

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 <input type="checkbox"/> M <input type="checkbox"/> 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: <input type="checkbox"/> Work <input type="checkbox"/> Auto <input type="checkbox"/> 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:

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

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

PATIENT'S CURRENT MEDICAL HISTORY

Objective Findings (note any deficits)	Date obtained ___/___/___	Mild	Moderate	Severe	Current condition
Attention/orientation					Date of onset ___/___/___ Date of initial evaluation ___/___/___
Initiation/follow-through					New condition <input type="checkbox"/>
Problem solving/judgment					Gradual onset <input type="checkbox"/>
Sequencing/organization					Behavioral change <input type="checkbox"/>
Following directions	1-step				Worsening of prior illness/trauma <input type="checkbox"/>
	2-step				Trauma <input type="checkbox"/>
	multi-step				Pt/family request <input type="checkbox"/>
Verbal expression	word level				Other <input type="checkbox"/>
	sentence level				
	Conversational				
	basic needs				
Motor speech					Summary of Clinical Findings Date of first tx at this office for this condition ___/___/___ Anticipated Release Date ___/___/___
Voice					
Fluency/prosody					
Pragmatics					
Swallow dysfunction	Preparatory				
	Oral				
	Pharyngeal (suspected)				
	Esophageal (suspected)				
Other					

DIAGNOSES

ICD-9 Code:	Description:	Additional Diagnostic Info	Prognostic Indicators
1. Primary _____	_____	Videofluoroscopy <input type="checkbox"/>	Motivation <input type="checkbox"/>
2. Secondary _____	_____	Endoscopy <input type="checkbox"/>	Cueing Responsiveness <input type="checkbox"/>
3. Additional _____	_____	CXR results <input type="checkbox"/>	Active Caregiver Participation <input type="checkbox"/>
4. Additional _____	_____	Other (describe) <input type="checkbox"/>	Safety Awareness <input type="checkbox"/>
		Summary:	

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:
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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 _____