**Visit Length:**

**Evaluation Referred by:**   **To assess**: Medical and treatment diagnosis:

Other factors impacting function include:

Prior level of function and education and social skills:

Current level of function:

Currently living in with

**CURRENT FUNCTIONAL STATUS – assessment and observation:**

Articulation and phonology

Language

Auditory comprehension

Expressive skills

Voice

Fluency

Pragmatics

Visual skills

Cognition

Swallow

Mobility ADLS, Pain,

Financial

Social support

**ASSESSMENT**:

**Treatment provided today:**

**Recommendations:**

**FREQUENCY**: \_\_\_\_ x’s per week or month **DURATION**: \_\_\_\_ # of months

**Long Term Goal**:

**Short Term Goal:** What performance will change; measured how, with how much help, under what conditions, for how long (Pick two or three goals)

**Therapist Signature: Date:**

**CERTIFICATION 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** 3-27-19