Nature of the condition.

Section II: Clinical Information

This section allows you to report what you found in your evaluation, reevaluation or assessment. The findings will vary depending on the treating practitioner's specialty and the condition the therapy is treating. PTs and OTs should choose the appropriate form as described above based on the patient diagnosis and age. SLPs should use either the **Speech/Language/Cognitive** or **Dysphagia Summary Sheets** for Evaluations and Re-evaluations or speech/language/cognitive or swallowing disorders. The Speech **Continuing Care Summary Sheet** is used for submission of updated findings for conditions that need continuing care. Athletic trainers will use the **Orthopedic** form when treating and reporting on a sports-related injury or condition. Forms are available for practitioners to submit objective findings or any pertinent clinical information to support interventions/care needed. Examples of clinical findings may include but not limited to: 1) any range-of-motion findings as degrees or percent (%) limited, 2) comment on any pain or other pertinent findings associated with the motion in the "Comments" section, 3) any pertinent orthopedic, neurologic, pediatric, speech, language or swallowing findings, 4) clinical assessment or updated goals. Be sure to be specific regarding the finding. For example, do not merely state a test was positive. A finding reported as "positive" is not meaningful without a description of the side on which the finding was noted and the location and character of the symptom produced.

Section III: Outcome Assessments

In this section, list an appropriate type of outcome assessment tool for the patient's condition. If this is your initial assessment, list the score obtained. If this is ongoing care, please provide both the initial score and the current score. We have specifically listed the most commonly used tools. List any other tools by name and score in the "Other" section.

Additional Comments

Please do not hesitate to provide any additional information you feel is important for us to know regarding the patient's condition that will aid us in making a medical necessity determination.

Clinical Information Summary Sheet

☐ **PT** ☐ **OT** ☐ **AT** - New or Continuing Care for **ORTHOPEDIC** conditions

Practitioner______________________________ Patient____________________________

I. Date of Onset/Exacerbation__________ Initial Start care (mm/dd/yyyy) for this condition__________

Chief Complaint(s)____________________________ ____________________________

Cause of Current Episode: ☐ Traumatic ☐ Repetitive ☐ Unknown

☐ Post-Surgical (date/type)____________________________

Stage of Condition ☐ Acute ☐ Sub-acute ☐ Chronic

Nature of Condition ☐ Initial Occurrence ☐ Exacerbation ☐ Recurrent / Chronic

II. Vital Signs Height________ Weight________ Blood Pressure____________________

Area/Joint Movement	Active ROM R/L(Degrees)	Passive ROM R/L (Degrees)	Strength R/L (0-5)	Mobility (0-6, 3=NL)	End Feel	Pain (Level/Location)
	/	/	/			
	/	/	/			
	/	/	/			
	/	/	/			
	/	/	/			

Pertinent Evaluation Findings (Please include location and intensity of findings and note any significant progress)____________________________

Pt's Goals, Functional Limitations & Planned Interventions____________________________

Medical /Social Hx &/or Co-Morbidities (that may affect recovery)____________________________

III. OUTCOME ASSESSMENTS (List both Initial / Current date(s) and score(s) as applicable)

Initial	List Date Obtained (mm/dd/yyyy)	Current	Initial	List Date Obtained (mm/dd/yyyy)	Current
	ROLAND-MORRIS			NECK INDEX (NDI)	
	OSWESTRY			OPTIMAL SCORE	
	FOTO			LEFS (LE) score	
	Other (name and score):			DASH (UE) score	

ADD'L. COMMENTS____________________________

Signature of treating practitioner (Required)____________________________ **Date**______________

Practitioners are encouraged to submit additional information as necessary to support the interventions / care submitted

Clinical Information Summary Sheet

☐ **PT** ☐ **OT** - New or Continuing Care for **NEURO** conditions

Practitioner____ Patient________________________________

I. Date of Onset/Exacerbation___________________________________ Initial Start of care(mm/dd/yyyy) for this condition_______________________________________

Chief Complaint(s)________________________________ ____________________________________

Cause: ☐ Traumatic ☐ Repetitive ☐ Unknown ☐ Post-Surgical (date/type)____________

Stage of Condition ☐ Acute ☐ Sub-acute ☐ Chronic

Nature of Condition ☐ Initial Occurrence ☐ Exacerbation ☐ Recurrent / Chronic

II. Vital Signs Height______ Weight_________ Blood Pressure______________________________

Cognitive / Perceptual ☐ Intact **Impairment:** ☐ Minimal ☐ Moderate ☐ Maximum

Communication ☐ Verbal ☐ Non-Verbal ☐ Unable to Communicate
☐ Relies on primary care giver for communication needs

Mobility: Ambulation / Gait Pattern__________________________
Wheelchair / Assistive devices__________________________
Transfers____
Bed____

Muscle Tone:

Location	Flaccid	Hypotonic	Ataxic	Athetoid	Normal	Spastic	Rigid
Head							
Trunk							
U. E.							
L. E.							

Balance/Coordination: ☐ Normal ☐ Deficits in the following:
Static Position________________ ☐ Good ☐ Fair ☐ Poor ☐ Zero
Dynamic Position______________ ☐ Good ☐ Fair ☐ Poor ☐ Zero

Activities of Daily Living ☐ Independent ☐ Deficits in the following:
Task__________________ ☐ CG/CS ☐ Min assist ☐ Mod assist ☐ Max assist
☐ Device ____
Task__________________ ☐ CG/CS ☐ Min assist ☐ Mod assist ☐ Max assist
☐ Device ____

Sensation: ☐ Intact ☐ Impaired ☐ Absent ☐ Location______________________________

Edema ☐ None ☐ Edema in the following location______________________________
☐ +1 minimal (<.5cm) ☐ 2+ mild (.5cm) ☐ 3+ moderate (.5-1.5cm) ☐ +4 severe (>1.5cm)

III. OUTCOME ASSESSMENTS (List both Initial / Current date(s) and score(s) as applicable)

Initial	List Date Obtained	Current	Initial	List Date Obtained	Current
______	(mm/dd/yyyy)	______	______	(mm/dd/yyyy)	______
______	TUG score	______	______	Peabody score	______
______	Berg Balance score	______	______	DASH score	______
______	Other (name/score)	______	______	LEFS (LE) score	______

ADD'L. COMMENTS____
____
____

If you are treating this member for an Autism Spectrum Disorder (ASD), please attest to the following by checking the box below:

☐ I am following state-specific rules and regulations of the state mandate for Autism Spectrum Disorder (ASD).

Signature of treating practitioner (Required)_________________________________ **Date**____________________

Practitioners are encouraged to submit additional information as necessary to support the interventions / care submitted

Clinical Information Summary Sheet

PT-OT - New or Continuing Care for **PEDIATRIC** conditions

Practitioner_______________________________ Patient_______________________

Date of Onset / Medical Diagnosis_____________________ **Chief Complaint(s**) _________________________

____

Cause of Current Episode ☐ Traumatic ☐ Congenital ☐ Unknown ☐ Post-Surgical (Date/Type)____________

Estimated frequency of treatment (per week/month)________________Estimated duration____________________

Pregnancy & Birth History: Complications during pregnancy ☐ Complications during delivery ☐

Weeks of gestation at birth;____

Behavior/Cognitive Status ☐ Alert ☐ Cooperative ☐ Responsive☐ Confused ☐ Uncooperative ☐ Impulsive ☐ Combative ☐ Unresponsive

Communication ☐ Verbal ☐ Non-Verbal ☐ Unable to Communicate ☐ Relies on primary care giver for communication needs____

Educational Level;________ Currently attending school? ☐Yes ☐No If yes, name of school:____________________

Developmental Milestones:____

____

Balance ☐ Normal ☐ Deficits in the following: **Mobility** Ambulation/Gait Pattern______________________

Static Position______________ ☐ Good ☐ Fair ☐ Poor ☐ Zero Wheelchair/Assistive device:_________________

Dynamic Position____________ ☐ Good ☐ Fair ☐ Poor ☐ Zero Transfers:______________________________

Muscle Tone:_________________ **Location:**__________

Gross Motor Development ☐ Independent/Age appropriate ☐ Deficits in the following:____________________

Activity____________________ ☐ CG/CS☐ Min assist ☐ Mod assist ☐ Max assist **Goal**:______________

Activity____________________ ☐ CG/CS☐ Min assist ☐ Mod assist ☐ Max assist **Goal**:______________

Fine Motor Development ☐ Independent/Age appropriate ☐ Deficits in the following:____________________

Activity____________________ ☐ CG/CS ☐ Min assist ☐ Mod assist ☐ Max assist **Goal**:____________

Activity____________________ ☐ CG/CS ☐ Min assist ☐ Mod assist ☐ Max assist **Goal**:____________

Self Care Activities: ☐ Normal/Age appropriate ☐ Deficits in the following:______________________

Activity:__________________☐ Good ☐ Fair ☐ Poor ☐ Zero **Goal**:_________________________

Activity:__________________☐ Good ☐ Fair ☐ Poor ☐ Zero **Goal**:_________________________

Summary of Clinical Findings/Functional Progress____

____

____

Med/Soc Hx / Co-Morbidities (that may affect recovery)____

Functional Limitations & Planned Interventions, including Goals__________________________________

____

____

____

OUTCOME ASSESSMENTS (List both Initial / Current date(s) and score(s) as applicable)

Initial		**Current**	**Initial**		**Current**
____________	**List Date Obtained** (mm/dd/yyyy)	____________	____________	**List Date Obtained** (mm/dd/yyyy)	____________
____________	BSID III	____________	____________	Peabody score GMQ/FMQ	____________
____________	Other (name and score)	____________	____________	BOT	____________

ADD'L. COMMENTS____

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____

If you are treating this member for an Autism Spectrum Disorder (ASD), please attest to the following by checking the box below.

☐ I am following state-specific rules and regulations of the state mandate for Autism Spectrum Disorder (ASD).

Signature of treating practitioner (Required)______________________________ **Date**____________________

Practitioners are encouraged to submit additional information as necessary to support the interventions / care submitted

Clinical Information Summary Sheet

ST – Evaluation or Re-evaluation for **SPEECH/LANGUAGE/COGNITIVE** conditions

Patient Name:___________________________ **Diagnosis:**__________ **Practitioner Name:**_________________________________

Date of Onset______________________________ **Chief Complaint(s)/Concern(s)**____

Cause of Condition: ☐ Traumatic ☐Congenital ☐ Unknown **Stage of Condition:** ☐Mild ☐Moderate (Mod) ☐Severe

Concurrent Conditions: ________________________________**Prior speech/language treatment**:_____________________________

Estimated frequency of treatment (per week/month)____________________**Estimated duration**______________________________

Cognitive Status: ☐Alert ☐Cooperative ☐Responsive ☐Confused ☐Follows commands ☐Impulsive ☐Capable of learning ☐Capable of retaining new information ☐Combative ☐Unresponsive. Does patient speak English? ☐Yes ☐No If no, what is primary language?________________________

Hearing Status: ☐WNL ☐Impaired. Hearing aids worn ☐Yes ☐No Cochlear implant ☐Yes ☐No Type of impairment____________________

Visual Status: ☐Normal ☐ Impaired: ☐Min ☐Mod ☐Severe Type of impairment____

Oral Motor Evaluation:

LIPS: ☐WNL ☐WFL ☐Impaired ☐Mild ☐Mod ☐Severe ☐rounds lips ☐retracts ☐can purse ☐retract with teeth closed ☐other__________

Observation: Symmetry, range, speed, tone:__________________ Can patient maintain labial seal at rest? ☐Yes ☐No Drooling? ☐Yes ☐No Can do strong lip "smacks" ☐Yes ☐No Add'l Comments:____

TONGUE: ☐WNL ☐WFL ☐ Impaired ☐Mild ☐Mod ☐Severe ☐can elevate to alveolar ridge ☐elevate outside of mouth ☐circle tongue around lips ☐lateralize to corners of mouth ☐without sliding along lips ☐using additional jaw movement ☐other________________

☐ tongue pops ☐ lateral pushes against tongue depressor **Observation:** Symmetry, range, speed, tone______________ Dyskinesia present? ☐Yes ☐No If yes, specify degree____________________

JAW: ☐WNL ☐WFL ☐ Impaired ☐Mild ☐Mod ☐Severe

Observation: Symmetry, range, speed, tone:__________________________ Involuntary movement_______________________________

SOFT PALATE: ☐WNL ☐WFL ☐ Mild ☐Mod ☐ Severe **Observation:**____

Symmetry, range, speed, tone:______________________________Involuntary movement____

Add'l Comments/Assessment____

____

☐**APRAXIA** Area affected: ☐lips ☐tongue ☐jaw ☐soft palate Severity: ☐Mild ☐Mod ☐Severe______________________________

☐**DYSARTHIA** Area affected: ☐lips ☐tongue Severity: ☐Mild ☐Mod ☐Severe____

Voice: ☐WFL ☐Dysphonia ☐Aphonia Severity: ☐Mild ☐Mod ☐Severe ENT Eval: ☐Yes ☐No

(Date/Results)____

Quality: ☐WFL ☐Impaired ☐breathy ☐hoarse ☐harsh ☐hypernasal ☐hyponasal ☐strained-strangled

Add'l Comments/Assessment ____

Max Duration of "ah" _____seconds Impaired: ☐Mild ☐Mod ☐Severe Consistent volume? ☐Yes ☐No

Volume: ☐WNL ☐WFL ☐Impaired Type/Deg of Impairment with: ☐single words______% ☐phrases______% ☐sentences_____%

Add'l Comments/Assessment____

☐**DIADOCHOKINETICS:** ☐WNL ☐Labored ☐Other__________ ☐pa ☐ta ☐ka ☐pataka ☐a oo ee ☐mommy baby daddy

SPEECH: ☐WNL ☐ Impaired. If Impaired, % of Intelligibility: Syllable_____% Word______% Phrase____% Conversation_________%

Add'l Comments/Assessment____

Fluency: ☐Yes ☐No Type/Degree of Dysfluency: ☐Min ☐Mod ☐Severe ______% of blocks ________% of prolongations

______% phrase repetitions _____% whole word repetitions _______% syllable repetitions _______% of sound repetitions

Add'l symptoms/findings (ie. facial/body movements)____

LANGUAGE(Spoken):

Comprehension: ☐WFL ☐Impaired ☐Mild ☐Mod ☐Severe Pointing to objects ☐Yes ☐No 1-step command ☐Yes ☐No Multi-step command ☐Yes ☐No Understanding conversation ☐Yes ☐No Can pt take turns in conversation independently? ☐Yes ☐No

Add'l Comments/Assessment____

____

Expression: ☐WNL ☐Impaired, Severity: ☐Min ☐Mod ☐Severe ☐ repetition ☐ automatic speech ☐ confrontation naming

☐Production (words, phrases, sentences) ☐Narrative (storytelling, picture description) Describe any impaired findings_______________________

Patient Name:______________________________ **Diagnosis:**__________ **Practitioner Name:**____________________________

LANGUAGE (Written): ☐ WNL ☐WFL ☐Impaired. If impaired, degree of impairment____

Use of keyboard? ☐Yes ☐No AAC device used? ☐Yes ☐No If yes, list which one____

Reading: ☐WNL ☐Impaired Describe impairments/findings____

Understands simple written items ☐WNL ☐Impaired Describe impairments/findings____

Understands written language ☐WNL ☐Impaired Describe impairments/findings____

Functional Reading ☐WNL ☐Impaired Describe impairments/findings____

COGNITIVE-COMMUNICATION: Attention ☐WNL ☐Impaired **Memory** ☐WNL ☐Impaired. If impaired, list areas of improvement needed______

Executive function ☐WNL ☐Impaired If impaired, list areas of improvement needed____

Can pt manage his/her own household chores? ☐Yes ☐No ☐N/A Add'l symptoms/findings____

Pragmatics ☐WNL ☐Impaired Describe any impaired findings____

Self-awareness ☐WNL ☐Impaired Describe any impaired findings____

Summary of Clinical Findings____

____

____

____

Functional Limitations & Planned Interventions, including Goals____

____

Med/Soc Hx /Co-Morbidities (that may affect recovery)____

OUTCOME ASSESSMENTS (List both Initial / Current date(s) and score(s) as applicable and date obtained)

Assessment	Initial Score and Date	Current Score and Date		Assessment	Initial Score and Date	Current Score and Date
Fluency Severity Scale				REEL		
PICA				SPELT		
CELF				BDAE		
CASL				PPVT		
PLS				TOLD		
NOMS Scores: Motor Pragmatics Spoken Language Written Language Problem Solving				Other (name and score) ________________		

ADD'L. COMMENTS____

____

If you are treating this member for an Autism Spectrum Disorder (ASD), please attest to the following by checking the box below.

☐ I am following state-specific rules and regulations of the state mandate for Autism Spectrum Disorder (ASD).

Signature of treating practitioner (Required)____ **Date**______________________________

Practitioners are encouraged to submit additional information as necessary to support the interventions / care submitted

Clinical Information Summary Sheet

ST – Evaluation or Re-evaluation for **DYSPHAGIA** conditions

Patient Name:_________________________ **Diagnosis:**_________ **Practitioner Name:**______________________________

Date of Onset/Exacerbation_____________________ **Chief Complaint(s)**___________________________ _____________

Cause of Current Condition: ☐Traumatic ☐Congenital ☐Unknown **Stage of Condition:** ☐Mild ☐Moderate (Mod) ☐Severe

Nature of Condition: ☐Initial Occurrence ☐Exacerbation ☐Recurrent / Chronic

Mental Status: ☐Alert ☐Cooperative ☐Responsive ☐Confused ☐Uncooperative ☐Impulsive ☐Lethargic ☐Combative ☐Unresponsive

Capable of learning and/or retaining new information ☐Yes ☐No if no, please explain____

Hearing Status: ☐WNL ☐Impaired Hearing aids worn ☐Yes ☐No Cochlear implant ☐Yes ☐No Type of impairment______________________

Visual Status: ☐Normal ☐Impaired ☐Min ☐Mod ☐Severe Type of impairment____

Voice: ☐WFL ☐Dysphonia ☐Aphonia Severity: ☐Mild ☐Mod ☐Severe ENT Eval: ☐Yes ☐No

(Date/Results)____

Quality: ☐WFL ☐Impaired ☐Breathy ☐Hoarse ☐Harsh ☐Hypernasal ☐Hyponasal ☐Strained-strangled

Add'l Comments/Assessment ____

Speech: ☐WNL ☐Impaired. If Impaired, % of Intelligibility: Syllable_____% Word______% Phrase______% Conversation_______%

Add'l Comments/Assessment____

ORAL PHASE FUNCTION: ☐WNL ☐WFL ☐Impaired Severity: ☐Mild ☐Mod ☐Severe Dentition: ☐WNL ☐WFL ☐Teeth missing, % teeth missing:______ **Dentures present:** ☐Yes ☐ No Indicate what is present ☐Uppers ☐Lower ☐Partials

Oral Motor, Respiration and Phonation:

LIPS: ☐WNL ☐WFL ☐ Impaired ☐Mild ☐Mod ☐Severe **Observation**: Symmetry, range, speed, tone:______________________________

TONGUE: ☐WNL ☐WFL ☐Impaired ☐Mild ☐Mod ☐Severe **Observation:** Symmetry, range, speed, tone:_____________________________

Dyskinesia present? ☐Yes ☐No If yes, specify degree____________

JAW: ☐WNL ☐WFL ☐Impaired ☐Mild ☐Mod ☐Severe **Observation:** Symmetry, range, speed, tone:_______________________________

SOFT PALATE:☐WNL ☐WFL ☐ Mild ☐Mod ☐ Severe **Observation:**____

Symmetry, range, speed, tone:_____________________________ Involuntary movement____

Add'l Comments/Assessment____

Respiratory Sufficiency and Coordination ☐WNL ☐Impaired, degree of impairment____

Check off and give date if applies: ☐Tracheostomy________________ ☐Mech. Ventilation __________________ ☐Recent intubation______________

Diet texture prior to onset: Food_______________________ Liquid_______________________________ Other:_____________________________

Facial/Oral Motor asymmetry ☐Yes ☐No If yes, etiology:____

Add'l Comments/Assessment____

Feeding Method: ☐Independent ☐Needs assistance, level of assistance______________ ☐Dependent Endurance during feeding: ☐ WNL ☐ WFL ☐Impaired Degree of impairment____

Management of oral secretions: ☐ WNL ☐ WFL ☐Impaired, Degree/Comments____

Drooling? ☐Yes ☐No Ifyes, degree __________________ Left, Right or Bilateral

Pocketing? ☐Yes ☐No If yes, degree ________________ Left, Right or Bilateral

PHARYNGEAL PHASE FUNCTION: Aspiration (signs/symptoms present) ☐Yes ☐No If yes, describe diet and/or liquid consistencies it occurred with____ Severity: ☐Mild ☐Mod ☐Severe

Volitional throat clear ☐Yes ☐No Volitional cough ☐Yes ☐No Spontaneous throat clear ☐Yes ☐No Spontaneous cough ☐Yes ☐No

Testing: FEES/Videoswallow Study (MBSS) ☐No ☐Yes, date______________ if yes Diet Recommendations from FEES/MBSS ___________________

Current Diet: ☐Solid Textures ☐Regular ☐Mechanical Soft ☐Puree ☐Liquids ☐Thin ☐Nectar ☐Honey ☐NPO ☐Other___________________

Add'l Comments/Assessment:____

Recommendation: Diet_________________ Liquid_____________ ☐NPO f/u MBSS indicated ☐Yes ☐No if yes date____________________________

☐NPO If NPO, alternative nutrition method: ☐NG tube ☐Gastrostomy ☐Jejunostomy ☐Total parenteral nutrition

Add'l Comments/Assessment;____

Patient Name______________________________ **Diagnosis**____________ **Treating Practitioner**__________________________

ESOPHAGEAL PHASE FUNCTION: ☐WNL ☐WFL ☐Impaired Severity: ☐Mild ☐Mod ☐Severe ☐Unknown

Swallow Precautions:____ Prognosis: ☐Good ☐Fair ☐Poor

Summary of Clinical Findings____

Pt's Functional Limitations & Planned Interventions, including Goals ____

Med/Soc Hx / Co-Morbidities (that may affect recovery)____

OUTCOME ASSESSMENTS (List both Initial / Current date(s) and score(s) as applicable and date obtained)

Assessment	Initial Score and Date	Current Score and Date		Assessment	Initial Score and Date	Current Score and Date
Alaryngeal Communication FCM				MASA		
D-COME-T				PAIS		
Oral Motor/Feeding Rating				SAFE		
OSMSE-3				TOSF		
NOMS Score: Swallowing				Other (list name and score) _____________		

ADD'L. COMMENTS____

Signature of treating practitioner (Required)____ **Date**_________________________

Practitioners are encouraged to submit additional information as necessary to support the interventions / care submitted

Clinical Information Summary Sheet

ST – CONTINUING CARE for **SPEECH** conditions

(Check one) ☐ Dysphagia ☐ Speech/Language/Cognitive

Patient Name__________________________ **Diagnosis**__________ **Practitioner Name**_______________________________

Date of Onset/Exacerbation___________ **Chief Complaint(s)**____

Initial Start of care (mm/dd/yyyy) for this condition: ____

Cause of Current Condition: ☐Traumatic ☐Congenital ☐Unknown

Stage of Condition: ☐ Mild ☐ Moderate ☐ Severe

DATE OF MOST RECENT VISIT (mm/dd/yyyy)_________________Response to care:_____________________

ASSESSMENT:

Chief Complaints____

Current Findings____

____

____

____

HAS THERE BEEN PROGESS OR IMPROVEMENT NOTED TOWARDS INITIAL GOALS?

☐ Yes ☐No, Explain____

____

FUNCTIONAL OUTCOME MEASURE (include name and score - initial and current)____________________

____

HAVE THERE BEEN ATTEMPTS TO WITHDRAW OR DECREASE FREQUENCY OF CARE? ☐ No ☐ Yes, Explain____

____

HAS A HOME EXERCISE PROGRAM AND/OR DIET RECCOMENDATIONS BEEN PROVIDED? ☐ No ☐ Yes, Explain____

____

OBJECTIVES FOR CONTINUED CARE AND CURRENT GOALS______________________________________

____

____

PATIENT/CAREGIVER EDUCATION OR TRAININNG? ☐ Initiated ☐ Completed ☐ Other Explain________

____

ESTIMATED DATE OF DISCHARGE (mm/dd/yyyy)____

Signature of treating SLP (Required)___________________________________ **Date**______________________

Practitioners are encouraged to submit additional information as necessary to support the interventions / care submitted