SPEECH & LANGUAGE EVALUATION
PROGRESS SUMMARY

Authorization Period: ______________ to ______________

PROGRESS SUMMARY/STATUS CHANGE
(Statement of effectiveness of therapeutic intervention)

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PROGRESS ON PREVIOUS LONG/SHORT TERM GOALS/PLAN OF CARE
☐ See attached
ATTENDANCE/ PARTICIPATION

Attendance during previous authorization period was:
☐ Good (>80%)  ☐ Fair (60-80%)  ☐ Poor (<60%)

If Fair or Poor, explain:
______________________________________________________________________________

☐ Unable to document/data not available. Why: ______________________________________

Patient participation/compliance during treatment sessions:
☐ Excellent  ☐ Good  ☐ Fair  ☐ Poor

Describe: _________________________________________________________________________
_________________________________________________________________________________

CAREGIVER TRAINING PROGRAM

Description of home program/caregiver training program implemented during previous authorization period:
_________________________________________________________________________________
_________________________________________________________________________________

Adherence to caregiver training/home exercise plan:
☐ Excellent  ☐ Good  ☐ Fair  ☐ Poor

Explain: _________________________________________________________________________
_________________________________________________________________________________

Skilled therapy services continue to be indicated to carryout plan of care because:
_________________________________________________________________________________
_________________________________________________________________________________

UPDATED THERAPEUTIC PROGNOSIS

☐ Excellent  ☐ Good  ☐ Fair  ☐ Poor

Given (mark all that apply):
☐ Responsiveness to therapeutic techniques
☐ Attendance and participation in therapy sessions
☐ Follow through with caregiver training program/home exercise program
☐ Stable medical status
☐ Met optimal functional potential
☐ Unstable medical condition
☐ Other: _________________________________________________________________________

Comments: _______________________________________________________________________
_________________________________________________________________________________

RECOMMENDATIONS

Recommendations are as follows:

☐ Continue with Speech Therapy:
  ☐ See Attached Plan of Care for Long Term Goals and Objectives

  Duration:  ☐ 6 Months
             ☐ 1 Year
             ☐ Other:

  Frequency: ___ times per week

  Time:  ☐ 30 Minutes per session
         ☐ 45-60 Minutes per session are medically necessary:

Reason: __________________________________________________________________________

☐ Continued therapy is not recommended at this time.

☐ Due to change in rehabilitative potential transition to consultative services/home maintenance program recommended.

☐ Therapy is not indicated at this time but a Re-Evaluation is recommended in 6 months.
Refer to:

- Developmental Pediatrician and/or Neurology
- Clinical Psychology Evaluation
- Applied Behavior Analysis
- Audiologist for:
- Physical Therapy
- Occupational Therapy
- Other: _______________________________________________________________________________

If you have any questions regarding this evaluation, please call Independent Living, Inc.- Pediatrics at (813) 963-6923.

Therapist Signature

______________________________

FL License #:

Supervisor Signature (if appropriate)

______________________________

FL License #:

Dear Physician,

If you agree with the treatment plan, please sign and date the report and mail/fax to Independent Living, Inc.- Pediatrics. Your signature will convert this report into a prescription.

______________________________

Physician Signature

______________________________

Date

Medipass Authorization Number (if applicable)