### Speech, Language & Dysphagia Assessment

**Patient Identification**

<table>
<thead>
<tr>
<th>DOB:</th>
<th>AGE:</th>
<th>GENDER:</th>
<th></th>
<th>DOA:</th>
<th>PHYSICIAN:</th>
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**Reason for Admission to Hospital:**

**Reason for SLP Referral:**

**Significant Medical History:**

**Mental Status:**

- **Orientation:**
  - Person
  - Place
  - Time
  - Circumstance

- **Level of Alertness:**
  - Alert
  - Lethargic
  - Unresponsive

- **Orientation:**
  - 1 Step
  - 2 Steps

**General Comments:**

**Vision & Hearing:**

- **Vision Functional**
- **Wearing Glasses**
- **Visual Problem**
- **Hearing Aid(s)**
- **Functional Hearing for face-to-face Conversation**
- **Hearing Loss**

**Oral Motor Function:**

**Pre-Morbid Skills / Deficits:**

**Speech / Language:**

- **Within Functional Limits**

- **See Page 2 for more details**

**Swallowing:**

- **No Dysphagia**

**Current Weight:**

**Chest X-Ray Results:**

**Assessment; Findings Include:**

(Continued on Page 2)

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**Part of the Medical Record**

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8850407 Rev. 11/05 Speech, Language & Dysphagia Assessment Short Form_REHAB PAGE 1 of 2
NAME: 

ASSESSMENT; Findings Include:  (Continued from Page 1)


RECOMMENDATIONS

☐ No service needs indicated while in Hospital
☐ No services recommended after discharge from Hospital
☐ Patient / Family Education Plans
☐ Swallow Function Study - Reason
☐ Other

DISCHARGE RECOMMENDATIONS

☐ Home
☐ Home with Speech, Language & Swallow Services
☐ Outpatient w/ Speech, Language & Swallow Services
☐ SKILLED REHAB / Sub Acute
☐ ACUTE REHAB / Comprehensive
☐ Long Term Care
☐ Other

TREATMENT PLAN:


NOTES / ADDITIONAL INFORMATION:


SIGNATURE:

TITLE:

TEL:

DATE:

PART OF THE MEDICAL RECORD