**SPEECH-LANGUAGE PATHOLOGY PROGRESS REPORT**

Check one

**PROGRESS NOTE DISCHARGE NOTE TRANSFER NOTE**

X

Must provide contact information:

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| YOUR FACILITY NAME/LOCATION | Therapy Lab of OC |  |
| TREATING THERAPIST w/credentials, (CCC-SLP, SLPA, etc.) | Kristin Bruning M.S., SLP-CCC |  |
| PHONE NUMBER | 714-861-9595 |  |
| EMAIL | kristin@therapylabofoc.com |  |

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| **Patient Name:** |  |
| **Kaiser Medical Record Number:** |  |
| Birth date: |  |
| Age: |  |
| Date of report: |  |
| Authorization period dates: |  |
| Is the report being submitted after the auth has expired? | X  No Yes  If yes, please explain why the report is submitted after the end of the auth date: |
| Date of Evaluation and Re-evaluations: |  |
| Next reassessment due: |  |
| Date of initiation of KP initiated speech services: |  |
| **Dates of first and last appointments during this authorization period:** |  |
| Authorized frequency and length of treatment sessions during current treatment authorization: ­­­­­­ | Individual Therapy        time(s) a week for        minutes per session.  Group Therapy \_\_\_\_ time(s) a week for \_\_\_\_\_ minutes per session. |
| **Total number of sessions attended during this period to date:** | Total number of both in person and teletherapy sessions completed so far during this auth:  In person:  Teletherapy:  Teletherapy was chosen by vendor OR family  If there was a lapse in services or a late start, please explain why: |
| 1. Therapist cancellations |  |
| 1. Family Cancellations |  |
| Name(s) of other involved SLP and/or SLPAs: | Kristin Bruning, SLP, Leah Buckler, SLPA, and Summer Carranza, SLPA |
| Techniques and therapies used: | Visual and verbal supports |
| Diagnosis (ICD-10 Code and description—these are provided to you upon referral. Do not add new ones without prior approval): Check one  \_\_\_\_\_ 80.9 Developmental Speech and Language Disorder  \_\_\_X\_ 84.0 Autism Spectrum Disorder | |
| Speech Language Diagnosis: | |

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| Current caregiver concerns related to speech and language development: |
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**CURRENT SLP GOALS**

List **current goals**, **baseline function** (from initial evaluation or from start of goal), and **current function** (as of the last visit) as related to each goal.***All goals should be functional communication goals***. Include **measurable baseline** (percentage, frequency, average) across time. **If goal is not met, please note if the goal will be continued.**

**If goals are met within the proposed treatment plan, please increase complexity to within age and/or developmentally appropriate levels to continue to address any areas of concern.**

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| Sample Goal | Goal: | In 6 months, patient will use 50 words to communicate wants and needs with familiar listeners with 80% accuracy. |
| Baseline: | 1/2020-Patient uses 5 words independently and imitates 10 additional words. |
| Current: | 6/2020-Patient uses 20 single words independently 80% of the time to express his wants and needs. |
|  | Progress: | Goal not met, continue goal. |

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| 1. | **Goal:** |  |
| **Baseline:** |  |
| **Current:** |  |
|  | **Progress:** |  |

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| 2. | **Goal:** |  |
| **Baseline:** |  |
| **Current:** |  |
|  | **Progress:** |  |

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| 3. | **Goal:** |  |
| **Baseline:** |  |
| **Current:** |  |
|  | **Progress:** |  |

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| 4. | **Goal:** |  |
| **Baseline:** |  |
| **Current:** |  |
|  | **Progress:** |  |

***Please note: If a goal is continued, please document in current level across time to track change. Please continue this process until goal is achieved allowing easy tracking of progress.***

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| **Behavioral Observations:** | Working for and first then token support systems are used for compliance and task completion. |

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| **Percent of intelligible speech to a familiar AND unfamiliar listener in an UNKNOWN context (no ranges, please)** | **%** |
| **IMPRESSION AND JUSTIFICATION OF RECOMMENDATION:** | Progress is good for stated goals. Functional language skills and gains have been made. MLU has increased. Joint attention and eye contact has increased. Following directions have increased. Vocabulary have increase.  Progress did not occur; However, we will introduce AAC and/or reach out to ABA to consult.  The performance on assessment(s) at this appointment(s) shows that there are areas of significant deficit; indicating that episodic MEDICALLY NECESSITATED speech and language intervention is warranted at this time. |
| **IF CONTINUING, KEY IMPAIRMENTS TO BE ADDRESSED:** | Receptive and expressive language skills. |

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| **HOME ACTIVITY PROGRAM:** |
| Specific home program activities: |
| Family participation (who, when, how often): |
| Is family able to demonstrate home program? |

**PROPOSED TREATMENT PLAN AND RECOMMENDATION**

List all goals. Goals must be SMART (specific, measurable, achievable, realistic and timely).

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| 1. | **Goal:** |  |
| **Baseline:** |  |
| **Current:** |  |
|  | **Progress:** |  |

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| 2. | **Goal:** |  |
| **Baseline:** |  |
| **Current:** |  |
|  | **Progress:** |  |

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| 3. | **Goal:** |  |
| **Baseline:** |  |
| **Current:** |  |
|  | **Progress:** |  |

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| 4. | **Goal:** |  |
| **Baseline:** |  |
| **Current:** |  |
|  | **Progress:** |  |

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|  | Speech language therapy services are not medically indicated. |
|  | Individual Therapy        time(s) a week for        minutes per session. |
|  | Group Therapy \_\_\_\_ time(s) a week for \_\_\_\_\_ minutes per session. |
|  | Is this recommendation a change in frequency or type of therapy from the previous authorization? (if continuing treatment, must check one) \_\_\_\_\_ Yes     \_\_\_\_\_\_ No  If there is a change in the frequency or type of therapy, please provide reason for change: |

**EPISODIC CARE REVIEW** (must check one)

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| X | Continue – patient progress and expectations for continued episodic care discussed with family. |
|  | Discharge – patient’s communication skills are functional. |
|  | Discharge – failure to make significant, functional progress over the course of treatment. Home program has been established with family. |
|  | Discharge-not able to participate in skilled therapy (e.g., attention, behavior, etc.). Plan to return to authorizing agency for review. |
|  | Discharge – from this facility due to vendor, reason for discharge is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (poor attendance, distance, copay, lack of vendor availability, etc.). Patient is returned to authorizing agency for review. |
|  | Discharge from this facility due to parent/patient request, reason for discharge is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Patient is returned to authorizing agency for review. |
|  | Transfer – patient continues to meet criteria for continued medical speech therapy, but current vendor can no longer provide therapy due to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Patient instructed to contact authorizing agency for assistance with new referral. Recommendations for continued services with new vendor are:  Individual Therapy        time(s) a week for        minutes per session.  Group Therapy \_\_\_\_ time(s) a week for \_\_\_\_\_ minutes per session. |

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| Other Treatment Plan:  \_\_\_ Request review for AAC readiness by KP SLP  \_\_\_ Refer to PCP for assessment for possible ABA  \_\_ Refer to PCP for possible multi-disciplinary team assessment; atypical behaviors noted:  \_\_\_ Other; refer to PCP: (include complaint, symptoms, specialty, service)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| Kristin Bruning, M.S., SLP-CCC | Kristin Bruning |
| Therapist Name | Therapist signature |
| [kristin@therapylabofoc.com](mailto:kristin@therapylabofoc.com) | 714-861-9595 |
| Therapist e-mail | Therapist phone number |