Maryjane Rees Center: Speech and Language Clinic
Required Documentation

At a minimum, Student Clinicians are responsible for writing Weekly Lesson Plan or SOAPS notes at the discretion of the Clinical Instructor, an Initial Case Report (ICR) and a Final Case Report (FCR).

WRITTEN REPORTS

As we transition to using CounselEAR for all medical records, reports will be uploaded to that platform. You will receive specific instructions and guidelines regarding professional report writing from your clinical methods course professors and your Clinical Instructors.

Final case reports should state the client's Long Term Goal(s) in addition to the Short Term Goals established for each semester.

Weekly lesson plans can be kept in the lesson plan folders in the CI observation room or on MS teams, and should be de-identified.

REPORT FORMATTING

Report formats will be provided to you by your clinical methods course instructor. Please use the following standard heading for ALL printed Initial Case Reports, Final Case Reports, and Assessment Reports: (NOTE: Headings are not to stand alone as a title page)

Report formatting for Discharge Summaries are at the discretion of your Clinical Instructors.

SACRAMENTO STATE

Maryjane Rees Language, Speech and Hearing Center
Department of Communication Sciences and Disorders California State University, Sacramento

6000 J Street MS 6601

Sacramento, CA 95819

916-278-6601

Initial Case/Final Case/Assessment Report Spring/Fall Semester (year)

Client Name: **File#:**

Date of Birth: **Date of Report:**

Age:

Parents:

Address:

Phone:

Graduate Clinician:

Clinical Instructor:

Diagnosis: ***Speech and Language Diagnoses only (<u>please include severity levels</u>)**

***If SSD, please indicate SSD characterized by articulation errors or phonological deficits, whichever applies**

***Please include ASD diagnosis if applies**

***If aphasic, please indicate fluent vs. non-fluent aphasia with severity level**

***If treating cognitive deficits, please indicate cognitive deficits secondary to TBI, etc.**

- **Fonts:** Please use **Garamond** as this is a Sac State authorized font.

- **Reporting ages:** Please report the ages of clients in the following manner depending on the sentence structure:
  - 4 years, 9 months of age
  - 4-year, 9-month-old
  - 4;9-year-old

- In the heading next to Age, it is acceptable to simply report 4;9

- **Footer:** You must have a footer which indicates **STUDENT REPORT** (centered) on each page, including first page.

- **Header:** You must have a header which indicates File # and page x of y (right alignment). ***Headers are not to appear on the first page of the report.***

- **Margins:**
  - Left and top @ 1"
  - Right @ 0.7"
  - Bottom @ 0.5"

CHART NOTES

- Students are expected to keep a daily record of therapy sessions for each client. Chart notes are in counselEAR. They document the number of minutes your worked with the client and what skills you targeted.

- This form will also serve as an attendance record. If the client did not show and did not call, Student Clinicians should record a "no show" for that session. The Student Clinician should indicate the reason if known or state "Unknown reason."

- The Student Clinician should indicate consistent client tardiness here, as well.

- Chart notes should be completed after each session.

- This is a part of the client's confidential file; chart notes are NOT permitted to leave the premises of the Clinic.

- At the end of the semester, you will print out chart notes for your Clinical Instructor to check clock hours submitted on Calipso.