

**Please refer to the *Progress Note Instructional Guide Sheet* for details on how to fill out each section.**

**All yellow highlighted sections are fillable or have dropdown options.**

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| --- | --- | --- | --- |
| **Service Type:** | **INDIVIDUAL SPEECH THERAPY PROGRESS NOTE** | | |
| **Patient Name:** |  | **Patient Medical Record #:** |  |
| **Report Date:**  **8/10/2020** | **Choose one: Mid-authorization End of Authorization** | | |

1. **ADMINISTRATIVE INFORMATION**

|  |  |
| --- | --- |
| **Facility Name and Location:** |  |
| **Treating Clinician:** |  |
| **Additional Clinicians Providing Treatment:** |  |
| **Medical Diagnosis on Authorization:** |  |
| **Frequency and Length of Treatment Sessions­­­­­­:** | **\_\_\_ x per Select Frequency ; \_\_\_ minutes per session** |
| **Dates of First and Last Appointments:** | **In-Person: Select Date to Select Date**  **Telehealth: Select Date to Select Date** |
| **Number of Therapist Cancellations:** | **Total: \_\_\_ (Illness: \_\_\_\_, Vacation:\_\_\_\_, Emergency:\_\_\_\_)** |
| **Number of Family Cancellations:** | **Total: \_\_\_ (Illness: \_\_\_, No-Show:\_\_\_, Vacation:\_\_\_\_, Emergency:\_\_\_\_)** |
| **Interpreter Used?** | **Yes / No** ; **If Yes: Language:** |

1. **CLINICAL INFORMATION / EPISODIC PLAN OF CARE**

|  |  |  |
| --- | --- | --- |
| **What is going well in therapy** (patient progress towards functional skills)**?** |  | |
| **What is not going well in therapy and why?** |  | |
| **Describe care coordination with other disciplines** |  | |
| **Describe testing** (if any) **administered by treating clinician and results.** | **Test 1:**  **Date:** | **Results:** |
| **Test 2:**  **Date:** | **Results:** |

1. **CURRENT GOALS**

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| --- |
| **Patient met \_\_\_\_ out of \_\_\_\_ goals during this reporting period.** |

|  |  |
| --- | --- |
| **Current Goal 1:** |  |
| **Baseline:** |  |
| **Current:** |  |
| **Goal met?** | **Yes/ No / (Dis)Continue** |

|  |  |
| --- | --- |
| **Current Goal 2:** |  |
| **Baseline:** |  |
| **Current:** |  |
| **Goal met?** | **Yes/ No / (Dis)Continue** |

|  |  |
| --- | --- |
| **Current Goal 3:** |  |
| **Baseline:** |  |
| **Current:** |  |
| **Goal met?** | **Yes/ No / (Dis)Continue** |

1. **NEW GOALS**

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| --- | --- |
| **This episode of medical therapy will be completed when the following functional skills have been addressed:** | **1.**  **2.**  **3.** |

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| --- | --- |
| **New Goal 1:** |  |
| **Baseline:** |  |

|  |  |
| --- | --- |
| **New Goal 2:** |  |
| **Baseline:** |  |

1. **RECOMMENDATION FOR NEXT STEPS**

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| --- | --- | --- |
| **Plan of Care:**  Choose option in 2nd column and answer all additional, related questions. | **Discharge** | **If recommending discharge of patient based upon a clinical rationale, please explain your reason(s):**  **If recommending discharge of patient from your clinic based upon an administrative rationale, please choose reason below:**  *If discharging for administrative reasons, please have family contact PDDO when ready to restart services.*  **Select Administrative Discharge Reason**  **If needed, add additional comments below:** |
| **Continue**  **Select Plan of Care Recommendation**  **\_\_\_\_ x per Select frequency** | **If recommending continued treatment, please answer all questions below:**   1. **Does the patient continue to need therapeutic intervention to meet functional goals? Yes / No** 2. **Describe family’s participation with home exercise program.**      1. **Describe the patient’s participation in therapy.** 2. **a. Please describe any attention problems or maladaptive behaviors that are present:**   **b. If present, how do these behaviors impact intervention(s) and progress?**   1. **If continued therapy is recommended at the same or different frequency, please describe your clinical rationale?** 2. **If this request is to increase frequency or duration of therapy, list additional gains expected (e.g., additional goals, additional practice, etc.) that will be accomplished with the increased frequency of care:**   a.  b.   1. **Who is making the request to continue treatment?**   **Select Requestor** |
| **Caregiver agrees with the recommendation?** | **Yes / No** | **Date discussed: Select Date**  **Caregiver Name:**  **Comment:** |
| **Caregiver received copy of progress note:** | **Date given: Select Date**  **Caregiver Name:** | |

1. **THERAPIST SIGNATURE AND INFORMATION**

|  |  |
| --- | --- |
| **Electronically Signed by Treating Clinician:**  (include credentials) |  |
| **Supervising Clinician:**  (if applicable) |  |
| **Treating Clinician’s E-mail:** |  |
| **Treating Clinician’s Phone Number:** |  |