

Eastern Michigan University
 College of Education Clinical Suite
 Speech and Hearing Clinic

SPSI 568: Diagnostic Manual

Revised October 2016

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Welcome to Diagnostics!

For many of you, SPSI 568, commonly referred to as “Diagnostics” is your first opportunity to apply the skills and knowledge you have acquired in the classroom to real people with communication disorders. This is exciting as it represents a big step forward into your graduate education. It is also challenging as many students learn that the difference between knowing information for a test and applying it to people who are sitting before you is larger than you may anticipate. It may be daunting, but it will get easier. In two years, you will look back and be amazed that it seemed like so much work

The clinic represents the Department of Special Education and the program in SLP. The Council for Academic Accreditation (CAA) of the American Speech-Language-Hearing Association (ASHA) accredits the graduate SLP program. It is important that uniform procedures be followed in the completion of all diagnostic sessions in order to maintain ASHA accreditation standards. Students are expected to be familiar with the contents of this manual PRIOR to beginning the diagnostics experience.

Grading

A grade of B or better is required for advancement in the graduate program. A grade of B- or lower is a failing grade. Your grade depends on completion of your class work and your diagnostic experience in clinic.

Clinic Policies

Dress Code:

Professional dress is expected while you are seeing clients in the clinic. If you appear for your diagnostic session dressed inappropriately, you will be sent home to change. If you cannot return in time for your diagnostic session, you will be given a failing grade.

General Guidelines:

“Dress casual” is appropriate

No jeans

No running shoes

No flip-flops

No T-shirts with writing on them

No low-cut blouses

No low cut trousers

No extremely short skirts

(Be sure to bend down in front of a mirror to see what is visible, including from behind)

Dress shirts are appropriate for men; ties and jackets are not required

HIPAA:

You will receive training on the Health Insurance Portability and Accountability Act of 1996 “HIPAA” guidelines in your SPSI 568 class. You will be expected to comply with these guidelines at all times will enrolled in any diagnostic or clinical practicum. Failure to do so will result in a failure of SPSI 568 and may result in dismissal from the graduate Speech-Language Pathology program.

Some specific guidelines to remember while you are in this class:

1. Do not discuss clients in public areas, including hallways, classrooms and walking outside.
 - If you must discuss a client with someone, be sure that you are behind a closed door.
 - If you discuss a client with another person, be sure that you do not divulge any identifying information about the client.
2. Do not include full names on papers that you may be using to take notes.
 - Instead use either initials or first names only.
 - This includes client names and their family’s names
 - Wait until final reports and letters are approved by your supervisor before placing full names on documents.
3. It is your responsibility to be sure that clients have completed forms appropriately such that reports can be shared with others, such as school districts or physicians.
4. Clients should be contacted from within the clinic.
 - It is not appropriate to record phone numbers and email address of clients to contact them from home.
 - Identify the location of the phone in the clinic to be used for this purpose.
 - You may ask a Clinical Educator for access to a phone for this purpose.
 - Plan accordingly to contact your client on days when you will be in clinic.
5. Under no circumstances should client files and paperwork ever leave the clinical suite.
 - All files must be signed out using a file card.
 - All files must be returned to the clinic files by 4:30 p.m. Monday-Thursday, Fridays by 2:00 p.m.
 - You may use one of the empty therapy rooms in the second hall from the right or the Case Analysis room to review files.

EASTERN MICHIGAN UNIVERSITY

Speech and Hearing Clinic

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Ypsilanti, MI 48197
(734) 487-4410

Clinical Policy

Subject: Clinic Materials

Date: April 10, 2012

1.0 POLICY

Uniform procedures will be followed to ensure that materials signed out of the Speech & Hearing Clinic Materials Room by students, faculty or staff are returned and in good condition, i.e.: with all parts intact and not torn or written on.

2.0 PURPOSE

The purpose of this policy is to inform clinical staff, faculty and students of the procedures to be followed prior to signing out materials and the consequences if materials are not returned in good condition.

3.0 RESPONSIBILITY

The Speech and Hearing Clinic Clinical Educators, clerical staff, Audiologist, and the SLI faculty members.

4.0 PROCEDURES

1. Faculty members are responsible for reviewing the checkout procedure, on page 19 of the online Clinician's Handbook, with their students prior to the students checking out the material. The office staff is **not responsible** for explaining procedures to students.
2. Before students sign out materials, they must sign and date the attached form accepting liability and return it to their instructor prior to requesting materials. The faculty member will bring the completed forms to the clinic secretary to be filed in the materials room.
4. The clinic secretary will give the class list to the Materials Librarian. The materials will be placed on the shelves on the right wall of the materials room.
5. If a SLI faculty member wishes to request material(s) for use in the classroom, he or she must email the clinic secretary with a **list of titles and the date(s) needed** at least one week prior to the date needed and return the attached, signed form. The secretary will forward the list to the Materials Librarian who will then place the materials on the shelves on the right wall of the materials room.
6. When the student or faculty member receives the material, they are responsible for checking them to be certain that all the parts are intact and not damaged or torn. If there is something missing or damaged, the materials librarian or a clinical educator must be notified immediately, to note or repair damage and/or to replace the missing item.
7. If the material(s) signed out to a student are not returned or are returned with a part or parts missing or are returned damaged, the student will receive a grade of Incomplete (I) in the applicable course until the material is replaced.

Speech and Hearing Clinic
Eastern Michigan University

STUDENT FORM FOR CLINIC MATERIALS

I, _____ agree to return materials that have been
(print name)
signed out to me when they are due and to return them in good condition; i.e.: with all parts intact and not torn, written on or otherwise damaged.

If I do not return them in good condition, I will receive an incomplete (I) in the applicable course until the material is replaced.

Signature

Date

E #

Universal Precautions

Universal precautions are used in the EMU Speech and Hearing Clinic to eliminate contact with body fluids, secretions and blood. The following fluids are to be treated as if they are known to contain Hepatitis, Human Immunodeficiency Virus (HIV) or other pathogens:

- Saliva
- Blood

It is not expected that clinicians will come into contact with other fluids such as semen, vaginal secretions, cerebrospinal fluid, pericardial fluid, etc. in the Clinic; however, all fluids are to be treated as if they are infectious.

Work Practice Controls

To minimize exposure to pathogens all Clinic personnel will do the following:

- Wash hands* prior to wearing gloves and as soon as possible after removing gloves.
- Wash hands* prior to each session and after each session.
- Clean all surfaces exposed to fluids with disinfectant spray.
- Equipment and therapy materials that become contaminated shall be cleaned immediately with disinfectants.
- Clinicians with open lesions or weeping dermatitis on his/her hands will wear gloves during treatment sessions and when handling all clinical materials. If the lesions cannot be covered the clinician will not conduct treatment.
- Clinicians with a fever or severe illness will cancel sessions to prevent infection of clients.

** Hands and wrists shall be thoroughly lathered and scrubbed for at least 15 seconds. Care must be taken to clean between fingers and under fingernails. Dry hands and wrists completely with a clean towel.

Every clinician must submit a copy of a negative TB test. All tests are valid for three years; however, a test may not expire during the middle of the term.

Appropriate clinical procedures must be observed at all times to protect both client and clinicians. This means that disposable gloves are to be worn during all oral peripheral examinations, at all times with clients who demonstrate self-destructive behaviors, and with all clients known to be carrying communicable viruses. When gloves are needed, the clinician must also take a paper bag into the therapy room and place the used gloves in the bag. The bag shall be disposed of in the trash bin in the Student Workroom. At NO TIME shall the bags be placed in the wastebaskets in the therapy rooms. When a client drools on tables or therapy materials or places materials in the mouth the materials should be disinfected with disinfectant spray. Alcohol wipes, disinfectant spray, tongue blades, paper bags and gloves are located on the sink cabinet outside of the audiology test booth.

You should make every effort to insure that your client is safe while under your care. Review your client's file to determine if there is a red Medical Alert Notice with special procedures of which you should be aware. If you have a child who mouths toys, be sure that toys with small pieces are NOT used in therapy. If you have a child who runs and jumps, be careful to prevent falls and bruises. Geriatric clients may need your assistance as they open clinic doors or navigate clinic hallways. All accidents or injuries to either clients or clinicians must be reported to your supervisor immediately and logged in the client file.

Universal Precautions, Health and Accident

The following procedures or conditions occur in the Clinic and may involve exposure to pathogens contained in body fluids or blood. Personal Protective Equipment (PPE) procedures are to be used to avoid exposure to these pathogens.

Procedure/ Condition	Personal Protective Equipment Needed					
	NSG*	SG*	UG*	FS*	PC*	OTHER
Oral Mech. Exam ³	X					
Oral-motor exercises ³	X					
Otoscopy with drainage	X			**		
Earmold modification	X					
Ear impressions	X					
Vomiting ²	X			**	X	
Toileting ²	X					
Equipment Cleaning			X			
Spill Cleanup			X		X	
Saliva Management	X					
Feeding evaluation ¹	X			X		
Videofluoroscopy ¹	X			X		
Dysphagia Evaluation ¹	X			X		
Cleaning Treatment Rooms			X		**	

Procedures vary depending on the setting and population served. Health care settings with clients/patients diagnosed with TB, Hepatitis, HIV, Meningitis, etc. will have specific procedures utilized by all staff.

* Code to abbreviations *:

NSG: Nonsterile Gloves

SG: Sterile Gloves

UG: Utility Gloves

FS: Face Shield

PC: Protective Clothing

** Optional

1- Procedure not performed in the EMU Clinic.

2- Housekeeping is to be notified IMMEDIATELY when a clean up is needed, the room shall be closed until clean up is completed.

3- All oral motor supplies are placed in a paper bag and disposed of in the waste basket in the Clinicians' Workroom after use.

Diagnostic Procedures

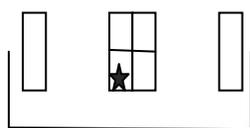
Step-by-Step

I. Your Schedules:

- a. At the beginning of SPSI 568, you will be asked to volunteer for several times frames during which you will be available.
 - i. As student and faculty times are matched with client availability, you will be notified via email (email address indicated by you) of your scheduled evaluation and your clinical partner will also be indicated.
 - ii. Requests for partnerships will not be honored due to scheduling difficulties.
 - iii. Your diagnostic experience will be supervised by faculty and clinical supervisors.

II. Prior to the Evaluation

- a. Clients/families will have completed and returned the initial questionnaire found in the chart.
- b. The office staff will request any additional information from outside sources that may assist the student to prepare for the evaluation.
- c. You need to check the file to determine that all releases of information and the Authorization to Treat have been signed by the family.
 - i. If these forms have not been signed then the student should obtain these signatures during the evaluation session.
 - ii. The family should sign the release of information form even if they are the only persons receiving a copy of the report.
- d. ★ **File location:** The drawer with the files for “Pending Dx” is the drawer facing the left wall of the office (if you are standing at the front window), top right, closest to the computer work station, where the star is located below. All pending diagnostic files are on the right side of the top drawer



(Front window)

III. Preparing for the Evaluation

- a. It is your responsibility to contact any other professionals you might deem necessary
 - i. Retrieve an “out” card from the student workroom, write the client’s initials and your name on the card. Please the card in the green folder when you remove the client file.
 - ii. Complete the Chart Review (see Appendices)
 1. Diagnostic files are kept in the clinic office, in a drawer labeled “Pending” in the file cabinet furthest from the left side door as you are facing the clinic office.
 - iii. Contact all the parent/guardian of the child or the adult client to conduct a pre-diagnostic interview.
 1. Phone calls to clients need to be made from within the clinic. You can use the phone in the Voice Lab. Long distance dial 8+1, then the number. Local calls, dial 6 and the phone number. If you must leave a message, please be sure to leave the main number for the clinic for call back (734-487-4410).
 2. Discuss client/parent goals for the upcoming evaluation session. Do not ask for personal information during this call unless instructed to do so by your supervisor.

3. ***All contacts, including messages should be logged on the yellow log sheet immediately.***
 4. Fill in the Diagnostic Disposition and Report Log (see Appendices and Workroom)
 - a. Available in the material room drawers.
 - b. When you have completed all the reports and paperwork this is to be returned to your supervisor as a record of the diagnostics completed this semester.
 5. Confirm the appointment by telephone *three* days before the diagnostic.
 - a. They should have received a letter after their appointment was scheduled with information for parking and payment information.
 - b. Confirm that the client and family know the location of the Porter Building, have adequate directions to EMU and know where they will park. (Note that they will need to pull up in the circle drive, come in and get a permit for their dashboard, and then move their car to one of the EMU Clinic parking spaces, designated with the red and white signs).
 - c. This is also a good time to determine any special interests, favorite toys or hobbies of your client. This information may help you to choose materials and activities that would be appropriate for your client.
- iv. Plan the evaluation
1. Standardized Tests: Request for Materials
 - a) All materials need to be requested by “Request for Materials” form (available in student workroom of clinic).
 - b) Please check student worker (above box where you turn requests in) schedule to determine when that person will be in and when your materials will be available.
 - c) Per Diagnostic Manual, it is recommended that materials for the Diagnostic date be requested at least 3 days in advance of the date you will need them.
 - d) Materials requested will be placed in student materials room (two doors to the left of the Resource Room on the shelf labeled “Diagnostics.”)
 - e) No materials can leave the clinic without the direct consent of a clinical educator. If you need to borrow the materials overnight, please see them and have them sign your Request for Materials form.
 - f) If you need to spend time perusing test materials or toys, please see one of the clinical educators. Let them know you need to review materials to determine which are appropriate and they will let you in.
 2. Plan informal assessments
 - a. Identify what materials you will use
 - b. Decide on speech and language behaviors you want to elicit
- b. Schedule a meeting with your supervisor *at least one week prior* to the evaluation.
- i. Complete a written Diagnostic Plan after reviewing the chart.
 - ii. Two days prior to this meeting, put a written list of tests/informal observations/questionnaires that you are including in your Diagnostic Plan in the supervisor’s mailbox.
 - iii. When you meet with the supervisor to review the Diagnostic Plan bring your completed Chart Review form with you.
 - iv. You should be prepared to explain your rationale for test selection, review pertinent information obtained in the pre-diagnostic interview, defend your particular plans for the evaluation and present any hypotheses you formed which have governed your planning.
 1. You should also have alternative plans should your hypotheses be invalid or the client does not respond to the procedures you have outlined. Your outline should include

- all the specific procedures (e.g. oral mechanism exam, language sample) and standardized or informal tests you intend to use in the session.
2. Your outline should include a blend of formal and informal assessment procedures
 3. You should be prepared to demonstrate to your supervisor that you are comfortable and familiar with any procedures you suggest in order for your evaluation to be reliable and valid.
 4. Give your supervisor a copy of the Rating Scale at this meeting completed with your name and diagnostic date.
- c. Complete a materials request *at least three days prior* to your scheduled session. Note that the materials librarian will not necessarily be available the day you make the request. See appendix for material check out policy and form.
- i. If you are using formal tests plan to check-out the test to give you enough time to be thoroughly familiar with it.
 - ii. If you are doing a hearing screening be sure to reserve an audiometer to be completely familiar with the operation of the instrument.
 - iii. It is highly recommended that you administer a hearing screening. Screening frequencies should include 500Hz, 1000Hz, 2000Hz and 4000Hz at 25 dB HL, bilaterally. If you have any questions, please contact the audiologist.
 - iv. If your client is seeing the audiologist you are responsible for coordinating with the audiologist to schedule the hearing evaluation and to reflect the results of that evaluation in your report.

IV. **Beginning the evaluation session**

- a. Prepare your room prior to the arrival of your client and make certain that your supervisor knows in which room you will conduct the evaluation.
 - i. You are expected to have all the materials you need to use universal precautions when interacting with your client.
 - ii. See Universal Precautions guidelines on page
 - iii. If the client and family have not arrived within 15 minutes of the designated time you should call to determine if there is a problem.
- b. Greet the client/family in the waiting room
 - i. Introduce yourself using your full name.
 - ii. Introduce your supervisor using their formal title and explain their role.
 - iii. Ask the client/family how they like to be addressed.
 - iv. Take the client and family (if appropriate) into the therapy room to begin the session
 - v. You should inform the client and/or family using appropriate lay language about your plans for the session.
 - vi. Ask the client or family if they have *any questions prior to beginning* the actual evaluation
- c. After completing the evaluation session ask the client and/or family to wait in the therapy room or waiting area while you discuss the results of the evaluation with your supervisor.
 - i. ***No results, impressions, or conclusions from the evaluation should be discussed until you have your supervisor's approval of your impressions.***
 - ii. During the exit interview with the family and/or client carefully explain, using lay language, the evaluation results, how you obtained those results and your recommendations.

- iii. If therapy is recommended be prepared to offer appropriate referrals.
 - 1. It is not appropriate to refer just to EMU; families should be allowed to choose where they wish to receive services.
 - 2. If you are referring to EMU be prepared to discuss how the clinic schedules clients, the fee for services and have them complete a preference sheet to allow them to be scheduled at times convenient for them.
 - 3. If the client is a child you must tell the family about Special Education Law and the services that would be available to them through the public schools.
 - 4. Be prepared to give them the contact information for their local school district.
 - 5. If the family states that they do not want the school involved be sure to log that you informed them of the special education services available to them and that they denied the services
- iv. Close the session by thanking the family/client for coming and reminding them that they will be receiving a copy of your diagnostic report in a few weeks.

V. After the evaluation session

- a. Clean up your room and return all materials to your shelf.
- b. Be sure that all formal tests are reassembled and that all parts are in the box or container of the test.
 - i. If you are taking a test home be sure to check it out. You will need to get permission from one of the Clinical Educators.
 - ii. *Use care when transporting tests and assessment instruments.* These are very expensive materials and should be treated carefully. If your supervisor determines that you have abused any materials you will be assessed for the replacement cost prior to receiving your grade.
 - iii. Meet with your supervisor for a conference. This will allow you to ask any questions you may have, discuss the details of the report.
- c. The draft of your report is ***due to your supervisor 48 hours*** following the evaluation.
 - i. The report should follow the outline presented in the appendix unless your supervisor informs you of any changes or additions to the format of the report.
 - ii. If therapy is recommended you should include some suggested goals and/or areas for additional evaluation.
 - iii. After receiving feedback on your draft, ***revisions are due back to your supervisor within 48 hours.***
- d. As soon as your supervisor approves your final report ask your supervisor for letterhead.
 - i. Be sure to follow the spacing, margins and headers shown in the sample.
- e. As soon as your report receives final approval by your supervisor prepare a draft cover letter to be mailed with the report.
 - i. Submit this letter to your supervisor with your final report for signature.
 - ii. If this draft is approved, you will be given to get letterhead and envelopes by your supervisor.
 - iii. Put the original cover letter and one copy of the report in an envelope in the outgoing mailbox in the Clinic office.
 - iv. File the original report and copy of the cover letter as the legal evidence of the results of your evaluation.
 - v. File all test protocols and records from testing in client file.

- vi. *No information is to be communicated to anyone without a signed release from the family.*
- vii. Log all test protocols, mailings, and communication on the yellow log sheet as you go along.
- viii. Enter your clock hours for the eval, including any hearing screening time, into CALIPSO.
- ix. You are responsible for making a final appointment with your supervisor to receive your grade and ASHA clock hours.

Expected competencies of students completing a diagnostic practicum

The clinician will demonstrate independence and competency in:

- Evaluating file information and interpreting case histories to determine client/family needs
- Selecting appropriate tests for evaluation and the tools/methods to accomplish the evaluation
- Adjusting their interview style to elicit maximum information from the client/family
- Managing the session to elicit maximum information from formal evaluation tools, informal evaluation measures, clinical impressions and the client/family interview
- Managing the exit interview in a manner that clearly informs the client/family of results obtained and makes specific, concise recommendations for needed evaluation and/or referral
- Preparing an evaluation report which is timely, contains all pertinent history, explains evaluation instruments and results, clearly describes clinical impressions, draws appropriate conclusions based on data presented in the report and makes appropriate recommendations and referrals
- Preparing a letter to the client/family and other agencies which meets all criteria listed above
- Managing the case and the file in a professional manner
- Explaining the philosophical and theoretical rationale for any position taken in the report.

General Guidelines for Diagnostic Report Writing

From Florida State University

1. Be sure you understand your test. In addition to knowing how to give it, understand why you are giving it. This will go along way towards helping you interpret and describe your client's performance.
2. Pay attention to small details on the report—be sure you have the client's name spelled correctly, as well as any family members, physicians, medications, etc. Double check the client's birth date. Be sure to include page headers in the upper right corner.
3. Know the difference between a grapheme and a phoneme. Graphemes go in quotes ("sh"). Phonemes go between slashes (/ /). If your computer does not do phonemes, **do not** use the closest looking letter on your keyboard. **Handwrite** the phoneme in.
4. Learn to recognize incomplete sentences and run sentences. Invest in a grammar book if grammar is not your strength.
5. Pick one tense and use it—that means either past or present tense. Check with your supervisor to determine tense preference.
6. Read your report **out loud** to help you look for problems with grammar, word choices, etc.
7. Use active voice whenever possible (as opposed to passive). **Example: Active** - The clinician presented the stimuli. **Passive** – The stimuli were presented by the clinician.
8. Your reader most likely is not another speech pathologist. Use examples to clarify your statements, especially for recommendations.
9. Be concise. **Example:** The client was able to read the paragraph. (wordy)
The client read the paragraph. (Better).
10. Be specific. **Example:** "The client had difficulty with reading sentences." does not state what the problem was. "On sentence completion tasks, the client consistently chose the incorrect word to complete the sentence." describes the client's problem.
11. Read what you want (or need) to write. That means if you need to write a diagnostic report, but have never read one, it is going to be hard to write one. Read as many diagnostic reports as time allows to get a feel for organization, wording, type of information reported, etc.
12. Remove qualifying adjectives (for example, *very, quite, much rather, somewhat, and approximately*).
13. **Spell check and grammar check.**
14. Avoid splitting charts.
15. The last page of a report should contain more than just signatures. If necessary, move the prognosis to the last page, as well.

Appendices

PRE-EVALUATION CHART REVIEW

Initials_____

DOB_____ Age_____ Siblings_____

Educational Information_____

Occupational Information_____

Native and Secondary Languages_____

Diagnoses; Date of Onset:

IEP Information

Developmental History:

Pregnancy/birth

Phonology

Language

Motor skills

Cognition

Hearing

Swallowing

Prior Medical History (PMH)

Previous Evaluations

Previous Treatment

Current Status

Receptive language

Expressive language

Articulation/Phonology

Oral Motor

Hearing

Fluency

Voice

Swallowing

Other

Pre-Diagnostic Phone Call:

- Confirm appointment day and time (tell them 15 minutes early to allow for parking process)
- Confirm that they know where to go
- Explain that they will need to park in circle in front of building, come in and get parking permit, then go out and move car to COE Clinic Parking (red and white signs).
- Client interests (if small child)

Oral and Speech Motor Control Protocol

Name: _____

Date: _____

Examiner: _____

Scoring:

- Score structural items- 1 - normal
 0 - abnormal
 Score functional items- 2 - adequate
 1 - impaired
 0 - incorrect or no movement

LIPS (CN- VII)

STRUCTURE AT REST:

1. Symmetry _____
 2. Relationship
 open _____
 closed _____

ORAL FUNCTION:

3. Rounding _____
 4. Protrusion (blowing) _____
 5. Retraction _____
 6. Alternate pucker/smile _____
 7. Bite lower lip _____
 8. Lip Seal _____
 9. Puff cheeks _____
 10. Open-close lips _____

SPEECH FUNCTION:

11. Rounding /ou/ _____
 12. Protrusion /u/ _____
 13. Retraction /i/ _____
 14. Alternate /u/, /i/ _____
 15. Bite lower lip /f/ _____
 16. Open-close lips /m^/ _____

MANDIBLE (CN-V)

STRUCTURE AT REST:

17. Symmetry _____
 18. Occlusion
 Normal _____
 Neuroclulsion _____
 Distocclusion _____ (posterior)
 Mesiocclusion _____ (anterior)
 Crossbite _____

19. Size in relation to face _____

ORAL FUNCTION:

20. Excursion (click teeth 5 times) _____

MAXILLA

STRUCTURE AT REST:

21. Symmetry _____
 22. Size _____

TEETH

23. Decay _____
 24. Alignment _____
 25. Gaps _____
 26. Missing _____
 27. Occlusion (re maxillary teeth) _____

TONGUE (CN- XII)

STRUCTURE AT REST:

28. Symmetry _____
 29. Carriage _____
 30. Fasciculations _____
 31. Furrowing _____
 32. Atrophy _____
 33. Hypertrophy _____

ORAL FUNCTION:

34. Protrusion _____
 35. Elevation to alveolar ridge _____
 36. Anterior-posterior sweep _____
 37. Interdental _____
 SPEECH FUNCTION:
 38. Elevation- alveolar ridge /l/ _____
 39. Touch lateral edges to teeth
 /f/ , /s/ _____

40. Interdental /θ/ _____
 41. Posterior tongue to palate /k/ _____

VELOPHARYNX (CN X)

STRUCTURE AT REST:

42. Symmetry _____
 43. Uvula _____
 44. Tonsils _____
 45. Vault height _____
 46. Palatal juncture-optional _____

ORAL FUNCTION:

47. Blow _____
 48. Suck through a straw _____

SPEECH FUNCTION:

49. /a:/ _____
 50. /ha/, /ha/, /ha/, /ha/ _____

LARYNX- RESPIRATION

STRUCTURE AT REST:

51. Posture during quiet breathing_____

ORAL FUNCTION:

52. Cough, laugh_____

SPEECH FUNCTION:

53. Pitch variation_____

54. Loudness variation_____

55. (same as 50)_____

COORDINATED SPEECH MOVEMENTS

(score for articulatory accuracy)

(score for # of repetitions per second,
over 3 seconds)

56. /pʌ/ repetitions (see 82)_____

82. /pʌ/_____

57. /tʌ/ repetitions (see 83)_____

83. /tʌ/_____

58. /kʌ/ repetitions (see 84)_____

84. /kʌ/_____

59. /pʌtʌkʌ/ repetitions (see 85)_____

85. /pʌtʌkʌ/ repetitions_____

60. "patticake" repetitions (see 86)_____

86. "patticake" repetitions_____

61. "you"_____

62. "top"_____

63. "beef"_____

64. "fume"_____

65. "cowboy"_____

66. "band-aid"_____

67. "half-time"_____

68. "banana"_____

69. "kitty cat"_____

70. "puppy dog"_____

71. "communicate"_____

72. "1950"_____

73. "potato head"_____

74. "Winnie the pooh"_____

SPEECH SAMPLE

PROSODY:

75. Rate_____

76. Intonation_____

VOICE:

77. Pitch_____

78. Loudness_____

79. Quality_____

80. Resonance_____

81. Maximum phonation time (in seconds)_____

From: Robbins and Klee, JSHD, 1987.

TABLE 3. Mean (M) and standard deviation (SD) of rate and duration measures for each age group and for the entire sample.

Age group	/pʌ/		/tʌ/		/kʌ/		/pʌtʌkʌ/		patticake		Max phon time	
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
2;6-2;11	3.70	0.86	3.70	0.76	3.65	0.49	1.00	0.27	1.26	0.11	5.55	1.87
3;0-3;5	4.66	0.80	4.56	1.02	3.82	1.45	1.06	0.29	1.36	0.32	5.51	1.49
3;6-3;11	4.81	1.20	4.78	1.13	4.83	0.57	1.76	0.90	1.75	0.83	7.79	2.37
4;0-4;5	4.89	1.12	4.77	1.05	4.58	1.08	1.37	0.28	1.56	0.25	8.01	2.11
4;6-4;11	4.64	0.82	4.46	0.62	4.29	0.57	1.34	0.27	1.33	0.10	9.22	2.19
5;0-5;5	4.76	0.84	4.82	0.85	4.56	0.94	1.40	0.43	1.58	0.28	8.06	1.97
5;6-5;11	5.09	0.44	5.22	0.45	4.91	0.25	1.58	0.19	1.65	0.21	9.42	1.65
6;0-6;5	5.36	0.64	5.32	0.48	4.94	0.28	1.45	0.25	1.61	0.23	10.99	3.06
6;6-6;11	5.51	0.43	5.37	0.72	4.85	0.71	1.72	0.19	1.64	0.26	11.47	3.02
Total sample	4.85	0.92	4.80	0.91	4.51	0.88	1.43	0.44	1.54	0.38	8.51	2.91

Speech and Hearing Clinic

Diagnostic Report

Name:	File No:
Address:	Date of Birth:
Phone:	Date of Evaluation:
Parent's Name:	Age at Evaluation:
Referred By:	Classification:

STATEMENT OF THE PROBLEM

This section contains one or two sentences which identify the client, his age, sex, etc. who referred him, who brought him to the clinic, and a “quote” or paraphrase of the reason for his being seen. The information that is required in this summary will probably be evident in the pre-diagnostic interview or the questionnaire that was completed at the time of the inquiry.

BACKGROUND INFORMATION

This section contains information obtained from the parent (s) or individuals(s) who serve as informant(s) for the interview. The information should be factual and objectively reported. Statements should be phrased in such a way that the reader knows that this was relayed to the clinician, not information directly observed. Lead phrases such as “the mother report”, “the mother stated”, etc., should be used; however every sentence or paragraph should not begin in the same way. It is unnecessary to present a totally detailed list of normal development. Statements such as “Physical development was considered to be age-appropriate”, based on reports from the mother/father etc. Nevertheless, any deviation from developmental norms, significant medical information, social/pragmatic concerns from the family and/or previous reports should be stated in this paragraph. As a guideline, patient background information considered for this paragraph are:

- Dates and locations of previous evaluations
- Previous treatment
- Hearing evaluations and results
- Medical summary
- Educational Status
- Psychological/Emotional Status
- Motor Development
- Speech Language Development
- Significant Family Information
- Social/Pragmatic Skills
- Occupational (adult)

EVALUATION RESULTS

This section contains information obtained during the actual evaluation of the client. It, too, should be reported objectively. It is not necessary to describe published tests used but scores should be reported accurately and validly interpreted. Informal evaluation strategies should be described completely as to what was done, what information was sought and what the results were. No subjective information such as “Johnny appeared to be a happy child” should be reported in this section. Subheadings will be used to summarize each section that was evaluated. Suggestions of information that could be reported on in each section are as follows:

Hearing Assessment

Results of your screening or formal audiological evaluation done here or at another facility

Oral Motor Functioning

Report on structures and functions that effect speech production

Language

Receptive language, including information from formal and informal evaluations

Expressive language including information from formal and informal evaluations language samples of semantics, syntax, morphologic features and pragmatics.

Cognition (if appropriate)

Articulation

Results from formal testing batteries

Report on conversational speech (sound errors, intelligibility)

Identification and analysis of sound errors

Consistency of sound errors and patterns of sound errors (error types, severity of errors, presence of any phonological processes)

Stimulability of errors (which sounds can be made with what type of cueing)

Voice (if appropriate)

Quality (hoarse, aphonic etc.)

Pitch (too high, too low, variable)

Resonance (nasal, denasal, mixed)

Breath support: type of breathing used (diaphragmatic, thoracic, clavicular)

Muscular tension

Stimulability of improved voice

Fluency (if appropriate)

Types and frequencies of dysfluencies

Associated motor behaviors (hand movements, eyeblinking, etc.)

Avoidance of sounds, words, or situations; anticipation of stuttering

Speech rates with and without dysfluencies

Stimulability of fluent speech

CONCLUSIONS AND RECOMMENDATIONS

The first paragraph of this section should contain the conclusion which may have been drawn from the consideration of the interview and evaluation information. No conclusions should be drawn which do not have factual basis which has already been mentioned in this report. This means that the conclusions would follow logically from the previously reported data.

The second paragraph should contain recommendations. These should follow the conclusions logically. No recommendations should be made which have not been foreshadowed in your conclusions. For example, you would not recommend therapy for a child who reports did not clearly state a communication problem and the nature of the problem. The recommendations may consist but are not limited to:

- specific suggestions for treatment (articulation, receptive/expressive and semantic language)
- further assessment's that may be needed to gain in depth knowledge of an area that showed some delay during your evaluation. Other tests may be necessary to acquire a better understanding of the specific

tasks that are difficult for the client in the general language area (e.g., **Assessing Semantic Skills through Everyday Themes ASSET**, **Test of Phonological Awareness TOPA**, **The Listening Test**, **The Language Processing Test** etc.)

- recommendations for outside sources including evaluations and/or treatment (OT, PT, school evaluations for intention of special education services etc.)
- home programs that focus on weaker language areas found during formal testing or informal assessments.

Student Evaluator, Degree

Supervisor's Name, Degree, Certification

DO'S AND DON'TS FOR LETTERS OF MORE THAN ONE PAGE

- DO:** 1. START your second page (and any additional pages) WITH an identifying HEADING (header) which indicates to whom the letter is written, the page number, and the date. For example:

Dr. I. Fix	Page 2 of 2	June 19, 1998
------------	-------------	---------------

OR

Dr. I. Fix Page 2 of 4 June 19, 1998
--

2. START your second page (and any additional pages) on the SEVENTH LINE FROM the TOP of the page.
3. leave a bottom margin of at least one inch (or, when using EMU letterhead, leave at least 2 lines above the printed footer. Bottom margins should be as uniform as possible. The only exception is the last page which may have a larger bottom margin.

- DON'T:**
1. use an additional page to print only the complimentary close and signature (even if enclosure and/or pc notations are used). **THERE MUST BE AT LEAST TWO LINES OF THE FINAL PARAGRAPH ON THE ADDITIONAL PAGE.**
 2. hyphenate the final word on a page.
 3. divide a paragraph between pages leaving less than two lines of the paragraph on either page.

SPECIAL NOTE: If you have problems setting up your letter correctly, please see the Clinic Secretary who will be more than willing to assist you.

INSIDE ADDRESS AND SALUTATION VARIATIONS

TRADITIONAL FORMAT FOR HUSBAND AND WIFE		
INSIDE ADDRESS	SALUTATION	SPECIAL NOTES
Mr. and Mrs. John Doe	Dear Mr. and Mrs. Doe,	always include husband's first name in the address, but not in the salutation
Dr. and Mrs. John Doe	Dear Dr. and Mrs. Doe,	
Mr. and Dr. John Doe	Dear Mr. and Dr. Doe,	
Rev. and Mrs. John Doe	Dear Rev. and Mrs. Doe,	
Capt. and Mrs. John Doe	Dear Capt. and Mrs. Doe,	
NON-TRADITIONAL FORMATS FOR HUSBAND AND WIFE		
INSIDE ADDRESS	SALUTATION	SPECIAL NOTES
Mr. John Doe Ms. Mavis Davis-Doe	Dear Mr. Doe and Ms. Davis-Doe,	husband and wife with wife using hyphenated last name
Mr. John Doe Ms. Mavis Davis	Dear Mr. Doe and Ms. Davis,	husband and wife with wife maintaining maiden name*

Sample Cover Letter
(Update Note: Clinic Phone Number is 734-487-4410)



EASTERN MICHIGAN UNIVERSITY
Ypsilanti, Michigan 48197

Speech and Hearing Clinic
Eastern Michigan University
Ypsilanti, MI 48197
April 8, 1998

[Redacted]

[Redacted]

It was a pleasure meeting your child. Enclosed you will find a copy of [Redacted] diagnostic report, activities you may want to try at home with [Redacted] and a copy of a brochure regarding the augmentative device Cheap Talk 8. If there are any questions, feel free to contact [Redacted] at the Speech and Hearing Clinic at 487-3300.

Sincerely,

[Redacted Signature]
Student Evaluator

[Redacted Signature] MA, CCC-SLP
A., CCC-SLP
Diagnostic Supervisor

Department of Special Education
Rackham Building 313/487-3300
Speech and Language Impaired 313/487-4412
Hearing Impaired 313/487-4413

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Board of the American Speech-Language-
Hearing Association and by the Council on
Education of the Deaf

Sample Reports



EASTERN MICHIGAN UNIVERSITY

Ypsilanti, Michigan 48197

Speech and Hearing Clinic Diagnostic Report

NAME: [REDACTED] FILE NO: [REDACTED]
 ADDRESS: [REDACTED] ve. DATE OF BIRTH: 5/20/94
 S: [REDACTED] DATE OF EVALUATION: 3/13/98
 PHO: [REDACTED] AGE AT EVALUATION: 3
 PARENT'S NAME: [REDACTED] Tamara CLASSIFICATION: Speech and
 REFERRED BY: [REDACTED] CLP Language
 H: [REDACTED] School Impairment
 S: [REDACTED]

I. STATEMENT OF THE PROBLEM

[REDACTED] a 3 year, 10 month old male was seen for a diagnostic evaluation on March [REDACTED] at the Eastern Michigan University Speech and Hearing Clinic. His mother, Mrs. [REDACTED] was in attendance for the entire evaluation. [REDACTED]'s primary concern was receiving help to assist [REDACTED] in his ability to communicate his needs and desires, reducing his and her frustration. [REDACTED] also stated that she wanted [REDACTED] involved in speech and language services during the spring and summer when he is not in school.

II. CASE HISTORY INFORMATION

[REDACTED] mother reported no significant complications during her full term pregnancy with [REDACTED] but noted that [REDACTED] was delivered two weeks past his due date. Additionally, she stated that [REDACTED] never crawled on his hands and knees but rolled to get to places. He walked at 15 months. [REDACTED] had an expressive vocabulary of approximately 6 words at 22 months but stopped speaking and began displaying temper tantrums and aggressive behavior when his younger brother, [REDACTED] was born.

[REDACTED] has a history of middle ear infections which have been followed and treated surgically by his physician. He received his first set of tubes at four months of age and his mother stated that then [REDACTED] "was a changed baby." According to Bogdasarian's most recent report of February 7, 1997 Justin underwent an adenoidectomy, left myringotomy and tympanostomy tube placement. The right tube, which was originally placed 5/3/96, was reported to be functional. At that time, an auditory brain stem response test was performed by [REDACTED] which reportedly indicated normal hearing at the frequencies tested.

[REDACTED] currently attends the Pre-Primary Impaired Program at Houghton Elementary School. He receives speech and language therapy two times a week for approximately 20-30 minutes. He has received speech and language and occupational therapy services since September [REDACTED] through Houghton Elementary School.

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██████████
page 2

III. EVALUATION INFORMATION

Receptive Language

Assessment of ██████████ receptive language, or the ability to understand what others say, was obtained through parental report and observation throughout the evaluation. The MacArthur Communicative Development Inventory: Words and Gestures was completed at home by ██████████. Norms for this were based on children ages 8 to 16 months. ██████████ achieved scores that place him in the age range equivalent of 15 months for receptive language skills. Mom reported on the in ██████████ry, that Justin can follow simple one-step directions, understands approximately 133 words and responds to his name when called.

During the evaluation, conducted primarily in the context of play, ██████████ did not respond to yes/no questions or understand the prepositions on top or behind. However, he did respond verbally, producing /ma/ to "who's that?", with gestures and with the augmentative device (Cheap Talk 8 by Enabling Devices) to wh-questions, "What's this?", and "Where's your shoe?" ██████████ understood and responded to commands "Show me...", "Give me...", and "turn it on/off". He followed simple two-step commands and recognized the body parts eyes, ears, head and lips. ██████████ did not consistently recognize the colors, red, blue, orange, yellow or green.

Expressive Language

Expressive Language, or the ability to convey thoughts and ideas, was assessed through parental report and observation in the context of play. The MacArthur Communicative Development Inventory: Words and Sentences was completed by ██████████ at home. Norms for this are based on children ages 16 to 30 months. ██████████ achieved scores equivalent to the expressive language skills of a 14 month old child. ██████████ reported that ██████████ can make most sound effects and animal sounds, and produce approximations of the words, "cheese, egg, juice, hot, keys, moon, brother, daddy, grandpa, please, and thank you."

██████████ demonstrated limited but appropriate eye contact with the clinician. ██████████ used facial expressions to express affection to his mother and others and shook his head "no" for refusal of objects or actions. He smiled in appropriate contexts. He often touched a communicative partner to gain attention and pointed with his finger to request actions or objects.

██████████ was able to imitate approximations of the clinician's model of one and two word utterances. He produced /pa/ for "please", /ā/ for "Jake", /na/ for "snack", /dʒus/ for "juice", /ha/ for "hi", /bʌbaɪ/ for "good bye", /ha/ for "hot", /ʃu/ for "shoe", /ah ah/ for "thank you", /na pa/ for "snack please" and /ma na/ for "more snack."

The Cheap Talk 8 by Enabling Devices, a voice output communication device, was used with ██████████ to provide four choices for snack; juice, fruit loops, carrots and raisins. With clinician prompting, direct selection of the four items was observed at least three times each. Generalization of this skill for requesting, selecting and labeling was noted. During play, direct selection of "bus" and "ball" occurred at least three times each while using the device. ██████████ was not cooperative using the device initially with his mother, but demonstrated the ability to request and label bus and ball with her, after clinician prompting.

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Articulation/Phonology/Voice

Justin's phonemic repertoire included /p,m,h,n,w,b,k/. These sounds were produced in consonant-vowel syllables; /pa/, /ba/, /na/, /ha/ and /ma/. Justin did produce 2 consonant-vowel-consonant words: /dʒʊs/ "juice" and /hɑ/ "hot". He produced /na/ for "snack" and /pa/ for "please" consistently throughout the evaluation. Vocalizations were sentence-like with varied rate, stress and intonation. Justin's voice appeared to be normal.

Hearing Evaluation

A formal hearing evaluation was completed by [redacted] Ph.D., CCC-A. Tympanograms revealed negative pressure which was worse in the right ear. Justin was only fairly cooperative for speech testing and obtained 80% correct at a soft presentation level. Results indicate borderline to normal hearing in at least one ear.

Oral Mechanism Observations

An informal oral mechanism examination revealed normal articulatory and facial structures. However, the rate and range of tongue movements were reduced and all required maximal modeling and tactile stimulation. Justin placed his tongue up, down and side to side in a groping manner. He imitated a variety of the clinician's facial movements in a mirror. He smiled with his lips closed and open to show his teeth, puckered his lips, and protruded his tongue. While blowing bubbles and drinking from a straw Justin demonstrated adequate lip seal. The oral cavity was not visible during examination. A vibrator, which may be used to help control oral motor movements in therapy, was brought into the evaluation. Justin was very interested in the device. Upon command and spontaneously he placed it on his cheeks, eyes, nose, lips and ears.

Fine and Gross Motor

Justin demonstrated age appropriate fine and gross motor skills according to the Batelle. During play, he stacked blocks 3 or 4 high, threw and kicked a ball, placed pegs into holes and cut paper with scissors. His ability to copy a vertical line and circle using crayon and paper is emerging.

Behavior Observation

Throughout the evaluation Justin was cheerful and socially interactive with clinicians. He remained on task and was compliant with clinician requests. While playing with mom, Justin demonstrated some refusal behaviors such as, shaking his head "no", and avoiding mother's request for action or turn taking skills by laying on the floor and looking away.

Justin's mother stated that Justin is a "finicky eater", reporting that his preferences in foods and textures are extremely limited. During the evaluation he willingly requested and ate carrots and raisins, things he had never tried before, during snack. Justin had difficulty biting the carrot and made attempts to imitate the clinician's model of biting movements.

IV. CLINICAL IMPRESSIONS

Justin appeared to be a delightful child with a secure bond to his mother. He was interactive with the clinicians and mother throughout the evaluation. Justin was attentive to

██████████
page 4

the conversations of the adults and the production of his name. He responded by turning his head when his name was spoken.

In addition to using the Cheap Talk 8 at school for snack, ██████████ demonstrated the ability to generalize it's use in the context of play and with different communicative partners. ██████████ was responsive and imitated some of the sounds of the digitized human voice.

██████████ appeared to be supportive and willing to aid Justin in his speech and language development.

V. CONCLUSIONS AND RECOMMENDATIONS

Parental report and the behaviors exhibited during the evaluation indicate that ██████████ is functioning at a symbolic level and does have a receptive and expressive language delay and probable developmental apraxia of speech (DAS). With continued family support and intervention, the prognosis for an increase in receptive and expressive language skills is good. Based on these findings the following recommendations have been made:

1. Further audiological evaluation to re-test hearing and continue monitoring ██████████ middle ear
2. Re-evaluation by school psychologist to evaluate ██████████ educational, emotional and social abilities, his learning styles, and possible developmental disorders.
3. Speech and language therapy two times a week focusing on:
 - a. ruling out DAS.
 - b. continued education of family members in methods of eliciting language.
 - c. increasing ██████████ expressive and receptive vocabulary to the short term goal of 10 words with a long term goal of 50 words.
 - d. increasing oral motor movements, such as full range and rate of motion of the tongue through exercises using a vibrator and tactile stimulation.
 - e. ongoing evaluation and instruction in the temporary use of the Cheap Talk 8 from Enabling Devices, a voice output augmentative communication device (see attached paper) to aid ██████████ functional use of language, such as requesting assistance, foods and toys at home and school.

██████████
Student Evaluator

██████████
Diagnostic Supervisor



EASTERN MICHIGAN UNIVERSITY

Ypsilanti, Michigan 48197

Speech and Hearing Clinic Diagnostic Report

NAME: [REDACTED] FILE NO.: [REDACTED]
 ADDRESS: [REDACTED] DATE OF BIRTH: [REDACTED]
Ann Arbor, MI 48103 DATE OF EVALUATION: January 29, 1999
 PHONE: (734) 663-0616 AGE AT EVALUATION: 59 yrs, 6 mo.
 REFERRED BY: [REDACTED] M.A.CCC-SLP CLASSIFICATION: Anoxic Encephalopathy

I. STATEMENT OF THE PROBLEM

[REDACTED] a 59 year old male, was accompanied to the Eastern Michigan University Speech and Hearing Clinic by his wife. [REDACTED] reported that since her husband's cardiac arrest he has trouble "constructing and organizing his thoughts." Mr. [REDACTED] former speech language pathologist, [REDACTED], from the Joyce M. Massey TBI Day Treatment Service, referred him to the clinic.

II. CASE HISTORY INFORMATION

Mr. [REDACTED] sustained an anoxic encephalopathy secondary to a cardiac arrest on November 25, 1997. He was admitted to the University of Michigan Medical Center for emergency and acute care, then transferred to St. Joseph Mercy Hospital Rehabilitation Unit on December 9, 1997. He was transferred to Riverview Extended Care on April 30, 1998 and discharged on July 25, 1998. Mr. [REDACTED] was referred to the Joyce M. Massey TBI Day Treatment Service and began receiving speech and language therapy there on August 31, 1998. In November he was discharged due to the fact that his HMO visits were exhausted.

In September 1998, the Boston Diagnostic Aphasia Exam and the Boston Naming Test were administered. Mr. [REDACTED] was diagnosed as having moderate to severe receptive and expressive aphasia, mild to moderate impairment of social skills, and moderate attention impairment. He was also found to have a moderate to severe impairment in memory, mild to moderate impairment in vocal intensity and mild apraxia.

Goals addressed by Mr. [REDACTED]'s former speech language pathologist included auditory comprehension, identifying pictures by naming, structure word retrieval tasks, maintaining attention, reading comprehension, receiving and acknowledging comprehension, and orientation (person, place, and time.) It was noted by Mrs. [REDACTED], and evident from reports, that Mr. [REDACTED] was making progress in therapy.

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III. EVALUATION INFORMATION

The following subtests of the Western Aphasia Battery were administered:

<u>SUBTEST</u>	<u>SCORE</u>
Spontaneous Speech	15 / 20
Comprehension	15.9 / 20
Repetition	8.2 / 10
Construction	2.4 / 10

According to the Western Aphasia Battery, Mr. [REDACTED]'s scores on the spontaneous speech, comprehension, and repetition sections of the test are consistent with the classification of Anomic Aphasia. During the spontaneous speech section Mr. [REDACTED] was able to answer 4/6 questions accurately and responded in full sentences when asked to describe a picture. He demonstrated circumlocutory but fluent speech and had some difficulty finding words. He also used complete, but sometimes irrelevant sentences. Mr. [REDACTED]'s auditory comprehension was good for Word Recognition and Yes/No Questions, but was poor for Sequential Commands. His repetition was good, but he was unable to repeat more than seven syllables. For these more difficult repetition tasks, he often perseverated on previous tasks, or exhibited literal paraphasias. Mr. [REDACTED] exhibited severe deficits in construction, visuospatial and calculation tasks. He was able to draw simple shapes such as a circle or a square, but was not able to draw complex shapes or to complete block designs. He was able to add easily, but was not able to subtract, multiply or divide. He was not able to complete any of the items in Raven's Coloured Progressive Matrices.

The Boston Naming Test was administered. His total score of 27 puts him at a Severity Level between 2 and 3 on a five point scale where 1 is most severe. Moderate perseveration, circumlocution, and latency (between 2 – 5 second) were noted throughout the exam. Due to circumlocutions, stimulus cues were not effective when prompting Mr. [REDACTED], however, when unable to answer in 20 seconds, a phonemic cue was sometimes helpful.

The following subtests of the Reading Comprehension Battery for Aphasia were administered:

<u>SUBTEST</u>	<u>SCORE</u>	<u>TIME</u>
Word Visual (WV)	6 / 10	8 min.
Word Auditory (WA)	7 / 10	7 min.
Word Semantic (WS)	8 / 10	4 min.

Excessive latency on the Word subtests suggest possible visual dyslexia. Errors such as lamb/lamp and glove/globe were noted.

During informal evaluation via interview, Mr. [REDACTED] exhibited poor eye contact. He was easily distracted and perseverated on items found in the room. When asked a question he was able to stay on topic for one to two utterances and then shifted topics inappropriately. He generally answered questions appropriately with one or two word utterances, indicating fair to good auditory comprehension. For longer utterances, he

exhibited poor organization and incompleteness in his thoughts. Some mild inappropriateness and verbosity were noticed.

According to informal evaluation, Mr. ██████'s long-term memory was found to be significantly better than his short term memory. He was able to answer questions accurately regarding his previous job location and his level of education. However, he was unable to accurately answer questions such as the evaluator's name, or the name of the building he was in. Mr. ██████ also exhibited deficits in orientation and awareness. He was not able to answer questions regarding the day, month, or year. He could not say why he was at the clinic or what kind of problems he'd experienced since his accident.

Voice and Fluency were informally evaluated and found to be within functional limits.

An oral mechanism exam was performed. Results reveal normal symmetry of face, mouth, and lips. Mr. ██████'s tongue deviated slightly to the left when ask to retract and when asked to make rapid side to side movements. His tongue was found to be slightly weak on the left side when ask to push against the tongue depressor. During an apraxia exam, Mr. ██████ exhibited mild verbal apraxia. His difficulty in repeating began with words over four syllables.

Mr. ██████'s hearing was evaluated by ██████, Ph.D., CCC-A. Pure tone air conduction was found to be within normal limits. An otoscopic exam was unremarkable and tympanogram indicated normal inner ear function. Word discrimination score was good.

IV. CLINICAL IMPRESSIONS

Mr. ██████ demonstrated fair pragmatics and appropriateness and demonstrated a good sense of humor, making jokes throughout the examination. He exhibited moderate to severe distractibility and perseverations, which effected communication and formal testing.

Administration of the RCBA was terminated due to the client's excessive distractibility, probably due to fatigue.

V. CONCLUSIONS AND RECOMMENDATIONS

Mr. ██████ presents with some aphasia-like behaviors as well as memory and attention deficits. These behaviors include moderate to severe anomia, circumlocutions, perseveration, and latency, as well as mild literal paraphasias and auditory comprehension. Mr. ██████'s scores on the Western Aphasia Battery are consistent with the classification of Anomic Aphasia. He is also distracted by auditory and visual input. Prognosis for Mr. ██████ is fair with continued therapy.

Due to the communication deficits stated above and progress noted in past therapy, it is recommended that Mr. [REDACTED] continue speech and language therapy.

The following recommendations are suggested:

1. Improve orientation by answering questions regarding place and time.
2. Improve short term memory by recalling recent events.
3. Improve attention by attending to a task for more than 15 minutes.
4. Improve reading comprehension by reading single words and matching them to pictures.
5. Improve naming ability by labeling common objects.

[REDACTED]
Student Evaluator

[REDACTED]
MA CCC - SLP
Diagnostic Supervisor

The current system being used to identify diagnostic codes is International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), however there are too many options to list. Please see the page from ASHA to identify the correct code. Both the code number and name should be entered in the heading of the report.

<http://www.asha.org/Practice/reimbursement/coding/ICD-10/>

ICD-9-CM CODES

INTERNATIONAL CLASSIFICATION OF DISEASES, 9TH REVISION, CLINICAL MODIFICATION

CODE	CLASSIFICATION
307.0	Stammering and stuttering; excludes: dysphasia (784.5), lispings or lalling (307.9), retarded development of speech (307.9)
315.3	Developmental speech or language disorder
315.31	Developmental language disorder, developmental aphasia, word deafness. Excludes acquired aphasia (784.3), elective mutism (309.83, 313.0, 313.23)
315.39	Other developmental articulation disorder, dyslalia. Excludes: lispings and lalling (307.9); stammering and stuttering (307.0)
315.4	Coordination disorder, Clumsiness syndrome, Dyspraxia syndrome, Specific motor development disorder
315.5	Mixed developmental disorder
389.0	Conductive hearing loss
389.1	Sensorineural hearing loss, Perceptive hearing loss or deafness
389.2	Mixed conductive and sensorineural hearing loss
749.0	Cleft palate
749.1	Cleft lip
749.2	Cleft palate with cleft lip
784.3	Aphasia. Excludes developmental aphasia (315.31)
784.4	Voice disturbance
784.40	Voice disturbance, unspecified
784.41	Aphonia
784.49	Other; Change in voice, Hypernasality, Dysphonia, Hyponasality, Hoarseness
784.5	Other Speech Disturbance, Dysarthria, Slurred speech. Excludes stammering and stuttering (307.0) of nonorganic origin (307.0, 307.9)
784.6	Other symbolic dysfunction. Excludes: developmental learning delays (315.0-315.9)
784.60	Symbolic dysfunction, unspecified
784.61	Alexia and dyslexia, Alexia (with agraphia)
784.69	Other, Acalculia, Agraphia, NOS (Not Otherwise Specified), Agnosia, Apraxia

SPSI 568: DIAGNOSTIC METHODS: DIAGNOSTIC DISPOSITION AND REPORT LOG

When you have completed both forms below, return this sheet to the Clinic office. **DO NOT PLACE IT IN THE SECRETARY'S WORKBASKET.** Use the special basket provided for this purpose.

CLIENT REFERENCE	
CLIENT: <small>LAST NAME</small> _____ <small>FIRST NAME</small> _____	CLINICIAN: _____
FILE NO.: _____	EVALUATION DATE: _____
DISORDER: _____	

DIAGNOSTIC DISPOSITION	
ACTIVE	already receiving therapy in our clinic
PENDING ENROLLMENT	add to the waiting list for therapy in our clinic
PENDING RE-EVALUATION	to be re-evaluated in month _____ year _____
ALTERNATE FACILITY	therapy recommended through another facility (school, hospital, etc.)
INACTIVE	no therapy or re-evaluation indicated
OTHER	_____

DIAGNOSTIC REPORT LOG				
ITEM	DATE SUBMITTED	INITIALS	DATE RETURNED	INITIALS
DRAFT				
REVIEWED BY AUDIOLOGIST				
SECOND DRAFT				
THIRD DRAFT				
FOURTH DRAFT				
FIFTH DRAFT				
FINAL REPORT				

DIAGNOSTIC LETTER LOG				
ITEM	DATE SUBMITTED	INITIALS	DATE RETURNED	INITIALS
DRAFT OF LETTER				
SECOND DRAFT OF LETTER				
THIRD DRAFT OF LETTER				
LETTER READY FOR SIGNATURE				

FILING/MAILING LOG	
ITEM	DATE
COPY OF REPORT, ORIGINAL LETTER MAILED TO CLIENT/PARENT/GUARDIAN	
PROTOCOLS FILED AND LOGGED	
ORIGINAL REPORT, COPY OF LETTER, AND DISPOSITION SUBMITTED TO SECRETARY	

**Please check with your supervisor as to how they would like this form completed during the evaluation. Form is available in workroom drawers.

**Eastern Michigan University
College of Education Speech & Hearing Clinic
Diagnostic Performance Evaluation***

Student Clinician: _____ **Supervisor:** _____

Date of Eval: _____ **Total Score =** _____ **Grade =** _____
FACULTY COMPLETE (point total/number of items)
A=90-100%
B=89-80%
C=79-70%

A. Pre-Diagnostic Responsibilities

1. Reviews client history information. ASHA Standard IVE (1); Accomplished Practice III A

4	3.5	3	2.5	2	1.5	1	0	N/A
Thoroughly reviews client file prior to seminar and is sufficiently familiar with client file to lead discussion on case; able to identify pertinent information.		Reviews client file prior to meeting and is sufficiently familiar to discuss case with guidance from the supervisor.						
								Cursory or failure to review client file prior to seminar; needs detailed, specific guidance to identify relevant history.

2. Plans thoroughly for case including rationale for assessment procedure, form of reinforcement, sequence of assessment tools, alternative assessment choices, interview questions, etc. ASHA Standard IV E (1); Accomplished Practice III A, B, C, E

4	3.5	3	2.5	2	1.5	1	0	N/A
Independently generates rationale and sequences appropriate assessment battery, including formal and informal assessments. When applicable, plans for type and frequency of reinforcement. Skillfully develops interview questions that help define client's/family's needs.		With guidance, generates rationale and identifies primary formal and informal assessments and sequence of administration. When applicable, plans for type and frequency of reinforcement with some help. Independently develops some interview questions.						
								Needs extensive guidance to generate rationale and select and organize formal & informal assessment battery; requires considerable help to identify type and frequency of reinforcement. Needs extensive guidance developing interview questions.

3. Application of classroom knowledge. ASHA Standard IV E (1) Accomplished Practice III A-E

4	3.5	3	2.5	2	1.5	1	0	N/A
Demonstrates clear understanding of relevant theory and research applicable to client by choosing diagnostic procedures which are a logical outgrowth of understanding.		Demonstrates some understanding of relevant theory & research applicable to client; needs guidance applying information and choosing diagnostic procedures.						
								Demonstrates minimal understanding of relevant theory & research; generally does not apply information to diagnostic work.

B. Diagnostic Session

4. Uses time efficiently during interview and asks questions in a clear and organized manner. ASHA Standard IV; Accomplished Practice III B, IX A-C

4	3.5	3	2.5	2	1.5	1	0	N/A
Remains focused on interview topics while allowing for flexibility during family centered interviews; however, recognizes when client or interviewee demonstrate irrelevant digression. Follows outline, asking most relevant questions first. Deviates as necessary and returns to the outline. Probes for more information as necessary.		Requires occasional cues to remain focused on clinical issues. Recognizes irrelevant digression, but has some difficulty with redirection. Somewhat flexible during family centered interview. Follows outline but may deviate unnecessarily or have difficulty returning to outline. Inconsistently recognizes need to probe for more information as necessary.			Requires multiple cues related to interview topics. Questions presented in no apparent order and does not return to previous line of questioning when digressions occur. Is inflexible or has difficulty completing family centered interviews. Unaware of need to probe for additional information			

5. Uses appropriate interview techniques (e.g., open-ended questions, transitions statements, clarification of unclear statements, etc.), and obtains a clear statement of the problem. ASHA Standard IV E (1); Accomplished Practice III B, IX A-C

4	3.5	3	2.5	2	1.5	1	0	N/A
Uses skilled presentation of questions. Provides interviewee adequate time to respond. Recognizes when repetition or rephrasing is needed.		Majority of questions open-ended; some abrupt transitions. Recognizes when interviewee fails to comprehend, but may have some difficulty with rephrasing adequately. Shows some insecurity in the interview setting, which does not greatly interfere with interview.			Few open-ended questions; awkward transitions. Failure to recognize when interviewee does not comprehend questions and unable to adequately rephrase to facilitate understanding. Difficulty relating to client at an open/honest level. Obvious insecurity resulting in client's reluctance to share information.			

6. Uses time effectively to establish rapport in informal warm-up tasks prior to testing and puts individual(s) at ease. ASHA Standard IV E (1); Accomplished Practice III B & C, IX A-C

4	3.5	3	2.5	2	1.5	1	0	N/A
Approaches individual(s) in facilitating manner; establishes a positive rapport. Relates to individual with openness and warmth. Shows self-confidence and preparedness to create atmosphere of trust.		Warm-up activities beneficial but were too short or too long to effectively/efficiently establish rapport; interactions generally facilitative. Generally relates to client with openness and concern.			Uncomfortable with some clients. Difficulty engaging clients. Needs direction in establishing rapport.			

7. Adequately administers assessment tools and judges responses so as to make decisions according to recommended procedures. ASHA Standard IVE (1); Accomplished Practice III A-E

4	3.5	3	2.5	2	1.5	1	0	N/A
Secures all necessary diagnostic manuals and materials prior to start of evaluation; administration of tests reflects advanced preparation and complete understanding. Accurately judges client responses; obtains basal and ceiling, as appropriate; follows test procedures for prompts and adaptations; provides neutral feedback.		Requires some reminders to obtain necessary diagnostic materials. Needs some general cues related to assessment procedures, reflecting adequate preparation but incomplete understanding. Requires some assistance to judge client responses and determine basal and ceiling; inconsistently follows test procedures for prompts and adaptations; some inappropriate feedback provided.			Unaware of some necessary diagnostic materials until specifically told; lacks skill in administration of some diagnostic tools, reflecting poor preparation and understanding. Frequently needs assistance to accurately judge and document response; provides inappropriate prompts, feedback and/or adaptations.			

8. Adequately completes informal assessments by skillfully observing client behaviors, interviewing caregiver and making necessary changes to complete developmental and/or functional assessments. ASHA Standard IV E (1); Accomplished Practice III B-E

4	3.5	3	2.5	2	1.5	1	0	N/A
Recognizes, describes and documents all comm. behaviors; uses a variety of strategies with caregivers to gather thorough information re. client's comm. within a variety of settings; skillfully uses alternative techniques when needed.		Needs guidance to recognize, describe and/or document comm. behaviors; uses some strategies with caregivers to gain information re. client's comm. in various settings; uses some alternative techniques or needs guidance to be successful.			Limited ability to recognize, describe and/or document comm. behaviors; limited use of interview strategies with caregivers; gains minimal information re. client's comm. in various settings; limited or no use of alternative techniques.			

9. Shapes and manages client behavior. ASHA Standard IVE (1) (2) & IVE(2); Accomplished Practice II B; III B, C, E; IV A, C

4	3.5	3	2.5	2	1.5	1	0	N/A
Demonstrates awareness of factors affecting client's performance such as motivation or comprehension of specific tasks. Maximizes client's performance through effective presentation of stimuli or reinforcement strategies.		Some awareness of factors affecting client's performance. Able to manage with some general suggestions from the supervisor.			Minimal awareness of factors influencing client's performance; unable to manage following specific suggestions from the supervisor.			

Comments:

10. Chooses appropriate materials and supplemental activities; arranges environment appropriate to client's needs and interest level to enhance attention and participation with the evaluation process. ASHA Standard IVE (1) (2) & IVE (2); Accomplished Practice II B; III B, C, E; IV A, C

4	3.5	3	2.5	2	1.5	1	0	N/A
Demonstrates skill and creativity in choosing materials and supplemental activities; arranges environment and selects interest appropriate materials; uses supportive strategies to help client remain focused and cooperative throughout the process.		Some skill and creativity in choosing appropriate materials and supplemental activities; environment is uncomfortable for client; some interest appropriate materials; with guidance or reminders uses strategies.			Materials and supplemental activities are lacking in: skill, appropriateness, creativity, quantity, and/or appropriate interest level; environment is uncomfortable for client; rarely uses supportive strategies.			

Comments:

11. Accurately scores formal and informal assessment tools. ASHA Standard IV E (1); Accomplished Practice IIID.

4	3.5	3	2.5	2	1.5	1	0	N/A
Accurately assigns numerical scores to client responses; calculates raw scores and other derived scores without error. Uses appropriate phonetic and linguistic transcriptions.		Minor problems of assigning numerical scores to client responses, calculating raw scores or other derived scores, and/or completing phonetic and linguistic transcriptions. Errors do not affect overall interpretation of test results.			Significant errors in assigning numerical scores to client responses, obtaining raw scores or other derived scores, and/or completing phonetic and linguistic transcriptions. Errors lead to inaccurate interpretation of test results.			

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12. Accurately formulates impressions and recommendations. ASHA Standard IV E (1);_Accomplished Practice IIIA-E, VIIA & B, IX C

4	3.5	3	2.5	2	1.5	1	0	N/A
Accurate and insightful interpretation of assessment results, client behaviors & observations to determine nature and extent of communication problem; generates appropriate, specific recommendations to address problem.		Needs general guidance to interpret diagnostic data and client behaviors to describe communication problem; generates some general recommendations, but unable to elaborate.				Unable to interpret diagnostic data or client behaviors, but could grasp their meaning when explained. Requires considerable help to generate recommendations.		

13. Presents feedback to client or caregivers clearly and thoroughly. ASHA Standard IVE (1), III F, III I; Accomplished Practice III A-E, VIIA & B, IX A-C

4	3.5	3	2.5	2	1.5	1	0	N/A
Uses appropriate terms free from jargon and provides examples to present accurate and comprehensive interpretation of diagnostic results to client/others; comprehends and alters explanation as necessary.		Describes majority of diagnostic findings; aware of need for clarification but demonstrates difficulty altering explanation and/or using terms free from jargon to facilitate comprehension.				Describes only most significant findings. Demonstrates difficulty using terms free from jargon, elaborating or generating examples; failure to recognize need for further explanation.		

C. Report Writing

14. Uses correct format, grammar, spelling, terminology, punctuation, etc. Follows guidelines for report writing and produces a professional product. ASHA Standard IIIA, IVE (3) III F; Accomplished Practice VIIA-B, IX C, VII A-B, IX C

4	3.5	3	2.5	2	1.5	1	0	N/A
Adheres carefully to clinic guidelines re: report format or adapts guidelines to individual cases as appropriate. Few, if any errors in spelling, grammar, punctuation, etc. (i.e., careful & consistent proof reading.)		Minor problems with report format or adaptation to individual cases; occasional minor errors in spelling, grammar, or punctuation, etc. (i.e., inconsistent proof reading)				Significant problems with report format or adaptation to individual cases; frequent errors in spelling, grammar, or punctuation, etc. (i.e., no evidence of proof reading)		

15. Writes relevant case history in concise, organized form. ASHA Standard IIIA, IVE (3) III F; Accomplished Practice VIIA-B, IX C, VII A-B, IX C

4	3.5	3	2.5	2	1.5	1	0	N/A
Skillful writing of case history that is comprehensive and well-organized.		Case history is generally well written, but may omit relevant facts or include irrelevant facts; minor problems with organization.				Case history omits or distorts facts; lacks organization.		

16. Accurately and concisely describes results of tests and informal procedures and covers all relevant information and areas including client strengths. Writes in lay-person terms, using examples to clarify. ASHA Standard IVE (1), IIIIF, III I; Accomplished Practice III A-E, VIIA & B, IX A-C

4	3.5	3	2.5	2	1.5	1	0	N
Skillfully integrates assessment data, observation of client behaviors, and available information into clear concise & comprehensive description of client's performance. Skillfully and appropriately uses lay terms & examples to describe evaluation results.		Requires general suggestions and examples to clarify, include, or delete information to generate an accurate and comprehensive report. Provides some appropriate examples and clarifications using lay terms to describe evaluation results.						Does not produce adequate report even after specific suggestions for revisions. Fails to provide sufficient or appropriate examples or use lay terms to describe evaluation results.

17. Provides an accurate summary of impressions and recommendations. ASHA Standard IVE (1), IIIIF, III I; Accomplished Practice III A-E, VIIA & B, IX A-C

4	3.5	3	2.5	2	1.5	1	0	N/A
Skillfully and concisely summarizes client's communication problem including strengths and weaknesses; provides comprehensive and detailed recommendations that address specific communication problems. Comments:		Incorporates general suggestions to generate concise and accurate summary of client's communication problems; recommendations may require some revisions for clarity and specificity.						Requires specific suggestions and examples for producing accurate summary of client's communication problems and for generating appropriate recommendations.

18. Generates reports in an acceptable time frame and revisions reflect supervisory feedback. ASHA Standard IVE (3), IIIA; Accomplished Practice VIIA & B, IX C

4	3.5	3	2.5	2	1.5	1	0	N/A
Rough drafts and completed reports always turned in on or before due date. No more than two drafts required before completion.		Turns in rough draftss and completed reports on or day after due date. Occasionally requires three or more drafts prior to finished report. Drafts occasionally do not reflect use of previous recommendations.						Rough drafts and completed reports consistently turned in late without sufficient reason. Frequently require four or more drafts. Drafts consistently do not reflect use of previous recommendations.

D. Professionalism ASHA Standard III F, III A; Accomplished Practice VII A-B, IX A

Professionalism is expected throughout the practicum experience. Your grade will be lowered by one letter due to a lack of professionalism demonstrated in any of the following areas:

- _____ Attendance and punctuality
- _____ Projects a professional appearance
- _____ Modifies and generalizes own behavior based on supervisors feedback and/or demonstration
- _____ Adheres to professional ethical standards
- _____ Team collaboration

**Summary of Diagnostic Lab Profile
Score**

- A. Pre-Diagnostic Responsibilities _____
- B. Diagnostic Session _____
- C. Report Writing _____
- D. Professionalism _____

Comments: _____
