**MEDICARE SPEECH THERAPY EVALUATION**

**Name of Patient:**   **DOB:**­­­  **Visit Date:**

**Therapist:**

**Diagnoses:**

**Prior Level of function:**

**Current Functional Status:**

Mobility:

ADLs:

Cognition:

Sensory /pain:

Mental health:

Socialization:

Financial:

**Assessment**:

**Problem List**:

**Recommendations:**

**Plan: Frequency, Duration:**

**LONG TERM GOAL:**

**Short Term Goals:**

**PATIENT SPECIFIC FUNCTIONAL SCALE (Add G-CODE area from** Mobility, Position, Handling, Self-Care, Other, Swallow, Attention, Memory, Motor Speech, Spoken Language Comp, Spoken Language Expr, Voice)

|  |  |  |  |
| --- | --- | --- | --- |
| I’m going to ask you to identify up to **three important activities and areas of participation** that you are unable to do or are having difficulty with because of the problems you described.  10 = unable 0 = fully able  (This is not a problem list, these are areas of engagement, what the client DOES that is not up to par.) Convert the 0-10 scale to %: i.e. 3 = 30% | **We may want to compare how you’re doing after therapy, so on a scale of**  **0 to 10, (10 = unable to do activity), HOW MUCH does this problem interfere with the activities or participation?** | **What is the GOAL for each area on a scale of 0 – 10**  **0 = fully able** | **10th Visit or D/C How do you rank the original activities today:**  **0 to 10**  **(0 = fully able)** |
| 1.  2.  3. | 1.  2.  3. | 1.  2.  3. | 1.  2.  3. |
| **Totals:  add scores and divide by # activities:  i.e. If scores were 2 + 4 + 1 = 7, (or 20 + 40 + 10 = 70) divide by 3 activities, would be: 70/3 = 23%** | **Total:**  **This % goes in box A on grid** | **Total:**  **This % goes in box B and C on grid** | **Total:**  **This % goes in box D on grid** |
| EVAL QUESTION: **How will you know if your therapy with us is making a difference?** | | | |
| PERIODIC QUESTION: **How is your therapy with us is making a difference?** Document this in progress notes | | | |

Therapist Signature: Date:

**CERIFICATION OF PLAN OF CARE:**

**\_\_\_\_** I agree with this plan and the medical information is complete.

\_\_\_\_ Other medical issues \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ I disagree with this plan because\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* **Physician’s Name Date Signature**

**\*\*Please fax this information to confidential fax: 877-334-0714**