Rancho Los Amigos National Rehabilitation Center

Communication Disorders Department
Policy and Procedure

SUBJECT: INITIAL COMMUNICATION EVALUATION REPORT

PURPOSE

To ensure complete and accurate documentation of communication assessment results.

POLICY

All patients who receive a complete communication evaluation will have an initial evaluation report recorded in the Medical Record.

PROCEDURES

Documentation of the initial evaluation process will reflect clinically appropriate consideration of the following key components of assessment and treatment planning. Due to time limitations, some aspects of the assessment process may not be addressed in the initial note, but may be addressed in subsequent therapy sessions in the early part of the therapy program. When the patient is referred by a provider with access to the Electronic Medical Record, it is not required that the information be repeated if it is readily accessible to the reader.

1. <u>Data Gathering:</u>
   Includes:
   a. Pertinent identifying information including age, sex, race, ethnicity and linguistic/cultural characteristics.
   b. Reason for admission/referral
   c. Relevant medical diagnoses/current interventions and resulting communication disorder(s)
   d. Social support system(s)
   e. Safety issues/risks
   f. In addition to all the above information, the Pediatric Evaluation also includes developmental history i.e. either normal developmental history or reported pre-onset delays.

2. <u>Administration/Interpretation of Assessment Data</u>
   Includes:
   a. Assessment process leading to reported findings, including plan for assessment of hearing status
   b. Relevant client factors affecting outcome
   c. Identification of need for specialized tests/further assessment
   d. Interpretation of evaluation results including summary of current communication status

3. Treatment Planning/Intervention
   a. Short and Long-term treatment goals, developed in collaboration with client and/or caregiver
   b. Type of treatment, intensity, frequency, and duration of treatment (e.g., Language, cognitive/communicative and dysphagia treatment for 60 minutes, 6 times weekly for 2 weeks.
   c. Recommendations including strategies for facilitating communication and/or safety as well as referrals for other services.

4. Signature/License number of Speech/Language Pathologist
   a. Evaluation reports are electronically signed/finalized by a licensed speech/language pathologist with a certificate of clinical competence.
   b. Students and Clinical fellows save documentation and a qualified supervisor finalizes.

5. Physician Signature
   Evaluation is forwarded to referring provider for signature approving treatment plan.

Signature(s) on File.