Section VIII: Documentation Templates

All documentation should be Calibri font, size 12.
The University of Texas at El Paso
Speech-Language Pathology Program
Speech-Language and Hearing Clinic

SOAP NOTE #

Client Name: Initials only  Semester:
Chronological Age:  Date:
Parameter:  ICD-10:
Graduate Student:  Supervisor:
Time: (Start and End Time)

Single Subject Design:

S:
Subjective information
Report if anyone accompanied the client
May include the client’s behavior prior to entering the treatment session
May include any relevant client and caregiver report: updated health/medical information, events that may affect
the client’s behavior, etc.

O:
Objective information
All of the data
Descriptive and relevant client behavior
Must include the goal/s targeted during the session.
LTG#
STG#
A. Antecedent- What the graduate student did to elicit a response
B. Behavior-What the client did
C. Consequence-What happened if the client did or did not provide a correct response
Graphs
Clinical Notes/Observations

A:
Qualitative Assessment
Clinical judgement
Patterns
Comparisons

P:
The plan for the next session --Must include goals

References
Include all assessments/protocols
Evidence to support assessment and treatment

____________________________  ______________________________________
Name  Supervisor Name, MA/MS/PhD, CCC-SLP
Graduate Student  Clinical Supervisor, Texas License Number
INITIAL SPEECH/LANGUAGE EVALUATION

Name: (Use initials until the clinical supervisor approves the report)
Address:
Telephone:
Email:
Date of birth:
Chronological age:
Parent’s/caregiver’s name:
Referral:

Date of evaluation:

Diagnosis:
  Diagnostic Category
  ICD-10 Code
  CPT Code

Case History:
Include the following: Current level of functioning, referral source, reason for evaluation, plus relevant background and medical information, and forms of assessment used

Hearing Screening:
Reason for screening, standards used, results. Is further evaluation necessary?

Oral Facial Mechanism Exam:
Reason for exam, forms of assessment used, results, interpretation, and may also include DDK

Feeding/Swallowing: (If Applicable)
Reason for evaluation, forms of evaluation, results, interpretation

SPEECH:
Articulation:
Reason for evaluation, forms of evaluation, results (Standard Scores if available), and interpretation

Voice:
Reason for evaluation, forms of evaluation, results, and interpretation

Fluency:
Reason for evaluation, forms of evaluation, results, interpretation

LANGUAGE:
Expressive Language:
Reason for evaluation, forms of evaluation, results (Standard Scores if available) and interpretation

Receptive Language:
Reason for evaluation, forms of evaluation, results (Standard Scores if available) and interpretation
Summary:
Summarize the results and interpretations, clinical assessment, and diagnosis

Recommendations/Treatment Plan:
Recommended treatment approach, recommended treatment schedule, and referrals

Prognosis:
Include with and without intervention. Include any positive or negative prognostic indicators.

References
Include all assessments/protocols
Evidence to support assessment and treatment

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Name  
Graduate student  

Supervisor Name, MA/MS/PhD, CCC-SLP  
Clinical Supervisor, Texas License Number
RE-EVALUATION

Name:  (Use initials until the clinical supervisor approves the report)
Address:
Telephone:
Email:
Date of birth:
Chronological age:
Parent’s/caregiver name:
Referral:

Date of evaluation:

Diagnosis:
  Diagnostic Category
  ICD-10 Code
  CPT Code

Case History:
Brief current level of functioning, reason for re-evaluation, therapy data review, plus relevant updated background and medical information

Hearing Screening:  (if applicable)
Reason for screening, standards used, and results.  Is further evaluation necessary?

Oral Facial Mechanism Exam:  (if applicable)
Reason for exam, forms of assessment used, results, interpretation, and may also include DDK

Feeding/Swallowing:  (If Applicable)
Reason for evaluation, forms of evaluation, results, interpretation

SPEECH:
  Articulation:
  Reason for evaluation, forms of evaluation, results (Standard Scores if available), and interpretation

Voice:
  Reason for evaluation, forms of evaluation, results, and interpretation

Fluency:
  Reason for evaluation, forms of evaluation, results, interpretation

LANGUAGE:
  Expressive Language:
  Reason for evaluation, forms of evaluation, results (Standard Scores if available) and interpretation

Receptive Language:
  Reason for evaluation, forms of evaluation, results (Standard Scores if available) and interpretation
Summary:
Summarize the results and interpretations, clinical assessment, and diagnosis

Recommendations/Treatment Plan:
Recommended treatment approach, recommended treatment schedule, and referrals

Prognosis:
Include with and without intervention. Include any positive or negative prognostic indicators.

References
Include all assessments/protocols
Evidence to support assessment and treatment

____________________________
Name
Graduate student

____________________________________
Supervisor Name, MA/MS/PhD, CCC-SLP
Clinical Supervisor, Texas License Number
ICD-10 (International Classification of Diseases) DIAGNOSIS CODES (updated 12/2016)

F98.5 Adult onset fluency disorder
F63.3 Trichotillomania
R45.1 Restlessness and agitation
F81.0 Specific reading disorder
F80.1 Expressive language disorder
F80.2 Mixed receptive-expressive language disorder
H93.25 Central auditory processing disorder
F80.4 Speech and language development delay due to hearing loss
F80.81 Childhood onset fluency disorder
F80.0 Phonological disorder
F80.82 Social pragmatic communication disorder
F80.89 Other developmental disorders of speech and language
H90.5 Unspecified sensorineural hearing Loss
I69.923 Fluency disorder following Unspecified cerebrovascular disease
R47.01 Aphasia

CPT (Current Procedural Terminology) CODES

Evaluation of speech fluency 92521
Evaluation of speech sound production 92522
Evaluation of speech sound production with evaluation of language comprehension and expression 92523
Behavioral and qualitative analysis of voice and resonance 92524
Individual Speech Therapy 92527
Group Speech Therapy 92508
DIAGNOSTIC PLAN

Name: (Use initials until the clinical supervisor approves the report)
Address:
Telephone:
Email:
Date of Birth:
Chronological age:
Parent’s/caregiver name:
Referral:
Medical Diagnosis: (if applicable)

Date of evaluation:
Graduate Student/s:
Supervisor:

Case History:
Forms of assessment/protocols

Hearing Screening:
Reason for screening and standards to be used

Oral Facial Mechanism Exam:
Reason for exam, forms of assessment used

Feeding/Swallowing:
Reason for exam, forms of assessment used

SPEECH:
Articulation:
Reason for exam, forms of assessment used

Voice:
Reason for exam, forms of assessment used

Fluency:
Reason for exam, forms of assessment used

LANGUAGE:
Receptive Language:
Reason for exam, forms of assessment used

Expressive Language:
Reason for exam, forms of assessment used

Pragmatics:
Reason for exam, forms of assessment used
Include all assessments/protocols
Evidence to support assessment and treatment

Name, BA/BS
Graduate Student

Supervisor’s Name, MA/MS/Ph.D., CCC-SLP
Clinical Supervisor, Texas License Number

Name, BA/BS
Graduate Student
TREATMENT PLAN

Client Name: Initials only  Semester:
Chronological Age:  Date:
Parameter:  ICD-10:
Graduate Student:
Supervisor:

Case History:
Include the following: Current level of functioning, referral source, reason for evaluation, relevant background and medical information, and forms of assessment used

Plan/Rationale:
Evidence based practice, Rationale for selected design and treatment approach, and additional data to support rationale

Single Subject Design:

Goals:
LTG1:
A:
B:
C:
STG1:
A:
B:
C:
STG2:
A:
B:
C:

References
Include all assessments/protocols
Evidence to support assessment and treatment

__________________________________________________________
Name
Graduate Student

____________________________
Supervisor Name, MA/MS/PhD, CCC-SLP
Clinical Supervisor, Texas License Number
DISCHARGE SUMMARY

Client Name: Initials only  Semester:
Chronological Age:  Date:
Parameter:  Graduate Student:
ICD-10:  Supervisor:

Case History:
Brief current level of functioning, relevant updated background and medical information

Progress to date:
Therapy data review to date- To include graphs, goals met/unmet and data/percentages, must justify reason for discharge

Recommendations:
Recommendations post treatment; for example, re-evaluation, home program, etc.

References
Include all assessments/protocols
Evidence to support assessment and treatment

____________________________________
Name  Supervisor Name, MA/MS/PhD, CCC-SLP
Graduate Student  Clinical Supervisor, Texas License Number