

MEMBER INFORMATION

- Member Name: _____
- Member Card #: _____
- Policy: _____
- Date: / / 202__
- Age: _____
- Gender: Female Male

PROVIDER INFORMATION

- Ordering Provider Name: _____
- Ordering Clinician (ID # & Name): _____
- Performing Provider Name: _____
- Performing Clinician Speciality (ID # & Name): _____

EVALUATION

Principal/ Primary Diagnosis: _____ ICD-10: _____

Has a speech therapy evaluation been done? If yes kindly attach results

Date of onset or exacerbation of disorder:

What are the treatment techniques you want to use?

What are the goals of treatment?

Kindly state a reasonable estimate of the time duration of when the goals will be met:

RE-EVALUATION

Is the patient improving on current therapy? If no why?

Are the previous goals being met?

Has the reasonable expected time for improvement been exceeded without any improvement? If reasonable expected time for improvement

Has the patient reached a plateau phase?

ASSESSMENT

1. Oral Motor Examination:
2. Receptive Evaluation:
3. Expressive Evaluation:
4. Pragmatic Assessment:
5. Articulation Assessment:
6. Voice Assessment:
7. Swallowing Evaluation:

Short Term Goals

Long Term Goals

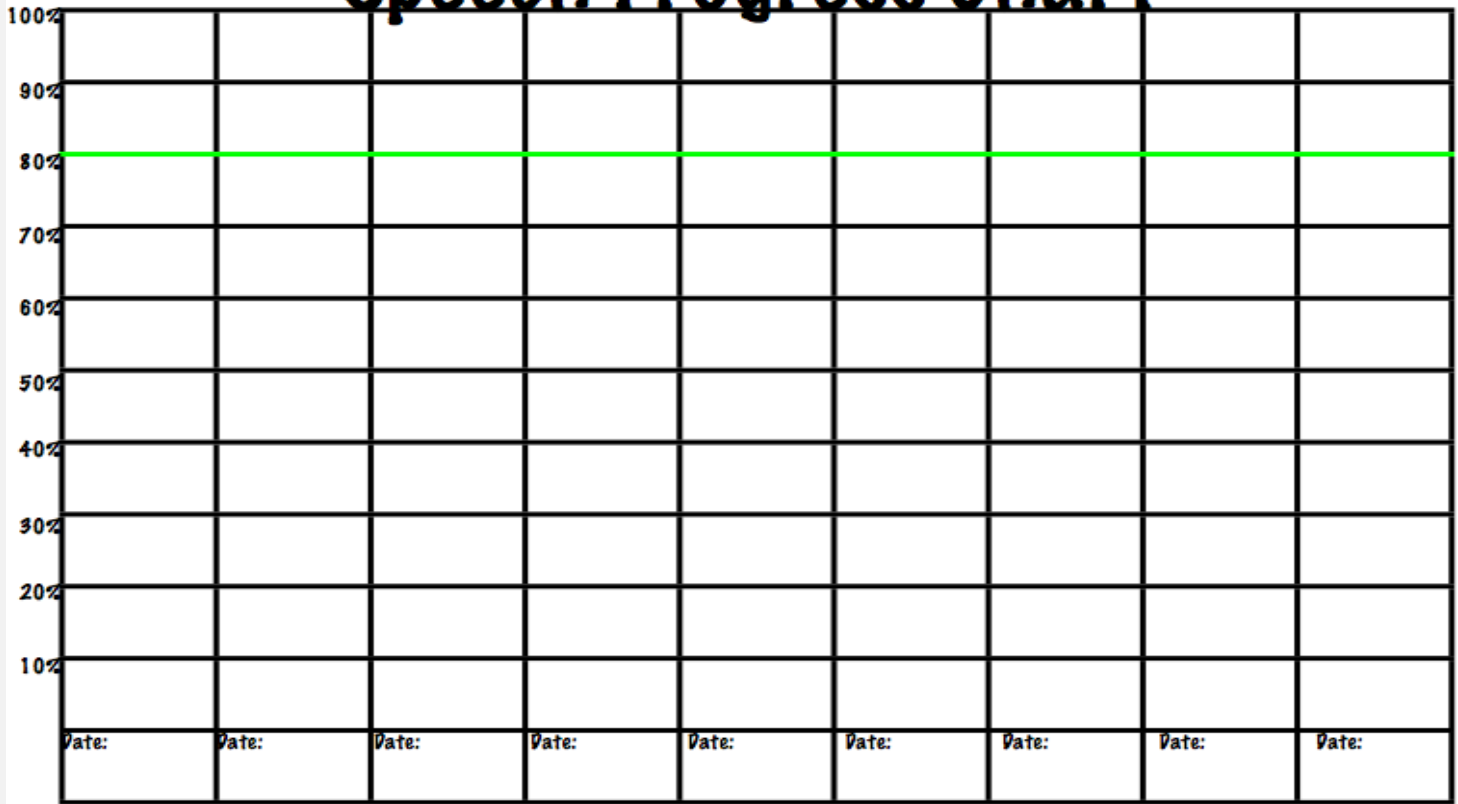
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National Health Insurance Company – Daman (PJSC) (P.O. Box 128888, Abu Dhabi, U.A.E. Tel No. +97126149555 Fax No. +97126149550)

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Graphical Representation of Patients progress

Speech Progress Chart



Name: _____ Sound: _____ Level: _____

*This is a sample, different graphs can be plotted, as long as they show clearly the patient’s progress and makes progress tracking easy.

Physician Information

Physician stamp and signature:

Speech therapist / Speech language therapist stamp and signature:

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