# Speech Therapy Treatment Plan

**Landmark Healthcare, Inc.**
**FAX (888) 565-4225**

**Date of this Request___/___/___**
**Please check type of care:**
☐Initial care ☐Continuing care

**INSURED**

| Patient Last Name | Patient First Name | M.I. | Gender ☐ M ☐ F | Age | Date of Birth (MM/DD/YYYY) _____/_____/_____ |
|---|---|---|---|---|---|
| Insured I.D. or SSN | Insured Last Name | M.I. | First Name | | Patient Phone (area code first) |
| Patient Address | City | | | State | Zip Code |

**PAYOR**

| Employer Name | Insurance Company | Group Plan # or Union Local (Submit Copy of Patient's Insurance I.D. Card) | |
|---|---|---|---|
| Injury or illness is related to: ☐ Work ☐ Auto ☐ Other | Referring Physician/Practitioner | Doctor License # | Date of Referral _____/_____/_____ |

**ST**

| Therapist Last Name | Therapist First Name | M.I. | Group Name | Provider/Group ID# |
|---|---|---|---|---|

| Provider/Group Address | City | State | Zip Code | Phone # ( ) Fax # ( ) |
|---|---|---|---|---|

**Previous Speech Therapy History**
1st Visit ___/___/_____ Discharge Date___/___/_____ # of Visits _____

**Subjective Complaints:**

**(Circle one)** Immediate pt. safety issue *or* Functional decline/improvement in ADLs

**Mechanism of Onset for Primary Diagnosis**
*Date of Onset* ___/___/_____ *Date of Initial Evaluation* ___/___/_____
☐ Acute Onset ☐ Developmental
☐ Congenital ☐ Neuro/CV/Cerebral Event
☐ Chronic ☐ Other
*Description:*

**PATIENT'S CURRENT MEDICAL HISTORY**

| Objective Findings *(note any deficits)* | Date obtained ___/___/_____ | Mild | Moderate | Severe |
|---|---|---|---|---|
| Attention/orientation | | | | |
| Initiation/follow-through | | | | |
| Problem solving/judgment | | | | |
| Sequencing/organization | | | | |
| Following directions | 1-step | | | |
| | 2-step | | | |
| | multi-step | | | |
| Verbal expression | word level | | | |
| | sentence level | | | |
| | Conversational | | | |
| | basic needs | | | |
| Motor speech | | | | |
| Voice | | | | |
| Fluency/prosody | | | | |
| Pragmatics | | | | |
| Swallow dysfunction | Preparatory | | | |
| | Oral | | | |
| | Pharyngeal (suspected) | | | |
| | Esophageal (suspected) | | | |
| Other | | | | |

**Current condition**
Date of onset __/__/____ Date of initial evaluation __/__/____
New condition ☐
Gradual onset ☐
Behavioral change ☐
Worsening of prior illness/trauma ☐
Trauma ☐
Pt/family request ☐
Other ☐

**Summary of Clinical Findings**

Date of first tx at this office for this condition _____/_____/_____
Anticipated Release Date _____/_____/_____

**DIAGNOSES**

**ICD-9 Code:**
1. Primary _____
2. Secondary _____
3. Additional _____
4. Additional _____

**Description:**
_____
_____
_____
_____

**Additional Diagnostic Info**
Videofluroscopy ☐
Endoscopy ☐
CXR results ☐
Other (describe) ☐
**Summary**:

**Prognostic Indicators**
Motivation ☐
Cueing Responsiveness ☐
Active Caregiver Participation ☐
Safety Awareness ☐

**TREATMENT PLAN**

**Treatment Plan** (MM/DD/YYYY)
From _____/_____/_____
To _____/_____/_____
**No. of Visits Requested** _____

**Treatment Goals** (Functional Improvement and Outcomes Expected)

**Special Considerations:**
Alternate nutritional delivery
Augmentive devices
Tracheostomy/Ventilator
Other:

I declare that the above information is true and correct to the best of my knowledge. Further, it is my professional judgment that speech therapy is not contraindicated for this patient. If I am required under state law to obtain a prescription prior to rendering this treatment, I have obtained such a prescription in compliance with state law.

Signature_____Date_____

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