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Initial/Final Case Report
Fall 2019

Note: All Italicized text must be deleted prior to submission.

Client Name: *Initials only until final draft*
Date of Birth: *Leave this blank until final draft*
Age: *Include the age in all drafts*

File#: *Leave this blank until final draft*
Date of Report: *The last day you saw client*

Parents: *Initials only until final draft*
Address: *Leave this blank until final draft*

Phone: *Leave this blank until final draft*

Graduate Clinician: *Include name and degree (e.g., M.A. or Ph.D., CCC-SLP)*
Clinical Instructor: *Include name and degree (e.g., Barbara Smith, MS CCC-SLP)*

Diagnosis:

REFERRAL AND COMMUNICATION CONCERNS

One to two sentences describing the date of referral, referral source, why the client was referred, and primary communication concerns.

PERTINENT HISTORY

Here, you want to discuss relevant history including remarkable (atypical) medical history (e.g., pregnancy and birth complications, illnesses or accidents, delays in motor development that might contribute to speech and language impairment or feeding/swallowing concerns), vision/hearing concerns or previous failed testing, or any genetic based disorder or relevant medical diagnoses. Relevant information about employment/education, family, social or behavioral areas can be included.

Speech and Language History: *Describe atypical speech and language development, as well as any pertinent parental report. Also include any previous SLP report information not otherwise reported by parents. Include a summary of goals and progress from previous semester, and/or IEP, clinic or other services, as applicable. Clearly summarize which goals were met/not achieved; if all were met or not achieved, state in one sentence.*

ASSESSMENT & OBSERVATIONS

Initial Observations: *Here, provide a brief description of what you observed on the first day you met the client, based on your impressions from your first interaction with him/her. Describe how the client presented, any behaviors observed that are pertinent to the testing that you did. Describe pertinent details that might have impacted test reliability and validity.*

Hearing:

Include thresholds, dB assessed (right and left), location tested (i.e., in the clinic room), results and interpretation. ***Do not state*** *that hearing is "within normal limits" unless you tested thresholds. Therefore, your interpretation of a hearing screening is either that they passed, or they need to be referred for follow-up. Perhaps state that the "client passed the hearing screening, indicating that a referral for further evaluation is not indicated at this time". For aural rehabilitation clients, add a summary of aural rehabilitation therapy/services if related to the domain of hearing.*

Speech:

Articulation/Phonology: *In this articulation/phonology section, report results of such things as standardized test scores for articulation/phonology, PCC in a sentence-repetition task or conversational sample, and intelligibility. An error analysis of results can follow – report any error patterns observed. If evaluating a client who receives accent modification, write in the results of the vowel and consonant productions from the POEC here.*

Rate of Speech/Prosody: *Include here for accent modification clients. Delete for all other clients and include in informal language assessment if you collected information.*

Voice/Fluency: *Jitter, shimmer, Fo, other parameters as appropriate, or state WNL as measured by conversational speech sample. Consider fluency relative to a native English speaker if considering results for a bilingual client. Describe %, type, nature and duration of dysfluencies, SSI results, etc. or state WNL as measured by conversational speech sample.*

Oral Mechanism: *If results are within normal limits, then state WNL. If results are abnormal, then provide a description of oral structure/function areas assessed and concerns. Include results of diadochokinetic test. Provide an interpretation of what the results mean in terms of the client's primary speech/language diagnosis. This section doesn't need to be long/exhaustive, but enough to provide the reader with the knowledge that you did your due diligence and evaluated the oral structure and function. If you did not test (for example, with an accent modification client), simply state, "was not administered during this evaluation."*

Interpretation: *In considering the client's speech, what is the individual's diagnosis? What do the results above MEAN?*

Language:

Informal Language Assessment: *Results of conversational language sample: MLU, type-token ratio, number of different words, mean babbling level (for young children), and other results, as applicable. Early book knowledge, print awareness, book orientation. Description of informal evaluation of pragmatics; results of checklists and parent questionnaires. Remember to consider four systems of language (i.e., morphology, syntax, pragmatics, semantics). If assessing a client who is receiving accent modification assessment, write in the language testing results from the POEC here.*

Formal Language Assessments: *Results of standardized testing for language. Use tables. Can include formal tests of phonological awareness. Remember to consider four systems of language (i.e., morphology, syntax, pragmatics, semantics). Aural rehabilitation summary can be presented here if considered to be in the area of formal language measure. You might*

not complete formal language assessments in the Speech I clinic – if so, you can simply say that a standardized language assessment was not administered.

Aural Re/habilitation and Auditory Processing:
Formal results of testing for aural rehabilitation or auditory processing should be written here unless it is appropriate to include in the sections on speech or language above. Delete this section for the Speech I clinic.

Interpretation:

ASSESSMENT SUMMARY: *2-3 sentence statement of what is within normal limits and what is indicative of a disorder/delay as a result of the assessment – speech sound disorder, mixed expressive-receptive language disorder, etc. Think of this as the part that the physician or insurance company reads!*

TREATMENT PLAN:

Here, I might say something like "in light of the current evaluation, the following intervention plan was developed"…Below, include a description of goals, baselines and methods. Ensure that goals are specific, measurable, attainable, results-oriented and time bound. Include a date for when the goal should be achieved (last day of treatment). For baseline and final data, include the date(s) that the data were collected, and include the level of support used in the baseline. Remember the measuring context of "as measured by clinician data" is not a measuring context that can be repeated. Instead, list a specific task (e.g., production following 10 word-initial probe word picture cards). Pretend that another clinician has to determine when the goal is achieved, make it clear in your goal what the context is.

Long-term Goal(s): *Here, describe the long-term goal(s) for the client. These are goal(s) set to be achieved in about one year, and identify the overall purpose for receiving speech and language therapy. Long term goal(s) are our projected final outcome we hope to help the client achieve.*

Semester Goal 1: *The client will exhibit the ability to X (independently/with support/prompting) with X% accuracy in X context as measured by X (describe baseline procedure) by (last session date).*

Baseline data: *X/XX (%) (date of data collection) Doesn't necessarily need to be % correct, could be number of productions or whatever unit of measurement is appropriate.*

Final data: *X/XX (%) (date of data collection)*

GOAL ACHIEVED/GOAL NOT ACHIEVED *(pick one for FCR)*

Example:

Semester Goal 1: *By December 10th, 2015, MG will independently produce /f/ and /s/ in the initial position of words with 80% accuracy as measured by a 20-item structured probe word task.*

Baseline: *word-initial /f/ - 0/10 (0%) (09/16/15)*
word-initial /s/ - 1/10 (10%) (09/16/15)
Final data: *TBD*

Methods: *Start with a brief description of how you collected the baseline (e.g., Baseline data for the goal were collected through a structured probe task. Ten words containing word-initial /f/ and ten words containing word-initial /s/ were selected. Each word was presented on a card with a corresponding picture. MG was presented with the card and was*

required to say the word in response to picture and the clinician prompt of "What's this". Target /f/ and /s/ phonemes were scored as correct if they were unquestionably correct).

For the methods, give a description of the methods used to target the goal. Give a reference for the treatment approach(es) used. Include information about the stimulus items, reinforcement for goal-directed and social behavior. Include a description of the treatment hierarchy used for each goal. If the same methods were used for all 3-4 goals, then the goals can be listed with one methods section written at the bottom. This is fairly common for the Speech I clinic!

Semester Goal 1: *Semester Goal 2:* *Semester Goal 3:* *Methods:*

<u>Semester Goal 2:</u> The client will exhibit the ability to X (independently/with support/prompting) with X% accuracy in X context as measured by X (describe baseline procedure) by (last session date).

Baseline*:* *X/XX (%) (date of data collection)*
Final data: *X/XX (%) (date of data collection)*

GOAL ACHIEVED/GOAL NOT ACHIEVED

Methods:

<u>Semester Goal 3:</u> *The client will exhibit the ability to X (independently/with support/prompting) with X% accuracy in X context as measured by X (describe baseline procedure) by (last session date).*

Baseline: *X/XX (%) (date of data collection)*
Final data: *X/XX (%) (date of data collection)*

GOAL ACHIEVED/GOAL NOT ACHIEVED

****END HERE FOR ICR****

(Please note that the presence/absence of baseline data and the quality of your baseline data will be graded on the ICR – see rubric. Please collaborate with your CI to ensure you can secure baseline data for your selected/anticipated goals in time for the in-class ICR deadline).

SUMMARY OF PROGRESS

One short paragraph for each goal explaining factors that lead to the goal being achieved or not achieved.
One-two short paragraphs describing behavior/motivational and/or other factors contributing to progress on goals.
One short paragraph describing areas of relative strength and areas of relative weakness that presented at the end of the therapy block.

DIAGNOSTIC STATEMENT AND PROGNOSIS

Start this section by stating who the client is, why they were referred and the referral source. State medical diagnoses, speech-language diagnoses and concerns. Give a short summary of the conclusions of the assessment (1 sentence). Include one short paragraph stating the diagnoses. Include one short paragraph stating the functional impact of communication concern and the

prognosis, including positive prognostic indicators. Include a summary of barriers and supports to improving speech and language skills.

RECOMMENDATIONS

Describe intervention recommended, and the clinic recommended to participate in (e.g., Language 1 Methods), recommend specific goals to start with – list sound(s) to target, word positions, grammatical markers to improve, specific language structures, specify homework/home program. Recommend any follow-up referrals to professionals/allied health, etc.

Include one final sentence thanking the client, indicating that we liked working with him/her (or something like that), wishing the client the best, etc. followed by something like "please contact the MRLSHC for questions related to this report."

____
Student Name, B.S.
Graduate Clinician

____
CI Name, degree (e.g., M.A. or Ph.D.), CCC-SLP
Clinical Instructor
CA License #: SPXXXX

CC: *parent, file, and any others who are receiving the report as signed on the release form.*

Notes on formatting **(delete prior to handing in)***:*

- ***Use this template to complete your report***
- ***Fonts:*** *Please use* ***Garamond*** *as this is a Sac State authorized font.*
- ***Footer:*** *You must have a footer which indicates* ***STUDENT REPORT*** *(centered at the bottom of the page).*
- ***Header:*** *You must have a header which indicates File # and page x of y (right alignment). Do not include file name on report until final draft is ready to be signed. No hanging headers.*
- ***Margins:***
  - *Left and top @ 1"*
  - *Right @ 0.7"*
  - *Bottom @ 0.5"*
- *Maximum length: 10 pages. Remember to present the results effectively and efficiently using an economy of words.*
- *Underline all test names. Spell out initially, then use an acronym throughout the report. Subtest names do not require underlining or italics*
- *Refer to clinic handbook for rules on reporting ages of clients*
- *Spell out dates e.g., November 17th, 2015*
- *Remember HIPAA – no personal information including dates of birth (ages are ok), full names (use initials), parent's last names, addresses, or other protected health information.*

- ***Having difficulty and need help in writing? Come see your methods or clinical instructors during office hours. There are also a number of resources on campus for support:***

1. http://www.csus.edu/parc/
2. http://www.csus.edu/writingcenter/