matrix
The Primary Source for Home Care

Speech-Language Pathology Plan of Care

PHYSICIAN PLAN OF CARE - CHANGE AND ADDITIONAL ORDERS

Patient/Client Name: _____ Date: _____

Patient/Client Address: _____

Physician's Name: _____

Physician's Phone: _____ Fax: _____

County: _____

Dear Doctor:
The orders shown below are being forwarded for your signature to authorize your verbal orders given on this date. Please sign and return this form within three (3) days for our patient's chart. *Thank you for the referral of your patient for services.*

❒ Initial Evaluation ❒ Routine Visit

❒ Frequency/Duration _____ AS OF Date ____ /____ /____

ST Evaluation Date: ___/___/___
ST for:
❒ Evaluation
❒ Administer diagnostic tests:
_____
_____
_____

Voice Disorder Treatment
ST to instruct on:
❒ Esophageal speech techniques
❒ Exercises to improve voice quality
❒ Exercises to improve voice production
❒ _____
_____
_____

Speech Articulation Disorder Treatments
ST to provide instruction on:
❒ Articulatory procedures
❒ Exercises to improve oro-motor function
❒ _____
_____

Dysphagia Treatment
ST to provide:
❒ Instruct on safe swallowing techniques
❒ Instruct on swallowing exercises
❒ _____
_____

Language Disorders
ST to provide and instruct on:
❒ Word finding exercises
❒ Exercises to improve oral-gestural language
❒ Exercises to promote spontaneous speech
❒ Exercises to facilitate reading comprehension
❒ Exercises to improve written language
❒ Exercises to improve memory
❒ Exercises to improve orientation
❒ _____
_____
_____

Aural Rehab
ST to:
❒ Upgrade speech reading skills
❒ Instruct manual communication
❒ _____
_____

Non-Oral Communication
❒ Establish a non-oral communication system
❒ Develop augmentative communication system,
❒ _____
_____

Other
ST to:
❒ Establish home exercise program
❒ _____
_____
_____

GOALS: Rehab Potential: ❒ Good ❒ Fair

1. Patient will require _____ (level of assistance) with feeding within _____ weeks.
2. Patient will demonstrate improved perceptual function as evidenced by _____ within _____ weeks.
3. Patient will demonstrate improved receptive language functioning (understanding or oral/gestural language) within _____ weeks.
4. Patient will demonstrate improved expressive language functioning: ❒ word finding ❒ orientation ❒ elaboration of verbal responses ❒ communication of functional needs ❒ memory within _____ weeks.
5. Patient will demonstrate increased speech intelligibility to _____ % within _____ weeks.
6. Patient will demonstrate safe swallowing skills related to _____ within _____ weeks.
7. Patient/Caregiver will be independent in home exercise program within _____ weeks.
8. Patient/Caregiver will verbalize understanding of discharge plan within _____ days/weeks.
9. Other: _____
_____

Therapist's Signature: _____ Date: ____ /____ /____

Physician's Signature: _____ Date: ____ /____ /____