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CLINIC CONTRACT

I. I have read the CMDS 7500 syllabus and I understand that I am responsible for all of its contents; specifically (but not exclusively):
   A. I am aware of all my clinical duties and clinical rights.
   B. I am aware that I must have current Professional Liability Insurance and a current T.B. skin titer in order to see a client. Clients will be cancelled or rescheduled to another clinician until I demonstrate proof of Professional Liability Insurance and a current T.B. skin titer. I am aware that I cannot count any hours with a client if my Professional Liability Insurance or T.B. skin titer is not current at the time.
   C. I am aware that one un-excused absence from a treatment session or an evaluation will result in a reduction of my total course grade by one letter. Further, I understand that two un-excused absences from a treatment or an evaluation session will result in a course grade of “F.”
   D. I am aware that an un-excused absence from a mandatory clinic meeting will result in a reduction of my total course grade by one letter. I understand that two un-excused absences from a mandatory meeting will result in a course grade of “F.”
      An un-excused absence from a treatment/eval. session and a mandatory meeting will result in a course grade of “F.”
      I understand that A FINAL MANDATORY MEETING WILL BE SCHEDULED DURING THE LAST WEEK OF CLINIC. FAILURE TO ATTEND WILL BE REFLECTED IN THE FINAL CLINIC GRADE
   E. I am aware that every attempt should be made to reschedule missed therapy sessions, with supervisor and clinic coordinator approval.
   F. I am aware that excessive absences may result in reassignment of clients and loss of clinical hours.
   G. I am aware that failure to sign my ASHA hours on the Daily Log will result in a forfeiture of clock hours.
   H. I am aware that I must be available to compute my hours on the designated day. Only an official University excuse will be accepted to change this date.
   I. I am aware that all speech documentation (reports, signed ASHA hours, etc.) is due on the designated day. Failure to comply will result in an incomplete and will ultimately affect my letter grade.
   J. I am aware of the AUSHC Professional Dress Code and understand noncompliance with such will be reflected in my grade.
   K. I understand any clinical changes (client time, room, etc.) must be cleared by the clinic coordinator; failure to comply will be reflected in my clinic grade.

II. I am aware that I will be assigned to clinic clean up duty on a rotating basis, and that failure to comply with clean up responsibilities will be reflected in my grade.

Signature of student ___________________________ Date ___________________________
CMDS 7500: CLINICAL RESPONSIBILITIES

I. Supervisor Meetings:
   A. Prior to your initial supervisor meeting you should (in accordance with your clinical competence level):
      1. Review the client’s information on Practice Perfect.
      2. Be prepared to present the client’s clinical and health history to the supervisor.
      3. Be prepared to discuss Long Term Goals and Short Term Objectives; including possible treatment procedures (targets, materials, cues, reinforcement).
      4. Be prepared to discuss your treatment objectives for the first day of treatment.
   B. You must attend all scheduled supervisor meetings with your clinical instructor, unless otherwise instructed.
   C. Please contact your supervisor if you are unable to attend a scheduled meeting and arrange another meeting time that is convenient for you both.
   D. You are expected to meet with your supervisor on a weekly basis until mid-semester at which time plans for continued meetings will be discussed.
   E. Please keep in mind your supervisor has other clinical and department responsibilities (faculty meetings, screenings,) and may occasionally need to reschedule a meeting.
   F. Failure to attend a scheduled supervisor meeting will be reflected in your grade.

II. Paperwork Responsibilities:
   *Please be sure to check with YOUR supervisor about paperwork responsibilities for each of your clients. Responsibilities vary from client to client.

   Unless otherwise specified please follow these guidelines:
   A. You will be responsible for the following clinic reports (check the clinic calendar for due dates)
      1. Treatment Plan
      2. Final Report
   
   B. Progress Notes
      1. Progress/SOAP notes and Objective Procedure Sheets should be completed each time you meet with your client.

      2. Please place data sheets and the supervisor’s Observation Form in your client’s working folder.
STUDENT SCHEDULE

CHECK ONE: GRADUATE STUDENT _____ UNDERGRADUATE STUDENT _____

NAME: ___________________________________________________________
LOCAL ADDRESS: __________________________ LOCAL PHONE: ___________
HOME ADDRESS: __________________________ HOME PHONE: ___________
E-MAIL: ___________________________ CELL PHONE: ___________
PLAN TO GRADUATE: ____________ SEMESTER: 20 ____________
PLAN TO INTERN: ____________ INTERN SITE: ____________ ADULT OR CHILD

Write class numbers (CMDS 7530) in the blocks when you are in class. DO NOT CROSS OUT BLOCKS FOR WORK OR COMMUTING. All X not identified as class are disregarded.

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CHECK THE ACADEMIC COURSES YOU HAVE COMPLETED:

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<td>__ CMDS 3000 Intro to Sp &amp; Audio</td>
<td>____ CMDS 7500 Clin Problems in SLP</td>
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<td>____ 3400 The Speech &amp; Hearing Mech</td>
<td>____ 7510 Artic Disorders</td>
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<td>____ 3410 Phonetics</td>
<td>____ 7520 Clin. Stratagies in Child &amp; Adol Lang Disorders</td>
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<td>____ 3550 Speech &amp; Hearing Science</td>
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<td>____ 4600 Intro to Audiology</td>
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<td>____ 7900 Independent Study</td>
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Clinic Orientation

I. Professional Conduct

A. This is a professional training program. You are expected to wear the navy jackets with your name tag. You are allowed to wear jeans on Fridays only.

B. Clients’ folders are CONFIDENTIAL. Information contained therein should not be discussed outside the clinic or in front of clients or other individuals in the clinic who are not directly involved with the client.

C. All personal as well as professional conversations should be held within the confines of an office or other appropriate room.
Clinic Policies

I. Eligibility for Services

A. Services are available to persons of any age, sex, racial or religious affiliation. Children under 18 are not eligible without the permission of their parents, duly appointed guardians, or responsible agencies (i.e., DHR).

B. No individual is denied services due to financial limitations. A sliding fee schedule is used to determine cost of the services when applicable.

C. Referral from agencies and professionals is common, but is not required.

D. Medicaid clients must have a current EPSDT in order for Medicaid to pay for services. All clients with Medicaid must have a current folder in the front office filing cabinet, labeled “Medicaid.”

II. Types of Services

A. Diagnostic services

1. Speech-language pathology evaluation is on an individual basis. A variety of disorders are served (see treatment).
   a. Speech-language screening
   b. Diagnostic evaluation
   c. Re-evaluation

2. Audiometric services
   a. Audiometric screening
   b. Referral for in-depth audiometric evaluation

B. Treatment services

1. Speech-language treatment is conducted in individual and/or group sessions to treat the following:
   a. Articulation impairment
   b. Dialect
   c. Dysphasia/swallowing disorders
   d. Expressive and receptive language disorders (including cognitive and social)
   e. Fluency disorders
   f. Neurological disorders
g. Voice problems

2. Aural (re)habilitation
   a. Auditory training and speech reading
   b. Aural rehabilitation
   c. Central auditory processing

III. Financial Policies

A. The Speech and Hearing Clinic, being a special facility of Auburn University, is a non-profit agency. However, the income generated through the delivery of services dictates the revenue available for equipment, personnel and general operating expenses. Therefore, to ensure continuous, high-quality, professional service to the clients, adequate financial support is considered basic to its operation.

B. The Clinic has a standard fee schedule for services rendered. Individuals who qualify for fee reduction on the basis of family size and income are charged according to the variable fee schedule. Arrangements for fee reduction are made through the secretary.

C. Failure to keep up monthly payments for services rendered in the clinic can result in the discontinuance of clinical treatment. Re-enrollment may be obtained only through payment of the outstanding balance.

D. Clients pay by the visit or by arrangement with the front office. If they are unable to do so, they must arrange for weekly/monthly payments. Payment is made to Auburn University.

E. AUSHC accepts Blue Cross/Blue Shield insurance.
1. Clinicians who have preregistered for CMDS 7500 clinical practicum the following semester must submit a Schedule Form completed in full, to the clinic coordinator prior to departure from campus. Because management schedules are arranged by the clinic coordinator during the semester break for the upcoming semester, it may not be possible to schedule cases for those clinicians who turn in class schedules late.

2. Address cards should be completed and submitted to the clinic coordinator or scheduling assistant at the beginning of each semester.

3. During the semester preceding onset of practicum experiences, each student must apply and pay for professional liability insurance. Clinicians must also have a T.B. Skin Titer updated annually.

4. Lockers in the Clinicians’ Room are available for use of students enrolled in clinic. However, department owned therapy materials are not to be kept in these lockers, but should be returned to the materials room after each use. Lockers are assigned to students by the clinic coordinator or scheduling assistant.

5. Clinic equipment and materials are available for student use as follows:

   A. All tests must be signed out by students. Tests and test forms are all contained in Room 1130. All test materials taken from the clinic for overnight use must be checked out after 4:30 p.m. Monday through Friday, and returned before 7:45 the following morning.

   B. Each student is required to formally check out all equipment, materials, and/or books if borrowing from a supervisor’s office. Each student is responsible for repair or replacement of damaged or lost equipment, materials and for books.

   C. Students are expected to supply their own tape recorders. In some instances, tape recorders and other equipment may be obtained from clinical supervisors.

   D. Toys, games, etc. are maintained in the Materials Room.

6. Keep in mind that the front office is a place of work for the secretary. Do not interrupt the secretary if she is discussing business with a fellow staff member or client.

8. Consult the secretary for assistance in identifying clients in the waiting room.

9. You may give your client your cell phone number in case they wish to cancel their session or are going to be late for their session.

10. Each of the supervisors has a mailbox in the faculty conference room (Room 1128). Reports and other correspondence can be placed in the appropriate box for communication with the supervisor. Do not leave documents on the supervisor’s desk or chair; they may get lost. Clinical supervisors are not responsible for lost papers that were left on the supervisor’s desk or chair.
11. Knock before entering an office and do not interrupt if the supervisor is obviously in conference – whether with a client, fellow faculty member or another student.

12. Clinicians should check the schedule board, mailboxes, and bulletin boards daily for pertinent information.

13. Various clinic forms are located in a file cabinet in Room 1130. When supplies are low, report it to the front office so additional copies may be made. Do not use the last form!

14. For answers to any questions not covered in the manual, see the clinic coordinator or Department Chair.

15. Clinicians receiving a practicum grade of “C” or lower will not have their practicum hours signed, and therefore will not receive clock hour credit for ASHA for that case or cases.

16. All clinic changes (client time change, room change, etc.) must be put in writing and placed in Mrs. Zylla-Jones’s box in a blue folder labeled, “Clinic Changes.” Failure to comply will be reflected in the student’s clinic grade.

18. Per HIPAA regulations, please call clients from a university phone.

19. You may not post pictures of clients on Facebook.
Paperwork should be restricted to a clinic computer. All documentation should be shredded if not filed or mailed. There is a box for all materials to be shredded in the clinician’s room.

**SOAP NOTES:**
SOAP notes must be typed at the AUSHC in Practice Perfect.

**OBJECTIVE/PROCEDURE SHEETS:**
Do not use patient’s name, file number or other identifying information. The Objective/Procedure sheet is placed in the observation room only for the duration of the session; it must be removed at the end of the session and placed in the patient’s working file.

**TREATMENT PLANS:**
Use the client’s full name and personal information. Clinicians must type final reports at the AUSHC. If you choose to type on a personal computer, you assume the burden of patient confidentiality.

**CLIENT FILES:**
Clinicians may not have a working file or client information outside the clinic.

**EVALUATION REPORTS:**
Clinicians must type evaluation reports at the AUSHC. If you choose to type on a personal computer, you assume the burden of patient confidentiality. Clinicians are prohibited from removing from the AUSHC original case history forms, test forms, audiograms, tympanograms, etc. Clinicians are prohibited from removing videotapes from the AUSHC.

**DISCUSSIONS:**
Clinicians are advised to restrict conversations about patients, treatment sessions, and evaluations to the clinicians’ room, the supervisor’s office, the treatment room, the observation room, or the evaluation room. Clinicians are strongly advised against discussions about patients in the hallways, the lobby, the front office, or other public places. When discussing a client in the clinicians’ room or in a class, the clinician should not include identifying information, such as a name, billing status, etc. When videotapes are used in a class for demonstration or example, the clinician should not discuss confidential or delicate information revealed in the video outside the classroom.

**E-MAIL:**
If e-mailing any reports or correspondence to the supervisor, no identifying information may be included. Please use the client’s initials rather than their name.

**FAILURE TO COMPLY WITH THESE PROCEDURES WILL RESULT IN A REDUCTION OF THE STUDENT’S CLINIC GRADE.** The above policies have been explained to me and I agree to abide by these policies.
Welcome to the Auburn University Speech and Hearing Clinic. Your clinical experiences at the AUSHC will be varied, and you will have received the required number of ASHA hours (in terms of appropriate disorders and sites) by the time you graduate. While all students will receive the required hours, it is not possible to provide every student with the exact same experience. For example, some students may receive aural rehabilitation hours with Cochlear Implant Clients, while others may receive their hours via Hearing Aid Groups. Similarly, some students may receive pediatric dysphagia experience, while others will receive adult dysphagia experience. Our goal is not to provide you with every type of disorder possible, but rather to teach you the academic and clinical skills that you will need in order to work productively in any setting. While at AUSHC, you will learn the critical thinking skills required to research any disorder with which you are presented.

Clinic Requirements Pertaining to Hours
In order to receive the ASHA required hours, it is important that you personally keep track of your ASHA hours earned on a regular basis; this means weekly, not just at the end of the semester when calculating ASHA hours. If your client consistently “no shows” or cancels treatment sessions, you will not be receiving those hours. It is important you keep the faculty clinic scheduler informed of clients that frequently no show or cancel. A new client will be assigned only if you inform the clinic scheduler of the situation. Please put these correspondences in writing and place in the faculty scheduler’s mailbox.

Clinic Requirements
The following reminders should assist with a smooth running clinic:
* All students are responsible for complying with all requirements in the Clinical Handbook. If you are uncertain of a requirement, please consult the Clinical Handbook or a Clinical faculty member. All students should own a Clinic Manual.
* Students are responsible for complying with all requirements in the Clinic Syllabus & Contract.
* Students are responsible for checking their mailboxes on a daily basis; you are responsible for responding to all correspondences from Clinical faculty members.
* Please remember, the clinic operates 5 days a week from 8:00 am to 5:00 pm. You are expected to be here Monday through Friday. We cannot accommodate commuting schedules, work schedules or child care schedules.

Clinic Course Work Requirements
All graduate students in Speech-language Pathology will be required to attend a weekly clinic class. Students will be expected to attend the course during every semester prior to the extern semester, excluding summer. While this clinic course is designed to be informative and does not consist of examination, your clinical grade will be partially dependent on attendance and participation in the course.
Minimum ASHA Hour Requirements

In order to be eligible to begin your externship in the spring you must have accumulated a minimum of 250 clock hours.

Semester clock hour requirements follow:

Fall Semester (1): Obtain 30 hours (3-4 hrs. of therapy per week) Spring
Semester (1): Obtain 80 hours (8-10 hrs. of therapy per week) Total hours
after Spring Semester: 110 hours
*if you had an off-campus assignment: 130 hours

Summer Semester: Obtain 40 hours (6-8 hrs. of therapy per week) Total hours
after Summer Semester: 150 hours
*if you had an off-campus assignment: 175-190 hours

Fall Semester (2): Obtain 75-100 hours depending on off-campus status Total hours
after Fall Semester: 250 hours

Spring Semester (2): 400 hours

Note:
*Students not meeting the minimum requirement of 30 hours by the end of Fall Semester (1) will not be eligible for an off-campus placement Spring Semester (1).

*Students not meeting the 250 hour requirement for Fall Semester (2) will not be eligible to begin their externship Spring Semester (2).

Off-Campus Requirements:
*Starting and ending dates for off-campus assignments differ from the on-campus clinic calendar.
*If you are assigned to an off-campus site during the Fall or Spring Semesters, you are required to obtain a minimum of 100 clinic clock hours.
*If you are assigned an off-campus site during the Summer Semester, you are required to obtain a minimum of 80 clinic clock hours.
OFF-CAMPUS PROTOCOL

Introduction
Every graduate student will be assigned to at least one part-time off-campus site and one full-time internship site.

One site will be primarily adult and the other primarily child.

If you are planning on doing an adult internship site, your part-time off-campus placement will be a child site.

If you are planning on doing a child internship site, your part-time off-campus placement will be an adult site.

Selection for part-time off-campus sites
Student selection is made by all of the clinical faculty members. Clinical faculty will provide information pertaining to the students they have supervised.
Academic faculty may also offer input as to whether or not GTAs may be placed at an off-campus site.

To be eligible for off-campus placement during the spring 1 semester, you must have completed a minimum of 30 hours at the Auburn University Speech and Hearing Clinic. Supervisors cannot reliably make judgments about students’ ability to handle an off-campus placement with fewer than 30 hours.

Once the names of eligible students are submitted to the clinic coordinator by clinical faculty members, the clinic coordinator will assign the student to an off-campus site based on their intern choice. If students do not know if they are going to do an adult or child internship, they will not be assigned to a part-time placement until after they have made a decision.

Most off-campus placements are three times per week (M/W/F). You will need to provide your own transportation. Students may have up to a 1 hour commute for part-time off-campus placements.

In rare circumstances, student may be placed at two off-campus sites if one of the sites is with an Auburn University clinical faculty member at a part-time site (contracts with schools, etc.).

The last semester of clinic priority for off-campus placement is given to students that have not been off campus or who have not been supervised by a non-university supervisor.

*Please note: The scheduling GTA is not responsible for selecting students for off-campus placements. The clinic coordinator places students based on recommendations from other clinical and academic faculty members.
A. The *Daily Log Book* is the weekly record of services rendered at the Speech and Hearing Clinic. The administrative secretary bills from this log and it is also used to verify ASHA hours earned by clinicians. It is located in the filing cabinet in the clinician’s room. Due to its important record-keeping function, it is imperative that it be signed correctly as described in the following:

1. If the client attended the session, describe the Service Rendered (articulation evaluation, language management, fluency management, hearing evaluation, speech-reading, hearing aid check, etc.) in the designated column. Under the Time column, record the length of the session. Verify information by initialing name under appropriate column.

2. If the client notifies the clinic in advance that he/she will not be present for a session, write “CX” (canceled) under Services Rendered and initial.

3. If the client fails to keep the appointment and does not notify the clinic, write “NS” (no show) in the Services Rendered column and initial.

4. If it is necessary for the clinical instructor or clinician with prior approval to cancel a session, state “cancelled by clinic” in the Services Rendered column and initial. NOTE: Failure to sign the daily log by the end of the week will result in the loss of hours earned.

B. The Supervision Record Form is used to verify ASHA hours and to document supervision time. This form is located in the client’s working file, in Room 1130 or your supervisor’s office. Follow guidelines noted above regarding attendance.

C. At the end of each semester, Summary of Supervised Clinical Practicum Forms (ASHA Hour Forms) must be submitted.

1. In speech-language pathology, the hours turned in on this form must match the hours verified by the clinical instructor on the Daily Log.

2. This is your permanent record of ASHA hours earned. Each semester you are enrolled in clinic, you will complete a new *Summary of Supervised Clinical Practicum* Form. You will add current hours to previous hours.
Where to Sign

On Campus: Speech

I. Screenings and Full Diagnostics:

1. **DAILY LOG BOOK** – It is located in the clinician’s room. The book has dividers for *Speech Evaluation* and *Screening*.

   A. For Evaluation – you must record all pertinent information: date, exact minutes, supervisor, student name (printed), client name, disorder, age, payment status, student initials.

   B. For Screenings – record the same information except record the site of the screening or type (example: AUSHC – free screening or high priority, etc.) and no billing status.

2. **SPEECH EVALUATION(S) RECORD** – this form is for you to keep, to help you organize the breakdown of your ASHA hours by disorder. This form is optional; however, it is very helpful to you at the end of the semester when completing your ASHA hours (found in file cabinet in room 1130).

II. Treatment:

1. **DAILY LOG BOOK** – in the same book, clients are alphabetized by client’s last name or site. You will record your information: date, exact minutes and your initials on the pre-printed pages.

   **Note:** All documentation of hours must be recorded every week before 5:00. If the hours are not documented, they will be forfeited. Logs will be checked weekly on Fridays.

2. **SUPERVISION RECORD FORM** – this form is located in the client’s working file. Indicate the time you treated/evaluated the client and the supervisor will document their supervision time. Please use increments of 15, 30, 45, and 60 minutes. If the client missed a session, document if it was a cancellation or no show.

III. Audiology Hours:

1. If an SLP supervisor is present, you record your hearing screening hours in the speech Daily Log Book, under “Screening.”

2. If the screening is supervised by an Au.D. clinical supervisor, please record hours on the audiology screening form, which can be found in the file cabinet in Rm. 1130.
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Meeting with supervisor:

Sessions by client:

Sessions by supervisor:

Percent of supervision
Billing Receipts /Clinical Supervisor License Numbers

Speech Pathology billing forms are used as a means to monitor patient evaluation/ treatment, billing and reimbursement. You are responsible for the following:

1. Please enter patient’s name, date, faculty provider and their ABESPA license number at the top of the form.

2. Under speech CPT code, indicate the appropriate type of evaluation or treatment provided. Treatment is divided into time allotments (1 hour, ¾ hour, ½ hour) and individual or group therapy.

3. Under ICD-10 codes, check the most appropriate diagnosis code (may be more than one code).

4. If you are not aware of your client’s pay source, ask the front office staff. If Medicaid, make sure the EPSDT form is current.

5. **Do not check any other spaces on the billing form except the above mentioned.**

4. All clinic supervisors’ ABESPA and ASHA numbers are also listed here for your reference; *ASHA numbers are not included on the billing form.*

    Embry Burrus  2045/12005724  
    Heather Gotthelf  3243/12062071  
    Kimble Eastman  2637/01020613  
    Dajuandra Eugene  3654/12083629  
    Marsha Kluesing  1065a/00318295  
    Katherine McAtee  3142/9145855  
    Lawrence Molt  2186/00594671  
    Laura Plexico  2596/12044669  
    Mary Sandage  2436/1090055  
    Kelly Tucker  1810/12017173  
    Kelli Watts  1031a/12086016  
    Laura Willis  2703/12082449  
    Martha Wilson  656a/00415489  
    Elizabeth Zylla-Jones  911/00942607

5. **When you walk the client to the front window,** please give the billing form to the clinic secretary. This must be done after every session. If she is unavailable, put the form on her desk.
Instructions for ASHA Hours Meeting

Please sign up for a meeting with your assigned clinical supervisor to review your ASHA hours. Graduate students will need an hour to review ASHA hours, KASA, and clinic grades.

SUPERVISOR MEETINGS TO REVIEW YOUR GRADES ARE NOT MANDATORY. (Supervisor’s schedules are posted outside offices.)

1. Complete supervision form in client’s working file as well as Daily Log Book by last day of clinic.

2. Total hours on the ASHA Summary of Hours form. The ASHA hour form can be found on the c: drive on the computers in the student room as: ASHA HOURS SPREAD SHEET BLANK FORM. When you pull up this template, COPY it onto your flash drive.

3. Once checked, you are responsible for obtaining all of your supervisor’s initials on ASHA form. This may mean you need to travel to an off-campus site for signatures, or you may need to return another day if your on-campus supervisor is not available the day you complete your ASHA hours. Clinical faculty is not responsible for obtaining signatures for you.

4. Copy the original form(s) for a personal copy to retain for your records.

5. Place the completed original ASHA hours form in the designated box labeled “ASHA Hours” in the GTA’s office (Room 1119). If you do not turn in the forms by the designated day, you will not receive credit for the hours, and may receive an incomplete for the semester.
# AUBURN UNIVERSITY SPEECH AND HEARING CLINIC SUMMARY OF SUPERVISED CLINICAL PRACTICUM

Level: _____ I, II, III or IV _____ Clinician: ___Your name_____________ Semester: _Fall, 2014_________

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| Semester Total         | 2 | 2 | 0 | 3 | 0 | 7 |
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| Cumulative             | 4 | 4 | 2 | 5 | 2 | 17 |

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<p>| Semester Total         | 7 | 5 | 10 | 0 | 0 | 22 |
| Previous Total         | 1 | 1 | 1 | 0 | | 3 |
| Cumulative             | 8 | 6 | 11 | 0 | 0 | 25 |</p>
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</table>
## AUROUN UNIVERSITY SPEECH AND HEARING CLINIC SUMMARY OF SUPERVISED CLINICAL PRACTICUM

<table>
<thead>
<tr>
<th>AUDIOLOGY</th>
<th>Date</th>
<th>Evaluation</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervisor</td>
<td>ASHA/STATE #</td>
<td>CCC Area</td>
<td>Complete</td>
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<tr>
<td>Embry Burrus</td>
<td>12005724/2045</td>
<td>SLP</td>
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<tr>
<td>Cumulative</td>
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</tbody>
</table>

## CLINICAL PRACTICUM HOURS

<p>| | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>A.</td>
<td>Observation hours</td>
</tr>
<tr>
<td>B.</td>
<td>Undergraduate speech and language</td>
</tr>
<tr>
<td>C.</td>
<td>Graduate speech and language</td>
</tr>
<tr>
<td>D.</td>
<td>Undergrad and graduate speech and language excluding observation hours</td>
</tr>
<tr>
<td>E.</td>
<td>Audiology evaluation</td>
</tr>
<tr>
<td></td>
<td>Audiology treatment</td>
</tr>
<tr>
<td>F.</td>
<td>Total clinical practicum hours</td>
</tr>
</tbody>
</table>
EVALUATION PROCEDURES

If you have been assigned a diagnostic slot, please keep in mind, the client is your responsibility. It is your responsibility to determine when clients are scheduled and the presenting concern. Your diagnostic responsibilities include:

I. **Scheduled evaluations**
   A. Evaluations may be scheduled as late as 5:00 p.m. the night before your scheduled evaluation slot.

   B. An evaluation may be scheduled on the day of your scheduled evaluation slot if a similar client (for which you have already prepared) has canceled. Any new client will be scheduled by 9:00 a.m. the day of the evaluation.

II. **Verifying evaluations**
   A. Consult Practice Perfect on a regular basis to determine if you have an evaluation scheduled for the week.

   B. Client information can be obtained from Practice Perfect. Information will include client’s name, age and contact information. A brief description of the problem may also be included. However, it is your responsibility to contact the client to determine concerns and to remind them of the evaluation time.

   C. Meet with your supervisor to discuss the evaluation protocol. If your client is scheduled after your regular supervisor meeting time, be sure to consult with your supervisor to outline diagnostic procedures.

III. **Confirm appointments**
   A. Contact your client to confirm the appointment.

   B. Notify the clinic coordinator, case supervisor and department secretary immediately if the client has canceled.

   C. When you contact your client, obtain any additional information you may need to prepare for the client.

   D. If you are unable to reach the client after several attempts, leave a message for the client indicating the day and time of the evaluation. Also leave the clinic phone number and your phone number if you wish for the client to return your call.

   E. Schedule a hearing evaluation with your assigned audiologist via e-mail as soon as possible if the client requires a hearing screening. If your client has Medicaid, he/she must have a hearing screening. Before scheduling a hearing screening, consult your supervisor to see if you may screen the client using a portable audiometer. **Clients seen upon referral from the Disability Determination Service (DDS) do not require a hearing screening.**
IV. Follow-up Procedures

A. Complete the Evaluation Routing Form (yellow) and place in the folder labeled, “Management Request Forms.” The folder and the forms are kept in the clinician’s room filing cabinet. Please complete this form immediately after the evaluation.

B. Complete the evaluation checklist stapled in the folder labeled “Evaluations to Schedule.” Be certain to indicate not only if the client attended, but also if treatment is needed.

C. The checklist (on the left side of diagnostic folder) must be completed each time a client is scheduled for you. For example, if a client cancels complete the checklist indicating the client canceled. If the client reschedules and cancels a second time, complete the checklist again. This documentation is the only way the clinic coordinator has to determine if a client attended.

D. The Evaluation Routing Form may not be needed if the client cancels and or no shows for a second time as long as you have completed the checklist in the folder labeled “Evaluations to Schedule.” Make sure the front office does not need that information for rescheduling purposes before making the decision not to complete the form.

V. Clinic Grades

A. You are responsible for complying with all diagnostic requirements. Failure to comply with documentation requirements will be reflected in your grade. Not completing Evaluation Routing Forms completely and/or failure to complete the checklist in the scheduling folder may result in a rating of (0) or (1) on the grading form, depending on the circumstances.

B. Only university excused absences will be accepted for missing a scheduled evaluation. Documentation to obtain an excused absence is expected.
DIAGNOSTIC WORKSHEET

Client Name: _______________________________   Age: ________________________

DOB: __________________    D.O.E:      _____________________

Parent Name: _____________________________ Disorder/Complaint: ________________

Phone: ____________________________             Billing Source: _______________________

1. **Call your client before you meet with your supervisor** to verify their appointment. If you are unable to contact them, please notify your supervisor at your pre-evaluation meeting. If you are able to contact your client, verify receipt of the case history packet and parking pass. Please advise them to arrive on campus at least 15 minutes before their appointment time. **Attempt to call the client the night before the evaluation if possible.**

2. If your client has Medicaid, check to make sure their Medicaid referral (EPSDT) is current.

3. If your client is here for a Disability Evaluation, and the client requests therapy, please notify the family that we will need a Medicaid or physician referral.

4. Review case history information in Practice Perfect.

5. Notify your assigned Audiologist via e-mail to let them know if the client does or does not request a hearing screening. **If your client is Medicaid, a hearing screening must be completed.** Inform the audiologist of the client’s age and concerns (e.g., history of ear infections; articulation disorder). Remember, if the client cancels or reschedules, notify the Audiology Supervisor immediately.

6. After reviewing the case history, select diagnostic tools and/or procedures appropriate for the client **to the best of your ability using the protocols from your clinical manual.** You will be expected to present this information to your supervisor.

7. Meet with your clinical supervisor **at least 48 hours** prior to the scheduled diagnostic. **Bring Holding File, list of selected protocols, and any other pertinent information.** (Please consult your supervisor’s schedule for your evaluation meeting slot).

8. At the end of the evaluation, complete the billing form and provide this, as well as the sliding fee application, if applicable, to the front office as you walk the client to the waiting room.

9. Please complete the yellow Evaluation Routing Form and place in the filing cabinet in the clinician’s room in the Management Request Form file. Complete this form even if your client cancels or was a “no show.” **Log the client’s name and appropriate information on the left side of the folder.**

10. Document your hours as indicated in the “**Where to sign**” handout. If the client does not attend, you must indicate this in the Daily Log Book and on the Evaluation Routing Form.
11. Turn in **SCORED TEST PROTOCOLS, CASE HISTORY**, etc. to your supervisor when you turn in your report. Please double space rough drafts. The first draft of the report is due within **2 working days** of the evaluation. Reports for Friday evaluations are due on Tuesday. Corrections are due within **24 hours** of being returned.

12. Upon completion of the report, please check with your supervisor to finalize all paperwork.

13. If the referral was made from the Pediatric Clinic, Dr. Tole or East Alabama ENT, please fax a copy of the report to the office. All other reports should be mailed to the referral source.
This form is to be placed in the file labeled “Speech Evals” in Room 1119. Turn in the form immediately after each evaluation. Obtain all information directly from the client or parent and do not rely upon previous records.

Client’s Name: _____________________________ Date of Birth: ____________________________
Parent’s Name: ____________________________ CA: ___________________________________
Address: _________________________________ Phone: ______________________________________
_________________________________________ ______________________________________
Work  Home
_________________________________________ Cell
E-Mail: ___________________________________ File # _________________________________
Payment type:____________________________ Medicaid Expiration date if applicable:_________

1. Need Treatment:  _____Yes  _____No

2. Diagnosis:   _____Artic  _____ Fluency  _____ Aphasia
               _____ Lang.  _____ Voice  _____ Motor Speech
               _____ Other___________

3. Briefly describe problem: _____________________________________________________________
   ___________________________________________________________________________________

4. Number of sessions per week: _________________________________________________________

5. Length of session(s): ________________________________________________________________

6. Days available: _____________________________________________________________________

7. Times available: ____________________________________________________________________

8. Preferred days and times: _____________________________________________________________

9. Days and times not available: _________________________________________________________

For Scheduler’s Use: Day/Time: ______________________________
Clinician: ______________________________
Supervisor: ______________________________
Room:__________________________________

Supervisor’s initials: __________
Supervisor’s clinician request/Comments: ________________________________________________
Procedure for Hearing Screening during SLP Evaluations

Procedures for requesting hearing screening as part of speech evaluation:

- **If you are evaluating a child under three years of age or a special needs child you will need to e-mail your assigned Audiologist to inform them of the appointment**
  - On the day of your evaluation and prior to the arrival of the patient, touch base with the audiologist who will be working with your patient to confirm their availability.
  - Before the patient arrives for the evaluation, obtain a yellow audiology charge sheet from the front office and complete all information including type of payment.
    - Prior to the start of the hearing screening, give this completed charge sheet to the audiologist. The audiologist/audiology doctoral student will mark the services completed and give the sheet to the front office for billing
    - For patients referred by disability Determination Services no charge sheet is completed
  - The audiologist /audiology doctoral student will complete otoscopy, OAE testing and pediatric testing in the sound treated booths as indicated. The SLP student will participate in the evaluation when possible and will receive audiology hours only if actively participating in the hearing screening.
  - Make note of the audiological recommendations given to the parent or the SLP supervisor at the end of the hearing screening so that these recommendations can be included in the report, i.e.:
    - Hearing within normal limits with normal eardrum mobility and middle ear pressure
    - Restricted eardrum mobility, medical referral. Re-screen following medical intervention
    - Child could not be conditioned to test procedures. Recommend return for audiological evaluation
  - If audiological evaluation is recommended, ask parent if you can assist them in scheduling appointment at this clinic following the S/L evaluation

- **If you are evaluating a cooperative child three years of age or older,**
  - You are expected to complete the hearing screening independently under the supervision of your SLP clinical professor. The purpose of this training is to prepare you to successfully complete hearing screenings on adults and cooperative children. This is within your scope of practice and a requirement for graduation from this program
  - Prior to the hearing screening, sign out a portable audiometer under the name of your SLP supervisor. When you return the audiometer to the storage area, be sure to sign it back in. Your SLP supervisor will be responsible for any lost equipment.
  - Complete a biological check of the equipment prior to the hearing screening to assure the equipment is functioning properly and your results are accurate.
  - Be prepared to do play audiometry if indicated
  - Return the portable audiometer to the storage area immediately following your evaluation.
  - On your final hour form record the audiology hours you have received under the name of your SLP supervisor. It is within their scope of practice to supervise audiology screenings and they will initial your end of semester hours for any audiology hours obtained.
CHILDCASE HISTORY FORM

Our evaluation of your child’s speech and hearing problems will depend on information about the child’s past history. Please fill out this form as completely as possible and return in the enclosed envelope. If there are any items you do not fully understand, put a check mark in the left margin and we will discuss them when you come for the appointment.

Person completing this form__________________________________________

Relationship to child _______________________________ Date_______________________

Person or agency responsible for payment of services received

__________________________________________________________________________

Name __________________________ Telephone Number ________________

Address_____________________________________________________________________

City, State, Zip

Referred by______________________________

__________________________________________________________________________

Name __________________________ Telephone Number ________________

Address_____________________________________________________________________

City, State, Zip

I. Identification Information

Child’s Name _____________________________ Sex __________

Birth date__________________________ Age________

Address________________________________ Phone___________________________

City, State, Zip____________________________

Mother’s Name ____________________________

Address________________________________

Occupation________________________________

Father’s Name ____________________________

Address________________________________

Occupation________________________________

32
II. Family Information

Brothers and sisters

<table>
<thead>
<tr>
<th>NAME</th>
<th>AGE</th>
<th>SEX</th>
<th>SPEECH, HEARING OR MEDICAL PROBLEM</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Are there any other languages spoken in the home? If yes, by whom and how often?

III. Educational History

Did child attend day care or pre-school? If yes, where?

Kindergarten? If yes, where?

School/Grade now attending

What are your child's average grades?

Best subjects

Poorest Subjects

How does child feel about school and about his/her teacher?

IV. Statement of the Problem

Describe as completely as possible the speech, language, and/or hearing problem

When was the problem first noticed?
How has the problem changed since you first noticed it? ________________________________

____________________________________

What has been done about it? Has this helped? _______________________________________

____________________________________

What do you think caused the problem? ______________________________________________

____________________________________

V. General Development

**Please complete this section only if there were difficulties during pregnancy, labor, or delivery.

A. Pregnancy & Birth History
1. a. Age of Mother at child’s birth ______________________________ 
   b. Age of Father at child’s birth ______________________________ 
2. Length of Pregnancy ________________________________________ 
3. Weight of child at birth ________________________________
   (For the following questions, circle yes or no. If yes, explain)
4. Any illnesses during the pregnancy? Yes/No __________________
   a. Any diseases during the pregnancy? Yes/No __________________ 
   b. Any accidents during the pregnancy? Yes/No __________________ 
5. Was there Rh incompatibility between mother & father? Yes/No ________ 
6. Was delivery normal? Yes/No ____________________
7. Were forceps used? Yes/No ____________________
8. Any bruises, scars, or abnormalities on child’s head? Yes/No ____________
   ______________________________________
9. Were drugs used? Yes/No ____________________
10. Did infant require oxygen? Yes/No ____________________
11. Was child blue or jaundiced? Yes/No ____________________
12. Was blood transfusions required? Yes/No ____________________
13. Were there any problems immediately following or during birth? The first two weeks of infant’s life (health, swallowing, sucking, feeding, sleeping)
   ______________________________________
B. Developmental Milestones

**Please complete this section only if your child is/was delayed in achieving developmental milestones.**

<table>
<thead>
<tr>
<th>Held Head Up while lying on stomach</th>
<th>Month/Year</th>
<th>Don’t Know</th>
<th>Can’t Accomplish</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sat unsupported</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Followed simple directions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stood alone</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walked with assistance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toilet trained (bowel, bladder, or both)</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

How would you describe your child’s current physical development? __________________________________________

____________________________________________________________________________________________________

C. General Speech Development

Give approximate ages when your child did the following:

- Babbling
- First Word
- Two word Utterances
- Three word utterances
- Sentences

VI. Medical History

Check as the following apply to your child and indicate the age of occurrence.

<table>
<thead>
<tr>
<th>Tonsillectomy</th>
<th>YES</th>
<th>NO</th>
<th>AGE</th>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Sinus problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergies</td>
<td></td>
<td></td>
<td>Encephalitis/Meningitis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
<td>Headaches</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Blood disease</td>
<td></td>
<td></td>
<td>Heart problems</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Chickenpox</td>
<td></td>
<td></td>
<td>High fever</td>
<td></td>
<td></td>
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<tr>
<td>Convulsions/seizures</td>
<td></td>
<td></td>
<td>Influenza</td>
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<td></td>
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<tr>
<td>Croup/whooping cough</td>
<td></td>
<td></td>
<td>Measles/Mumps</td>
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<td></td>
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<tr>
<td>Dental problems</td>
<td></td>
<td></td>
<td>Rheumatic fever</td>
<td></td>
<td></td>
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<tr>
<td>Neuromuscular disorders</td>
<td></td>
<td></td>
<td>Pneumonia</td>
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<tr>
<td>Runny ears</td>
<td></td>
<td></td>
<td>Chronic colds</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Ear infections treated with tubes</td>
<td></td>
<td></td>
<td>Head injury</td>
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<tr>
<td>Ear infections</td>
<td></td>
<td></td>
<td>Adenoidectomy</td>
<td></td>
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</tbody>
</table>
Other:________________________________________________________________________________________

Describe any other serious illness, injuries, operations, or physical problems not mentioned above.
________________________________________________________________________________________

________________________________________________________________________________________

Explain any significant speech or behavior changes accompanying any of the above diseases, injuries or surgeries.________________________________________________________________________________________

List any medications your child is currently taking and for what purpose __________________________________________
________________________________________________________________________________________

________________________________________________________________________________________

Does your child have a hearing problem? Yes/No If yes, does he/she wear a hearing aid?____________________

Has child had a hearing test? Yes/No, When?________________________ Result________________________
VII. Description of Speech and Language Problems

I. Articulation
   - Substitution of sounds for other sounds (thick for sick, ban for man, tar for car, "tun" for sun)
   - Omission of sounds ("le" for leg, "ady" for lady, "tew" for stew)
   - Distortion of sounds (something isn’t “perceptually” correct)
   - Addition of sounds ("fishenerman" for fisherman)
   - Deletion of syllable ("re" for ready, "phant" for elephant)
   - Cannot understand speech
   - Uses baby-talk

II. Language
   - Reduced vocabulary and/or limited concepts
   - Cannot remember recent information
   - Cannot follow simple directions
   - Short or vague responses
   - Difficulty staying on conversational topic and in participation in conversation
   - Immature sentences
   - Poor grammar (S-V agreement, verb tenses, question forms, plurals, possessive forms, etc.)
   - Inappropriate responses

III. Voice
   - Hoarse, Husky
   - Breathy
   - Hyper-nasal (talks through nose)
   - Hypo-nasal (sounds like has a cold)
   - Monotone (lacks variety and expression)
   - Soft/Loud voice
   - High/Low pitch for age and sex

IV. Fluency
   - Repeats words/phrases (I-I-I want to go)
   - Repeats first part of words (suh-suh-suh-sally)
   - Interjects frequent “filler” words (uhm, wait a minute)
   - Frequent revision of sentences
   - Prolongs sounds (shhhhhhh-she)
   - Associated facial and body movements with speech attempts

V. Hearing
   - Breathes through mouth
   - Complains of noises in ears
   - Inattentive and listless
   - Requests repeats often
   - Withdrawal from group activity where hearing is essential to participation
   - Interrupts conversation of others, being unaware that others are talking
   - Turning head/leaning forward in effort to hear better (other behaviors noted under I-1V)
Our evaluation of your child’s oral-motor feeding issues will depend on information about the child’s past history. Please fill out this form as completely as possible and return in the enclosed envelope. If there are any items you do not fully understand, put a check mark in the left margin and we will discuss them when you come for the appointment.

Person completing this form ________________________________

Relationship to child ________________________________

Person or agency responsible for payment of services received

Name ________________________________ Telephone Number ________________________________

Address __________________________________________________________________________

City, State, Zip ___________________________________________________________________

Referred by ________________________________

Name ________________________________ Telephone Number ________________________________

Address __________________________________________________________________________

City, State, Zip ___________________________________________________________________

I. IDENTIFICATION

Date ________________

Child’s Name ________________________________ Sex ________________

D.O.B.: ________________ Age ________________

Address ________________________________ Phone ________________________________

City, State, Zip ___________________________________________________________________

Mother’s Name ________________________________

Address ________________________________

Last Grade Completed in School ________________________________

Occupation ________________________________

Father’s Name ________________________________

Address ________________________________
Last Grade Completed in School______________________________

Occupation______________________________________________

Family Doctor____________________________________________

Address__________________________________________________

Pediatrician_______________________________________________

Address__________________________________________________

II. FAMILY INFORMATION

Brothers and sisters

<table>
<thead>
<tr>
<th>NAME</th>
<th>AGE</th>
<th>SEX</th>
<th>SPEECH, HEARING OR MEDICAL PROBLEM</th>
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</tbody>
</table>

Are there any other languages spoken in the home? If yes, by whom and how often?____________________

III. EDUCATIONAL HISTORY

Did child attend day care or nursery school? If yes, where?________________________________________

Kindergarten? If yes, where?__________________________________________________________

School/Grade now attending___________________________________________________________

Grades failed___________________________________________________________

What are your child’s average grades?_____________________________________________________

Best subjects___________________________________________________________

Poorest Subjects_______________________________________________________

Is the child frequently absent from school? If yes, explain____________________________________
IV. STATEMENT OF THE PROBLEM

Describe as completely as possible the oral-motor/feeding problem ______________________

_________________________________________________________________________________

When was the problem first noticed? ________________________________________________

_________________________________________________________________________________

How has the problem changed since you first noticed it? _______________________________

_________________________________________________________________________________

What has been done about it? Has this helped? _______________________________________

_________________________________________________________________________________

What do you think caused the problem? _____________________________________________

_________________________________________________________________________________

Is there a family history of oral motor/feeding problems? _______________________________

_________________________________________________________________________________

V. GENERAL DEVELOPMENT

A. Pregnancy & Birth History

1. a. Age of Mother at child’s birth __________________
   
   b. Age of Father at child’s birth __________________

2. Length of Labor __________________

3. Weight of child at birth __________________

(For the following questions, circle yes or no. If yes, explain)

4. Any illnesses during the pregnancy? Yes/No
   
   a. Any diseases during the pregnancy? Yes/No
   
   b. Any accidents during the pregnancy? Yes/No

5. Was there Rh incompatibility between mother & father? Yes/No

6. Was delivery normal? Yes/No

7. Were forceps used? Yes/No

8. Any bruises, scars, or abnormalities on child’s head? Yes/No

_________________________________________________________________________________

9. Were drugs used? Yes/No

10. Did infant require oxygen? Yes/No

_________________________________________________________________________________

11. Was child blue or jaundiced? Yes/No

_________________________________________________________________________________

12. Was a blood transfusion required? Yes/No

_________________________________________________________________________________

13. Were there any problems immediately following or during birth? The first two weeks of infants life (health, swallowing, sucking, feeding, sleeping)

_________________________________________________________________________________
B. Developmental Milestones

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Month/Year</th>
<th>Don’t Know</th>
<th>Can’t Accomplish</th>
</tr>
</thead>
<tbody>
<tr>
<td>Held Head Up while lying on stomach</td>
<td></td>
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<tr>
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<td>Toilet trained (bowel, bladder, or both)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How would you describe your child’s current physical development?  


C. Oral-motor feeding development

Give approximate ages when your child did the following:

- First given pureed solids with a spoon
- First given junior chopped foods
- First given soft solids (i.e., noodles, rice)
- First given crunchy foods (cracker, cookies)
- First given meats (ground meet, chicken, etc)
- Exposed to un-lidded cup
- Drinks from un-lidded cup independently

What foods does child tolerate best?  


What foods does child tolerate least?  


Describe child’s tolerance to above foods:


VI. MEDICAL HISTORY

Check these as they apply to your child and indicate the age of occurrence

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>AGE</th>
<th>YES</th>
<th>NO</th>
<th>AGE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tonsillectomy</strong></td>
<td>Head injury</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Allergies</strong></td>
<td>Encephalitis/Meningitis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Asthma</strong></td>
<td>Headaches</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sinus problems</strong></td>
<td>Heart problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Chickenpox</strong></td>
<td>High fever</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Convulsions/seizures</strong></td>
<td>Influenza</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Croup/whooping cough</strong></td>
<td>Measles/Mumps</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Chronic colds</strong></td>
<td>Rheumatic fever</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Neuromuscular disorders</strong></td>
<td>Pneumonia</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Runny ears</strong></td>
<td>Dental problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ear infections treated with tubes</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ear infections reflux</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Blood disease constipation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments: ____________________________________________________________

Describe any other serious illness, injuries, operations, or physical problems not mentioned above.

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

Explain any significant changes in child’s eating habits accompanying any of the above diseases, injuries or surgeries.

List any medications your child is currently taking and for what purpose ________________________________

____________________________________________________________________

____________________________________________________________________

When was child’s last examination by a G.I. specialists? ________________________________

Results of examination: _____________________________________________________________

____________________________________________________________________

____________________________________________________________________

When and where did your child last receive a modified barium swallow study? ____________________

____________________________________________________________________

Results: ____________________________________________________________________________
### VII. BEHAVIOR

Check those that apply to your child.

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>EXPLAIN BELOW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eating problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sleeping problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toilet training problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty concentrating</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short attention span</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Underactive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laughs easily</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cries a lot</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficult to manage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overactive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personality problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Easily upset</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Makes friends easily</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prefers to play along</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other behavior issues: ________________________________________________________

________________________________________________________________________

________________________________________________________________________
ADULT CASE HISTORY FORM

Name: ________________________________ Date: _______________________

Address: _______________________________________________________________

Birthdate: _______________ Age: _______________

Phone: ____________________________ Cell Phone: __________________________

Referred by: ________________________________

Primary Care Physician: ________________________________________________

Person completing this application: _______________________________________

1. Briefly describe the speech and/or language difficulty: ____________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

2. Please describe any previous speech or language therapy: _________________

______________________________________________________________________

______________________________________________________________________

3. What was the date of onset for the speech/language difficulty: ______________

4. How has this difficulty affected the patient? ________________________________

______________________________________________________________________

5. Does the patient have any hearing problems? Yes No

6. Does the patient wear hearing aids? Yes No

7. What was the patient’s handedness (before stroke or disease onset)?

Right _________ Left _____________ Ambidextrous _________

8. Does the patient wear glasses? Yes No

9. Can the patient see well enough to read? Yes No

10. Does the patient have any other visual problems, such as right or left visual-field cut or cataracts?

______________________________________________________________________

11. How would you describe the patient’s general health? ____________________

______________________________________________________________________
12. Does the patient have a history of the following? Onset Date and Current Status

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aphasia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other communication disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Right- or left-sided weakness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dementia (e.g., Alzheimer's disease)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Memory Impairment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other neurologic disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seizure disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatric problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol abuse/problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other substance abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other major illness</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

13. What is the patient’s native language? ____________________________

14. If not English, at what age did the patient learn English? ____________________________

15. What other languages does the patient speak fluently? ____________________________

16. What is the preferred language in the home? ____________________________

17. What is the patient’s highest level of education? ____________________________

18. What (is/was) the patient’s primary occupation? ____________________________

19. Who (is/was) the patient’s employer? ____________________________

20. Is the patient presently working? Yes No

21. Describe the patient’s work history (for example, kind of employment and approximate dates). ____________________________
22. State daily responsibilities outside the work environment:__________________________________________

23. Please check the following which apply to marital status:

Single_______________  Widowed_______________  Separated_______________
Married_______________  Divorced_______________  Remarried_______________
24. Please list names and ages of the patient’s children: ____________________________

25. Has the patient’s speech and language problem affected the family in any way? If so, how?

26. What percentage do family and close friends understand the patient’s communication? ________
27. What percentage do other (unfamiliar) adults understand the patient’s communication? ________
28. If the patient is living at home, are there others living in the home besides the immediate family?

29. Does the patient need to be taken care of at all times? _________________________________
30. If so, who performs this function? _________________________________________________
31. To what extent can the patient care for himself (dress, feed, and wash himself)?

32. How much does the patient communicate now? ________________________________

33. Is he or she attempting to communicate verbally? Yes No
34. Is he or she attempting to communicate in writing? Yes No
35. Is he or she attempting to communicate using gestures? Yes No
36. Can he or she tell you his or her name and address? Yes No
37. Can he or she write his or her name and address? Yes No
38. Is his or her writing intelligible? Yes No
39. Can he or she say short sentences? Yes No
40. Can he or she write short sentences? Yes No
41. Can he or she repeat or copy words? Yes No
42. Is there automatic speech (e.g., “Hello,” “Thank you,” “I’m fine.”)? Yes No
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>43. Can he or she understand conversational speech?</td>
<td>Yes</td>
</tr>
<tr>
<td>44. Can he or she read and understand the newspaper?</td>
<td>Yes</td>
</tr>
<tr>
<td>45. Have you read or heard anything about aphasia/head injury/illness?</td>
<td>Yes</td>
</tr>
<tr>
<td>46. If yes, what did you hear and where did you hear it?</td>
<td></td>
</tr>
<tr>
<td>48. What kind of information do you think you need about aphasia/head injury/illness?</td>
<td></td>
</tr>
<tr>
<td>49. What are the patient’s interests or favorite activities?</td>
<td></td>
</tr>
<tr>
<td>50. Can the patient engage in these activities as he or she did before aphasia/head injury/illness?</td>
<td></td>
</tr>
<tr>
<td>51. Does the patient show the same interest level in these activities?</td>
<td></td>
</tr>
<tr>
<td>52. Are the patient’s favorite activities the same now or different than before the aphasia/head injury/illness?</td>
<td></td>
</tr>
<tr>
<td>53. Does the patient watch TV? If so, what are his or her favorite programs?</td>
<td></td>
</tr>
<tr>
<td>54. Does the patient read much? If so, what type of reading material does he or she enjoy?</td>
<td></td>
</tr>
<tr>
<td>55. Did the patient like to read before aphasia/head injury/illness? Yes No</td>
<td></td>
</tr>
<tr>
<td>56. Is his or her level of reading the same now or different than it was before the aphasia/head injury/illness?</td>
<td></td>
</tr>
<tr>
<td>57. Does the patient write notes or letters?</td>
<td></td>
</tr>
<tr>
<td>58. Did the patient like to write before the aphasia/head injury/illness? Yes No</td>
<td></td>
</tr>
</tbody>
</table>
59. Is his or her level of writing the same now or different than it was before the aphasia/head injury/illness?

60. Has the patient been seen for any of the following?

<table>
<thead>
<tr>
<th></th>
<th>Dates</th>
<th>Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Speech therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Audiology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Physical therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Occupational therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Psychological counseling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Other rehabilitation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

61. What medications is the patient currently taking?

________________________________________________________________________

________________________________________________________________________

62. Does the patient have any difficulty chewing or swallowing food or liquids?  Yes  No

If yes, please describe:________________________________________________________________________

________________________________________________________________________

63. What are you expectations for this evaluation and/or treatment? ________________

________________________________________________________________________
VOICE EVALUATION CASE HISTORY

Name: _______________________________________________  Date: ____________
Address: _______________________________________________________________________
DOB: ____________________________  Age: _______________
Occupation(s): __________________________________________________________________
Primary Phone: __________________________
Referred by: __________________________________
Primary Care Physician: ___________________________________
Person completing this application: _____________________________

1. Describe your voice concern:
When did your voice problem start?

2. Did it start suddenly or gradually? ________________________________

3. It is getting worse, staying the same or getting better? ________________________________

4. Does anything help your voice improve?

5. Does anything make your voice worse?

6. Describe any treatment or care you have received for your voice problem.

7. Does your voice require more effort than it used to?  Yes  No
   If the answer is yes, please use the line below to indicate how effortful voicing is for you. Make a small mark on
   the point of the line that matches how much effort you use for your voice. A mark on the left end would
   indicate little or no effort. A mark on the right end would indicate a lot of effort.

_______________________________________________________________________________

               No effort                                           Maximum effort
9. Does your voice keep you from doing anything?

10. Do you have any problem with breathing, e.g., asthma or COPD?

11. Do you use a CPAP for breathing help at night? Yes _______ No _____
   a. If yes, does it have a humidifier? Yes _______ No _____
   b. If not, do you often snore while sleeping? Yes _______ No _____

12. Do you have any problem with swallowing or choking when eating? Yes ________ No ___
   If yes, describe below:

13. Do you have allergies? Yes _____ No
   If yes, please list them: ________________

14. Do you have frequent sinus problems? Yes ________ No __

15. List all your medical conditions (we can copy a list if you have it):

16. List all of your surgeries (we can copy a list if you have it):

17. List all medications-prescription and over-the-counter (we can copy a list if you have it):

18. Do you currently smoke? ____Yes ___No
   a. If yes, how much per day? ______________________ How many years? ______________________

19. How much water do you drink each day? ________________________________

20. How much caffeine do you drink each day? ________________________________

21. How much alcohol do you drink each week? ________________________________
22. Please check the line if you have experienced any of the following symptoms of acid reflux:  heartburn

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequent coughing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequent belching</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequent bad breath</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waking at night coughing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequent vomiting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lump in throat</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regurgitation of food</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acidy or burning throat</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequent throat clearing</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
AUTHORIZATION FORM

NAME: ____________________________________________ DATE:_________________

PERMISSION TO EVALUATE: I hereby give permission to the Auburn University Speech & Hearing Clinic to conduct an evaluation of the speech, language, voice, and/or hearing abilities of the above named individual.

PERMISSION TO TREAT: If results of evaluation procedures indicate the need for therapy, I give permission to the Auburn University Speech & Hearing Clinic to provide treatment for the above named individual.

LIABILITY AGREEMENT: I release the Auburn University Speech & Hearing Clinic of liability of any nature arising from my/the client’s participation in procedures and activities at the Auburn University Speech & Hearing Clinic.

AUTHORIZATION FOR RELEASE OF CLINICAL INFORMATION: I consent to the release of relevant confidential material, related to evaluation and treatment procedures, to qualified professional personnel in furtherance of clinical services on behalf of the above named person, as deemed necessary by personnel of the Auburn University Speech & Hearing Clinic. I permit faculty, staff, or student clinicians to contact the above named person at the place of employment regarding appointments. In addition, I permit representatives from the Auburn University Speech & Hearing Clinic to contact the above named person regarding future services, events, and/or programs (i.e. hearing aid open house, research).

I have received the Notice of Privacy Practices information and I have been informed of my rights regarding services provided by the Auburn University Speech & Hearing Clinic.

____________________________________    ______________________________________
Print name                                          Address

_________________________    _________________________________________
Relationship                             City                          State     Zip code

____________________________________
Signature                                               Home or cell phone number

____________________________________
E-mail address                                         Work phone number
Protocol for School-Age Language Evaluation

All assessments should include the following procedures:

I. Case History (Background questionnaire and/or interview)
   a. Family information
   b. Description of the problem
   c. Pregnancy and birth history
   d. General development
   e. Referral Source
   f. Medical history
   g. Speech and language development
   h. History of services received
   i. Impact of the problem on child/family

II. Standardized Language Test
   • May use the following measures, as appropriate:
     o CELF
     o TOLD-P; TOLD-I
     o OWLS (Oral Expression and Listening Comprehension Scales)
     o CASL
     o Additional comprehensive assessments, as appropriate

IV. Pragmatic Analysis
   • May use the following measures, as appropriate
     o Test of Pragmatic Language
     o Informal Measures
       1. Clinical Discourse Analysis
       2. Topic Manipulation Analysis
       3. Prutting and Kirchner’s Pragmatic Protocol

IV. Language Sample (a minimum of 50 utterances)
   • MLU per T-Unit
   • Error Analysis
   • Type Token Ratio

V. Narrative Analysis
   • Story grammar analysis
   • Cohesion Analysis

V. Phonology
   • Articulation screener or formal evaluation as appropriate

VIII. Oral mechanism exam
   • May use the following measures, as appropriate:
     o OSMSE
     o Informal assessment, as appropriate

IX. Hearing Screening

X. Other Areas
   • Informal assessment of voice and fluency
   • Supplemental assessment measures may be used as appropriate
Protocol for Early Child Language Evaluation

All assessments should include the following procedures:

I. Case history (Background questionnaire and/or interview)
   a. Family information
   b. Description of the problem
   c. Pregnancy and birth history
   d. General development
   e. Referral Source
   f. Medical history
   g. Speech and language development
   h. History of services received
   i. Impact of the problem on child/family

II. Behavioral observation of client’s temperament and level of cooperation

III. Standardized Language Test
   - May use the following measures, as appropriate:
     o PLS-4
     o CELF-P
     o TOLD-P
     o Additional comprehensive assessments, as appropriate
   - For the hard to test child, select from the following:
     o Rossetti Infant-Toddler Language Scale
     o Receptive-Expressive Emergent Language Scale

IV. Expressive Vocabulary Measure
   - May select from the following:
     o Macarthur Bates Communication Development Inventory
     o Language Development Survey

V. Measure of Developmental Level
   - May use any of the following, as appropriate:
     o Westby’s Symbolic Play Scale
     o Mullen Scales of Early Learning
     o CSBS DP

VI. Language sample.
   - For verbal children, enough to elicit 50 spoken utterances for purposes of semantic and syntactic analysis
   - For nonverbal and verbal children, use to measure communicative intent

VII. Pragmatics
   - Select from the following, as appropriate
     o Communicative Intent worksheet
     o Peanut Butter Protocol
     o Prutting and Kirchner’s Pragmatic Protocol
     o Parent Rating Scale (Girolametto, 1997)
     o Clinic Developed Protocol
VIII. Phonetic Inventory and/or standardized articulation assessment as appropriate

IX. Oral mechanism exam
   • May use the following measures, as appropriate:
     o OSMSE
     o Informal assessment, as appropriate

X. Hearing Screening

XI. Other parameters
   • Informal assessment of voice and fluency
   • Supplemental assessment measures may be used as appropriate
Protocol for Adolescent Language Evaluation

All assessments should include the following procedures:

I. Case history (Background questionnaire and/or interview)
   a. Family information
   b. Description of the problem
   c. Pregnancy and birth history
   d. General development
   e. Referral Source
   f. Medical history
   g. Speech and language development
   h. History of services received
   i. Impact of the problem on child/family
   j. Impact of the problem on academic performance

II. Standardized Language Test
   • May use the following measures, as appropriate:
     o CELF-4
     o TOAL
     o TOLD-I-4
     o OWLS (Oral Expression and Listening Comprehension Scales)
     o CASL
     o Additional comprehensive assessments, as appropriate

III. Pragmatic Analysis
   • May use the following measures, as appropriate
     o Test of Pragmatic Language-2
     o Pragmatic Checklist from the CELF-4
     o Informal Measures, including:
       1. Adolescent Conversational Analysis
       2. Pragmatic Rating Scale

IV. Language sample (a minimum of 50 utterances)
   • MLR per T-Unit
   • Error Analysis
   • Subordination Index (Ratio of Clauses to T-Units)

V. Narrative Analysis
   • Story Grammar Analysis (pay particular attention to internal response and internal plan at this stage)
   • Cohesion Analysis

VI. Phonology
   • Articulation screener or formal evaluation, as appropriate (see artic protocol)

VII. Oral mechanism exam
   • May use the following measures, as appropriate:
     o OSMSE
     o Informal assessment, as appropriate
VIII. Hearing Screening

IX. Other Areas
  • Informal assessment of voice and fluency
  • Supplemental assessment measures may be used as appropriate

For clients with language and literacy concerns, include the following measures:

X. Reading Comprehension
  • May use the following measures, as appropriate:
    o Grey Diagnostic Reading Test
    o Test of Reading Comprehension

XI. Written Product Analysis
  • May use the following measures, as appropriate
    o TOWL-4
    o OWLS: Written Language Scale
    o May also assess through any of the following measures by analyzing
      either a 3 to 5 minute timed sample or conducting an artifact analysis;
      See Paul for more information
      1. Holistic Evaluation (provide a numerical score based on overall impression of the writing)
      2. Primary Trait (measures writing against a rubric based on a 5 point scale)
      3. Analytic (evaluate aspects of the writing separately, such as DSS and TTR)
Protocol for Pre-Literacy Evaluation (Ages 6 and below)

All assessments should include the following procedures:

I. Case history (Background questionnaire and/or interview)
   a. Family information
   b. Description of the problem
   c. Pregnancy and birth history
   d. General development
   e. Referral Source
   f. Medical history
   g. Speech and language development
   h. History of services received
   i. Impact of the problem on child/family
   j. Impact of the problem on academic performance

II. Reading Comprehension, Fluency, Accuracy, Rate, and Overall Ability
   o Grey Diagnostic Reading Test

III. Writing

Administer 1 of the following:
- Test of Early Written Language
- Oral and Written Language Scales (OWLS) written expression subtest

IV. Standardized Language Test

- Select a standardized assessment from the appropriate protocol (may choose OWLS if using written subtest)

V. Phonology

- Articulation screener or formal evaluation, as appropriate (see artic protocol)

VI. Phonological Awareness

Administer 1 of the following:
- Test of Phonological Awareness (TOPAS)
- The Phonological Awareness Test-2
- Comprehensive Test of Phonological Processing

VII. Oral mechanism exam

- May use the following measures, as appropriate:
  o OSMSE
  o Informal assessment, as appropriate

VIII. Hearing Screening

Based on the individual client, the following should be considered:

VIV. Narrative Analysis

- Story grammar analysis (see Paul text)

VV. Story Retelling Analysis

- Analysis based on Culatta, Page, & Ellis, 1983
- Test of Narrative Language

VI. Metalinguistic Skills

- Test of Language Competence Expanded

Other Areas

- Informal assessment of voice and fluency
- Supplemental assessment measures may be used as appropriate
Protocol for Literacy Evaluation (Ages 7 and older)

All assessments should include the following procedures:

I. Case history (Background questionnaire and/or interview)
   a. Family information
   b. Description of the problem
   c. Pregnancy and birth history
   d. General development
   e. Referral Source
   f. Medical history
   g. Speech and language development
   h. History of services received
   i. Impact of the problem on child/family
   j. Impact of the problem on academic performance

II. Reading Comprehension, Fluency, Accuracy, Rate, and Overall Ability

Administer all of the following:
   • Grey Oral Reading Test-4 (GORT)
   • Grey Diagnostic Reading Test
   • Test of Silent Contextual Reading Fluency (TOSCRF)

III. Writing

Administer 1 of the following:
   • Test of Written Language (for children 9-17)
   • Oral and Written Language Scales (OWLS) written expression subtest

IV. Standardized Language Test

   • Select a standardized assessment from the appropriate protocol (may choose OWLS if using written subtest)

V. Oral mechanism exam

   • May use the following measures, as appropriate:
     o OSMSE
     o Informal assessment, as appropriate

VI. Hearing Screening

Based on the individual client, the following should be considered:

VII. Phonology

   • Articulation screener or formal evaluation, as appropriate (see articulation protocol)

VIII. Narrative Analysis

   • Story grammar analysis (see Paul text)

IV. Story Retelling Analysis

   • Analysis based on Culatta, Page, & Ellis, 1983
   • Test of Narrative Language

VV. Metalinguistic Skills

   • Test of Language Competence Expanded

Other Areas

   • Informal assessment of voice and fluency
   • Supplemental assessment measures may be used as appropriate.
Protocol for Literacy Evaluation

All assessments should include the following procedures:

I Case history (Background questionnaire and/or interview)
- Family information
- Medical history
- Description of the problem
- Speech and language development
- Pregnancy and birth history
- History of services received
- General development
- Impact of the problem on child/family
- Referral Source
- Impact of the problem on academic performance

II Standardized Language Test
- Select a standardized assessment from the appropriate protocol (i.e., school-age, adolescent)

III. Phonology
- Articulation screener or formal evaluation, as appropriate (see artic. protocol)

IV. Phonological Awareness (for children 5-8)
- Test of Phonological Awareness (TOPA)
- The Phonological Awareness Test 2
- Comprehensive Test of Phonological Processing

V. Narrative Analysis
- Story grammar analysis (see Paul text)

VI. Story Retelling Analysis
- Analysis based on Culatta, Page, & Ellis, 1983
- Test of Narrative Language

VII. Metalinguistic Skills
- Test of Language Competence Expanded

Writing
- Test of Early Written Language (for children 5-8)
- Test of Written Language (for children 9-17)

V. Reading Comprehension, Fluency, Accuracy, Rate, and Overall Ability
- Grey Diagnostic Reading Test
- PAL-II
- TERA 3 (for children under 9)
VI. Oral mechanism exam
- May use the following measures, as appropriate:
  - OSMSE
  - Informal assessment, as appropriate

VII. Hearing Screening

VIII. Other Areas
- Informal assessment of voice and fluency
- Supplemental assessment measures may be used as appropriate
Fluency Diagnostic Protocol: Child

I. Case history (Background questionnaire and/or interview)
   - Family information
   - Medical history
   - Description of the problem
   - Speech and language development
   - Pregnancy and birth history
   - History of services received
   - General development
   - Impact of the problem on child/family
   - Referral Source
   - Impact of the problem on academic performance

II. Informal language/fluency assessment – obtain via language sample with clinician/parent (assess severity and type of disfluencies)

III. Formal language assessment
Ages 2-6 (PLS-4, CELF-P)
Ages 6-13 (TOLD:P, TOLD-I:3, CELF-4, CASL, OWLS)

IV. Formal articulation assessment

V. Formal Fluency Assessment
   May use Stuttering Severity Instrument (SSI-4) or Stuttering Prediction Instrument (SPI)
   Attitudinal measures when appropriate (ACES, Kiddy Cat)

VI. Oral mechanism exam
   - May use the following measures, as appropriate:
     - OSMSE
     - Informal assessment, as appropriate

VII. Hearing Screening

VIII. Other:
Home speaking sample (if possible)
Fluency Diagnostic Protocol: Adolescents & Adults

I. Case history (Background questionnaire and/or interview for adolescents)
   - Family information
   - Description of the problem
   - Pregnancy and birth history
   - General development
   - Referral Source
   - Medical history
   - Speech and language development
   - History of services received
   - Impact of the problem on child/family
   - Impact of the problem on academic performance

For adults, you would include:
   a. Vocational history
   b. Therapy history (if any)

II. Language Sample/reading sample
   • 5-10 minute conversational sample
   • Reading passages from SSI-4

III. Formal Language Assessment:
   Adolescents: CASL, TOAL, CREVT

IV. Attitudinal Measures
   • Assessment of Child’s Experience of Stuttering (ACES)
   • Overall Assessment of Speaker’s Experience of Stuttering (OASES)
   • Erickson Scale
   • Perceptions of Stuttering inventory
   • Locus of Control
   • Self-Efficacy Scale

V. Formal Assessment of Stuttering

VI. Hearing Screening

VII. Oral Mechanism Exam (if necessary)
Protocol for Phonological Evaluation Procedure

All phonological evaluations must be audio recorded for post-session analysis

All phonological assessments should include the following procedures:

I. Case history (Background questionnaire and/or interview)
   - Identifying & family information
   - Description of the problem
   - Pregnancy and birth history
   - General development
   - Medical history
   - Speech and language development
   - Educational history

II. Standardized articulation or phonology test(s)
   Speech sound inventory (SSI) such as the Goldman-Fristoe Test of Articulation-2nd Edition (GFTA-2)

   When the SSI reveals multiple errors or errors which suggest an underlying pattern, use a pattern analysis (such as a phonological process analysis)

III. Independent analyses (Especially when phonology appears limited)

   Phonetic inventory (manner x place x voice)

   Syllable and word shapes

IV. Connected speech and language sample. (Enough to elicit 80-100 different words; usually at least 250 words total)

V. Non-standardized phonological probe (Additional words are elicited to further define or clarify patterns that might be suggested in other testing.)

VI. Stimulability testing

VII. Standardized language test (PLS-4, CELF-4, TOLD, etc.)

VIII. Oral mechanism exam

IX. Earing Screening

X. Other as needed

   Vowels
   Speech perception (Suggest Locke’s SPPT)
   Phonological awareness (e.g., TOPAS)
Protocol for the Assessment of Accent/Dialect

Assumptions
1. This protocol refers to persons learning English as a second language (L2), as well as English speakers with regional dialects.

2. The procedures described here are to be used when the problem is clearly understood to be one of dialect and accent. It is not intended that these procedures should be used in assessments for the purpose of distinguishing language/phonological differences and disorders.

Rationale
Accent and dialect differences present two primary problems for effective communication. The first is the overall intelligibility of the spoken message. The spoken English of some dialectal/accented speakers is so far from Standard English that the message cannot be easily decoded by the listener. However, many heavily accented speakers are highly intelligible but their speech sound production, supra-segmental aspects, syntax, and vocabulary may be so different from Standard English that it calls attention to itself and interferes with communication. In the latter situation the speech pattern may suggest geographic influences which, for various reasons, the speaker finds undesirable.

Assessment Procedures
Assessment of dialect and accent must take into account both intelligibility and accent. Although a standard reading passage such as the rainbow passage has some value in assessing specific differences in speech patterns, an assessment must also include spontaneous speech samples for which the listener is unaware of the intended content.

Every Dialect/Accent Assessment should include the following:
1. Administer a speech sound inventory appropriate for an adult such as the Photo Articulation Test (PAT) and elicit a sample of reading from a standard reading passage. Based on this sample:
   A. Determine phonemic errors- substitution or omission of phonemes
   B. Determine phonetic differences in the production of phonemes
   C. Determine intonation differences- within word and within sentence

2. Elicit a spontaneous speech sample
   - Write out, word for word, what is heard to determine a degree of intelligibility
   - Judge the sample for comprehensibility (easy to understand difficult to understand)
   - Rate the degree of accent
   - Note syntactic difference from Standard English
   - Note semantic differences from Standard English

In some cases a formal assessment instrument such as the Proficiency in Oral English Communication (POEC) may be substituted for the above procedures.
Protocol for Aphasia Evaluation

All assessments should include the following procedures:

I. Case history (Background questionnaire and/or interview)

The Adult AUSHC case history will be completed including the following:

- Personal information
- Description of the problem
- Social history
- Medical history including current medications

- Occupational history & needs
- Previous services received
- Expectations from evaluation/tx

II. Standardized Language Test (at least one complete test of the following)

Western Aphasia Battery (WAB)
Boston Diagnostic Aphasia Examination (BDAE)
BDAE Naming Test

III. Language sample (Comment on the following) Effectiveness

Efficiency
Modalities used to communicate

IV. Oral mechanism exam (including screening for Apraxia of Speech)

V. Hearing Screening (if appropriate)

VI. Analysis of assessment data

VII. Diagnosis and Prognosis

VIII. Recommendations

IX. Goals and treatment plan
Protocol for Central Auditory Processing Evaluation

All assessments should include the following procedures:

I. Case history (Background questionnaire and/or interview)
   - Family information - Medical history
   - Description of the problem - Speech and language development
   - Pregnancy and birth history - History of services received
   - General development - Impact of the problem on child/family
   - Referral Source - Impact of the problem on academic performance
     (Ability to remain on task and follow directions, any accommodations)
   - Sensitivity to specific sounds - Any audiological testing obtained
   - Psychological testing

II. Standardized Language Test
    May use the following measures, as appropriate for children 7 years and older:
    CELF-4
    TOAL
    TOLD-I-4
    CASL
    *Additional comprehensive assessments, as appropriate.

*If the client scores one standard deviation below the mean or greater, a language sample should be obtained and analyzed including the following: MLR per T-Unit, Error Analysis, Subordination Index (Ratio of Clauses to T-Units).

III. Auditory Processing Test (recommend both of the following)
    Test of Auditory Processing (TAPS)
    The Token Test

IV. Problem Solving
    Test of Problem Solving (TOPS)

V. Oral Mechanism Exam
    May use the following measures, as appropriate:
    OSMSE
    Informal assessment, as appropriate

VI. Hearing Screening

VII. Other Areas
    Articulation screener or formal evaluation, as appropriate
    Informal assessment of voice and fluency
    Supplemental assessment measures may be used as appropriate
Protocol for Pediatric Dysphagia Evaluation

All patients/clients with pediatric dysphagia disorders should be examined by a physician, preferably in a discipline appropriate to the presenting complaint. Usually this will be a pediatric gastroenterologist or pediatrician.

A modified barium swallow study and a medical release may be required for some cases. Pending physician recommendations, some portions of the assessment protocol may need to be omitted for client safety.

Assessment information obtained from Suzanne Morris, *Oral-Motor Development Assessment*, normed for children aged birth to three years.

A pediatric dysphagia evaluation may include the following:

I. **Relevant case history information:**

Whether gathered through a written case history form, interview, or both the examiner should obtain the following information:

- Birth and developmental history
- Medical history & current medical status
- Medical procedures
- Medications
- Oral-Motor development
- When and under what circumstances was the problem first noted? How has the problem changed since onset?
- Cultural and linguistic backgrounds

II. **Reported Information**

A. Typical diet
B. Amount and types of foods accepted
C. Foods accepted – typical response
D. Foods not accepted – typical response
III. Oral Motor reflexes

A. Rooting response
B. Phasic bite
C. Suck-swallowing reflex
D. Palmomental reflex
E. Gag reflex

V. Assessment of sucking/suckling skills

A. Bottle drinking
   1. Quality of suck (rapid, rhythmical)
   2. Suck versus suckle
   3. Level of active lip movement
   4. Amount of fluids taken by cup

B. Cup drinking
   1. Age cup was introduced
   2. Amount of fluids taken by cup
   3. Graded jaw movement on un-lidded cup
   4. Suck-swallow breathe sequence

C. Spoon
   1. Acceptance of spoon
   2. Lip movement on spoon
D. Tongue Configuration (i.e., thin cupped with central grooving or thick and bunched)

VI. Assessment of swallowing skills

A. Presence of normal easy tongue protrusion
B. Presence of forceful tongue protrusion
C. Elevation of tongue
D. Drooling
E. Food and or liquid loss
F. Presence of gagging

VII. Assessment of Biting and chewing skills

A. Jaw pattern (i.e., vertical, horizontal, diagonal-rotary)
B. Tongue movement (i.e., lateral, protrusion)
C. Chewing pattern (i.e., suckle-munch, munch)
D. Transfer of food (i.e., side to center or across mid-line)
E. Lip movement during chewing (down and forward to close on a spoon, lip closure, circular lip movements)
G. Graded jaw movements on a soft solid
H. Graded jaw movements on a hard solid

VIII. Sensory acceptance of a variety of textures
Protocol for Dysphagia Evaluation

All assessments should include the following procedures:

I. **Case history** (Background questionnaire and/or interview)
   Swallowing Questionnaire (**See Appendix A**)
   a. Personal information
   b. Description of the problem
   c. Medical history
   d. Social history
   e. Occupational history & needs
   f. Previous services received
   g. Feeding method
   h. Respiratory status
   i. Mental status

II. **Clinical-Bedside Swallow Assessment (See Appendix C)**
   Clinical – Bedside Assessment; will depend on information from history and Oral-Motor assessment
   Food consistency protocol:
   - ¼ teaspoon of thin or thickened liquids progress as patient can safely tolerate
   - Larger amounts and various consistencies
   - Attempt compensatory strategies as needed
   - Changes in patient (posture), Feeding activity (dry swallows, straw-no straw), Food – Liquid (consistency, amount)

III. **Speech-Language screening**
   Ability to understand and follow instructions

IV. **Oral mechanism exam (See Appendix B)**

V. **Hearing screening if appropriate**

VI. **Analysis of assessment data**

VII. **Impressions-Dysphagia Diagnosis**
   Impressions – Type of problem, Severity, Positives, Challenges, Prognosis

VIII. **Recommendations**
   - Treatment-No treatment
   - Referrals
   - Patient, feeding activity, Food
   - Further assessment (FEES, MBS) or other discipline (Neurologist, ENT,)

IX. **Goals and treatment plan**
Appendix A  

SWALLOWING HISTORY QUESTIONNAIRE

Patient’s Name ______________________________ Age

Referred by ________________________________ Family
Physician ________________________________

Swallowing History

1. Describe in your own words your swallowing problems (s):

2. How long have you had a swallowing problem?

3. Are the problems getting worse?

4. Are the problems constant?

5. How often do these problems occur? Please circle:
   - every meal
   - one or two meals a day
   - only occasionally

6. What types of food/liquids are you able to eat without difficulty?

7. Are liquids easier for you to swallow? ____________

8. What types of foods/liquids cause you problems with swallowing?

9. Are crisp fruits, vegetables, meats or breads difficult to swallow? ____________

10. Are carbonated beverages difficult to swallow? ____________

11. Is a certain food temperature better? ____________ If yes, please circle:
    - hot
    - lukewarm
    - cold

12. Are sweet or sour foods difficult to swallow? ____________ If yes, please explain.

13. Please list any foods/liquids you avoid because of your swallowing problems.

Presenting Complaints:

Please place a check beside those items that apply to you.

- poorly fitting dentures
- dry mouth
- excessive saliva in your mouth
- sour taste in your mouth
- drooling
- difficulty chewing
- food/liquid dribbling from your mouth
- food sticking in your cheeks or roof of mouth
- unable to taste food/liquids as well as you used to
- feeling of food/liquid coming through your nose
Feeling of food sticking in your throat during or after swallow

Pain in your throat when swallowing

Need to take more than one swallow per bite

Pain behind the breastbone after meals

Heartburn/indigestion

Regurgitation of food or liquid, without vomiting, especially when lying down

Recent loss of appetite

Chronic cough

Thick mucus in the throat

Wet pillow in the morning

Frequent sore throat

Coughing during meals

Sneezing during meals

Choking during meals

Hiccups during/immediately after a meal

Need to clear your throat when eating

Vomiting

Feeling of food sticking in the chest area

Need to make yourself vomit to relieve pain or discomfort

Eating Habits:
1. How many meals do you eat daily? ___________ Do you talk a lot during meals?

2. Do you use commercial nutritional supplements? (e.g. Ensure, Sustacal)?

3. Are you a slow eater? _______ fast eater? _______ average? _______

4. Do you get full quickly? _________________ Do you get tired during your meals?

6. Do you get anxious or nervous when eating at home? _______ When eating in restaurants? _______

Associated Factors

Have you noticed any change in your speech? _______ If yes, please explain.

________________________________________________________________________

________________________________________________________________________

2. Have you noticed any change in the sound of your voice? _______ If yes, please explain.

________________________________________________________________________

________________________________________________________________________

3. Check any that pertain to you.

_____ Arm or leg weakness  _____ Change in sleep

_____ Recent onset of fatigue  _____ patterns recent onset of snoring

Medical History

1. Please place a check beside any of the following medical conditions that pertain to you.

_____ heart disease  _____ thyroid disorder  _____ stroke

_____ hypertension  _____ respiratory problems  _____ cancer

_____ diabetes  _____ recent pneumonia  _____ oral surgery
2. List any allergies (including food allergies) that you have.

________________________________________________________________________

3. Have you had a recent weight loss? _______ weight gain? _______ If so, how many pounds have you lost or gained? _______ In what period of time? _______.

4. Do you have any relatives who have had similar swallowing problems? If yes, please explain.

________________________________________________________________________

5. Do you smoke? _______ If yes, how much?

6. Do you drink alcoholic beverages? _______ If yes, how often?

7. Do you drink coffee or other beverages containing caffeine? _______ If yes, how often?

________________________________________________________________________

8. Please list all medications that you are currently taking.

________________________________________________________________________

9. Please indicate places and dates of any previous evaluation or treatment for swallowing problems.

ENT evaluation

________________________________________________________________________

Gastroenterology evaluation

________________________________________________________________________

Neurology evaluation

________________________________________________________________________

Speech Pathology evaluation

________________________________________________________________________

Other

________________________________________________________________________

10. Please place a check beside the following test(s) you have had in the past year.

    _____ Chest x-ray
    _____ Upper GI
    _____ Lower
    _____ Barium swallow
    _____ Lower GI
Appendix B

Motor Speech Protocol

NAME: _______________________    DATE: ___________________________

AUTOMATIC:
1) Tell me your: Name: ________________________ Address: __________
   Birthdate: ___________ Age: ________________
2) Count to 20: 1 2 3 4 5 6 7 8 9 10
   11 12 13 14 15 16 17 18 19 20
3) Count as fast as you can on 1 breath (2x):
   _____________________________________________________________________
4) Count from 15-30 as fast as you can:
   _____________________________________________________________________

SPONTANEOUS:
1) Why are you in the hospital?
   _____________________________________________________________________
2) What do you or have you done for a living?
   _____________________________________________________________________
3) Tell me what is wrong with your speech.
   _____________________________________________________________________

READING:
Read “My Grandfather”

PHONATION:
Take a deep breath and say /a/ as long as you can:
_________________________________________________________________
/i/_________________________________ /u/
_________________________________________________________________

IMITATION:
1) Monosyllables (Scheull, 1965)
   pie __ two____ see ___ key ___ crow ___spry _____ boy _____ day ______
   free ____ street ____ four ___ lie ___ they ___ chew ___ play ___ school ______
   vote ___ row ___ you ___ clay ___ pray ___ screw _____ three _____ try ______
2) Phrases (Scheull, 1965)
   man and woman ___________________ easy does it __________________________
   paper and pencil ___________________ thirty three _________________________
   baseball and bat ___________________ father and mother ___________________
knife and fork __________________ a year yesterday __________________________
two times two __________________ bake a cake ____________________________
door and window _______________ guess again ___________________________
light the lamp __________________ sing a song _____________________________
drive a car _____________________ a kitchen chair ________________________
sell the house __________________ orange juice __________________________

NAME THE DAYS OF THE WEEK: Monday Tuesday Wednesday Thursday Friday Saturday Sunday

RAPID ALTERNATING MOVEMENTS:
Say: ma ma ma ma _________________________________
     la la la la _________________________________
     ka ka ka ka _________________________________
     ta ta ta ta _________________________________
     pa pa pa pa _________________________________

IMPRESSIONS:
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

RECOMMENDATIONS:
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
## Appendix C

### Oral Motor Examination

**NAME: ___________________ DATE: ____________ EXAMINER: ______________________**

Rating Scale: 4 = Normal, 3 = Slight Impairment, 2 = Significant Impairment, 1 = No Movement

### LIPS (VII)

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### MANDIBLE (V)

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### TONGUE (XII)

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**Sequential Movement:**

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<th>Precision</th>
<th>Timing</th>
<th>Rate</th>
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<th>/gip/</th>
<th>Norm</th>
<th>Precision</th>
<th>Timing</th>
<th>Rate</th>
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</thead>
</table>

### TEETH

**Occlusion:**

Dentures

### PALATE (XI & X)

**Hard**

**Soft**
Length _____________________ Shape ___________________ Gag Reflex ___________________

Mobility:  
Prolonged /a/ __________________

/i/ __________________

Repetition /a/ __________________

**LARYNGEAL MECHANISM (X)**

Quality: Normal ______ Breathy ______ Hoarse ______ Harsh ______ Tremor ______

Comments: ____________________________________________________________

Pitch: Normal ______ High ______ Low ______ Pitch Breaks ______

Comments: ____________________________________________________________

Loudness: Normal ______ Excessive ______ Low ______ Variable ______

Duration: /a/ _____ seconds  /i/ _____ seconds

Coughing: Normal _____ Hypoadduction _____ Hyperadduction _____

Comments: ____________________________________________________________

**PROSODY**

Normal _____ Monopitch _____ Monoloudness _____ Reduced Stress _____ Excess Stress _____

**IMPRESSIONS:**

<table>
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<th></th>
<th>WNL</th>
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<th>Moderate</th>
<th>Severe</th>
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<td>Voice</td>
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</tbody>
</table>

**RECOMMENDATIONS:**

No Oral Motor recommendations

Restore: __________________________________________________________________________

Compensate:

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

Adjust: ____________________________________________________________________________
Appendix D  Structure and Function Assessment Summary

Is the face symmetrical? Yes ___ No ___
Are the angles of the mouth symmetric? Yes ___ No___
Is asymmetry due to drooping of the entire face on one side ___, a droop at the corner of the mouth ___, or flattening of the naso-labial fold ___?
Is the face expressionless ___, masklike ___, or unblinking ___?
Is it held in a fixed expression of smiling, astonishment, or perplexity? Yes ___ No ___
Does the upper lip appear stiff? Yes ___ No ___
Are abnormal spontaneous, involuntary movements present? Yes ___ No ___
Do the eyes shut tightly and uncontrollably? Yes ___ No ___
Is there quick or slow symmetric or asymmetric pursing or retraction of the lips? Yes ___ No ___
Are there spontaneous smacking noises of the lips? Yes ___ No ___
Can the patient inhibit these movements on request? Yes ___ No ___If so, do they reappear when inhibitory efforts cease? Yes ___ No ___
Are the lips tremulous or are there tremor +like rhythmic movements of the lips? Yes ___ No ___
Are fasciculations present in the face, especially around the mouth or chin? Yes ___ No ___
Are lip retraction, rounding, and puffing symmetric? Yes ___ No ___
Is their range of movement normal ___ or restricted___?
When opening the mouth, is the configuration of the lips symmetric ___or does one side lag___?
Is the patient able to resist the examiner’s attempt to push the upper and lower lip toward the midline when the lips are retracted___ or when they are rounded___ ? Yes ___ No ___
Does air escape through the lips when the patient puffs the cheeks? Yes ___ No____
Can the seal be broken with less than normal pressure when the examiner pushes in on the cheeks? Yes ___No___
Does tremulousness appear ___or disappear___ during sustained facial postures? Yes ___ No___
Are additional movements present that distort or alter the ability to maintain the sustained posture? Yes ___ No ___
Can the patient maintain the posture for several seconds ___ or does he/she stop the effort even when instructed to maintain it___? Yes___ No___
Does the jaw hang lower than normal? Yes ___ No___
Are there spontaneous, apparently involuntary quick or slow movements of the jaw (clenching, opening/pulling to one side, tremor-like up and down movements)? Yes ___ No____
Has the patient learned any postural adjustments or tricks that tend to inhibit sustained involuntary
movements (i.e. clenching the jaw, holding a pipe in the mouth, touching a hand to the side of the jaw or neck)? Yes ___ No___

Does the jaw deviate to one side when the patient attempts to open it as widely as possible? Yes ___ No___

Is the patient able to open the mouth widely ____ or is excursion limited?
Can the patient resist the examiner’s attempt to open the jaw when told to clench the teeth? Yes___ No___

Can the jaw be closed against resistance from the examiner (either by holding the midline of the jaw with the hand or by placing a tongue blade on the lower teeth and resisting closure)? Yes ___ No ___

Do the masseter and temporalis muscles have normal bulk and bulge when the patient bites down? Yes ___No___

Can the patient resist the examiner’s attempt to close the jaw when told to hold it open? Yes ___ No___

Is the tongue full and symmetric? Yes___ No ___

If symmetric, is its size normal? Yes___ No___

If small, are there symmetric or unilateral grooves ____ or furrowing in the tongue representing atrophy? Yes ___ No____

Are fasciculations present? Yes ___ No___

If so, are they best observed when the tongue is at rest inside the mouth? Yes ___ No__

Does the tongue remain quiet on the floor of the mouth? Yes ___ No___

Are quick, slow, or sustained movements of large portions of the tongue apparent in the form of protrusion ___, retraction___, lateralization ___, or writhing____? Yes ___ No___

Is the tongue excessively wet ____ or dry___? Yes ___ No___

Can the patient protrude the tongue to a normal degree? Yes ___ No___

Does the tongue consistently deviate to one side or the other? Yes ___ No___

Can the patient resist the examiner’s attempt to push the tongue back into the mouth? Yes ___ No____

Does the palate hang low in the mouth? Yes ___ No____

Does it rest on the tongue? Yes ____ No____

Are the palatal arches symmetric ____ or does one side hang lower than another___? Yes ___No___

Are there spontaneous rhythmic or arrhythmic beating movements of the palate? Yes ___No ____

Is the palatal movement symmetric? Yes ___ No___

If asymmetric, does the palate elevate more strongly to the side opposite that which hung lower at rest? Yes ___ No___
Is there evidence of nasal airflow on a mirror held at the nares during vowel prolongation, prolongation or repetitions of pressure sounds (/s/, /p/), or words or phrases with non-nasal consonants? Yes ___ No___
Does resonance change during vowel prolongation with the nares occluded versus unoccluded? Yes ___ No___

Respiration:
Is the patient’s posture normal? Yes ___ No___
If not, is the patient slouched in the chair or bent forward or to the side? Yes ___ No___
Does the patient tend to gravitate over time toward abnormal posture? Yes ___ No___
Does it require effort or assistance to resume a more normal posture? Yes ___ No___
Does the patient complain of shortness of breath at rest, during physical exertion, or during speech? Yes ___ No___
Is breathing rapid, shallow, or labored? Yes ___ No___
Are abdominal or chest wall movements asymmetric or limited in range during rest breathing, speech, or maximum inspiration? Yes ___ No___
Is breathing accompanied by shoulder movement, neck extension, retraction of the neck just above the upper sternum on inhalation, or flaring of the nares on inhalation? Yes ___ No___
Is breathing irregular? Yes ___ No___
Are there any abrupt or slow abdominal or chest wall movements that alter or interrupt normal cyclical breathing during rest breathing, speech, or maximum inspiration? Yes ___ No___
Does the patient have hiccups? Yes ___ No___

Reference:
Protocol for Resonance Disorders

Qualifying statement
Resonance problems, especially hypernasality, often indicate velopharyngeal inadequacy. The best methods for verifying the presence and extent of VPI are endoscopy and radiography. Therefore all clients presenting with consistent unstimulable hypernasality and nasal emission should be referred for nasendoscopy and/or radiographic studies. In the case of children, this referral may best be made to a cleft palate or craniofacial clinic. Resonance disorders frequently overlap with articulation disorders. For example hypernasality may also be accompanied by nasal emission and/or the presence of compensatory articulation errors. Therefore all resonance evaluations should also include an articulation assessment.

I. Oral mechanism exam
Pay particular attention to:
- Craniofacial anomalies that might suggest a syndrome
- Ability to develop intraoral pressure with nares occluded and un-occluded
- The presence of any fistulae
- Scarring or abnormalities of the hard palate
- Signs of a sub-mucous cleft
- Mobility of velum

II. Speech sound production
Standard articulation test such as the Goldman-Fristoe Test of Articulation
Connected speech sample
Specialized reading passages and sentences to assess hyper, hypo nasality and nasal emission
Following the evaluation of speech sound production the examiner must determine whether errors are:
   a) Related to structural problems: Nasal emission
      Perceptual
      Mirror or See-Scape Weak pressure consonants
      Sibilant distortion (due to possible cross bite)
   b) Represent compensatory errors
   c) Are developmental in nature

III. Resonance
Perceptual ratings based on words and connected speech. Speech samples should include words with and without nasal consonants.
- May use a rating scale such as Buffalo resonance
- Objective assessment of nasalance using the Nasometer

IV. Phonation
- Listen for hoarseness
- Soft voice
V. Language
For children with clefts or craniofacial anomalies a language screening is required

7. Hearing
   Due to the high incidence of middle ear problems in the cleft population at the minimum a threshold test be conducted by audiology.
Protocol for Motor Speech Evaluation

All assessments should include the following procedures:

I. Case history (Background questionnaire and/or interview)
   a. Personal information
   b. Description of the problem
   c. Medical history
   d. Social history
   e. Occupational history & needs
   f. Previous services received
   g. Speech Questionnaire (Appendix A)

II. Speech Assessment Test (at least one complete test)
    Motor Speech Protocol (See Appendix B)

III. Language screening

IV. Oral mechanism exam (Appendix C, including screening for Apraxia of Speech)

V. Hearing screening (if appropriate)

VI. Analysis of assessment data (Structure and Function Assessment Summary: Appendix D)

VII. Impressions—Speech-Language Diagnosis

VIII. Recommendations

IX. Goals and treatment plan
Appendix A

Speech Questionnaire

Tell me why are you here?

Do you have problems with your speech? Yes____No____ If so, please explain your speech difficulty.

When did the problems first begin?

Did the problem start suddenly____ or gradually____ Who noticed it first? You ____ Someone else _____

Did you notice other problems when your speech problems began? Yes____ No____ Before? After? Please explain

Has the problem stayed the same Yes____ No____ If not is it Better____Worse____

Is the problem consistent or does it change? If so when? ________________

Has your speech ever returned to normal? Yes____ No____ if so when? ________________

Are you taking medications that affect your speech? Yes____ No____ if so explain

When your problems began did anything feel differently? ________________

Have you noticed any change in the appearance or feeling in your face or mouth? ________________

Describe your speech difficulty. How does it sound to you? ________________

Is it faster___, slower___, louder___, softer___, less precise___, effortful ___

If 100% represents your speech before the problem began, where is it now?

____________________

Do people ever have trouble understanding you? Yes____ No____ If so, when? ________________

What do people do if they can’t understand you? ________________

Have you altered any of your work or social activities because of your speech? Yes ____ No ____ If so, how?

____________________

Does your speech prevent you from doing anything? Yes ____ No ____ If so, what?

____________________

What have you done to compensate for your speech difficulty?
Have you had any help for your speech? Yes ___ No ___
If so, when and for how long?

What was done? ______________________ Did it help? ______

Do you think you need help for your speech now? Yes ___ No ___

What have you been told is the cause of this problem? ______________________________

What does the diagnosis mean is going to happen? ______________________________

Have you had any difficulty with chewing? Yes ___ No ___ Drooling? Yes ___ No ___

Is it difficult to move food around in your mouth? Yes ___ No ___ Why? ________________

Does food get stuck in your cheeks or on the roof of your mouth? No ___ Yes ___

Do you have to remove it with your finger or a utensil? No ___ Yes ___

Do you have trouble moving food back in your mouth to get a swallow started? Yes ___ No ___

Do you have trouble with swallowing? Yes ___ No ___ If so, with food __, liquid ___

Do you have trouble getting a swallow started? Yes ___ No ___ Do you lose food you liquid out of your mouth? Yes ___ No ___

Does food or liquid ever go into or out of your nose when you swallow? Yes ___ No ___

Does food/liquid go down before you start to swallow and cause coughing/choking? Yes ___ No ___

Do you gag or choke when swallowing? Yes ___ No ___ After completing a swallow? Yes ___ No ___

Have you had to modify your diet because of these problems? Yes ___ No ___ Have you lost weight? Yes ___ No ___

Have you had any change in your emotional expression? Yes ___ No ___

Do you cry or laugh more easily ____ or less easily ____ than in the past? No ____

Reference:

Appendix B  

Motor Speech Protocol

NAME: ______________________  DATE: ______________________
AUTOMATIC:
   1) Tell me your: Name: ______________________  Address: ________

   Birthdate: ________  Age: ________

   2) Count to 20:  1  2  3  4  5  6  7  8  9

   10  11  12  13  14  15  16  17  18  19

   20

   3) Count as fast as you can on 1 breath (2x):

   __________________________________________________________

   4) Count from 15-30 as fast as you can:

   __________________________________________________________

SPONTANEOUS:
   1) Why are you in the hospital?

   __________________________________________________________

   2) What do you or have you done for a living?

   __________________________________________________________

   3) Tell me what is wrong with your speech.

   __________________________________________________________

READING:
   Read “My Grandfather”

PHONATION:
   Take a deep breath and say /a/ as long as you can:

   __________________________________________________________

   /i/  ____________________________/u/  

IMITATION:
   1) Monosyllables (Scheull, 1965)

   pie _ two___see____ key___crow___spry_____boy_______day_______

   free___street_____four____lie_they___chew_________play_____school_______

   vote____row_____you    __clay_pray____screw__three____try_______
2) Phrases (Scheull, 1965)

man and woman ___________ easy does it ___ thirty
paper and pencil ___________
baseball and bat ___________
knife and fork _____________ a year yesterday _________________
two times two ____________ bake a cake ________________
door and window __________ guess again _________________
light the lamp _____________ sing a song _________________
drive a car _________________ a kitchen chair _________________
sell the house ______________ orange juice ________________

NAME THE DAYS OF THE WEEK: Monday Tuesday Wednesday
Thursday Friday Saturday Sunday

RAPID ALTERNATING MOVEMENTS:
Say: ma ma ma ma _____________________________
     la la la la _____________________________
     ka ka ka ka ____________________________
     ta ta ta ta ____________________________
     pa pa pa pa ____________________________

IMPRESSIONS:
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

RECOMMENDATIONS:
_________________________________________________________________
_________________________________________________________________
Appendix C  Oral Motor Examination

NAME:  DATE:  EXAMINER:  
Rating Scale: 4 = Normal 3 = Slight Impairment 2 = Significant Impairment 1 = No Movement

### LIPS (VII)

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<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>Smile</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>Press</td>
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<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Pucker (whistle)</td>
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<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>Mobility:</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>/u-i/</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>/pʌ/</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>/b/</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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</table>

### MANDIBLE (V)

Range
- Lateral: 1 2 3 4 1 2 3 4
- Depression: 1 2 3 4 1 2 3 4

| Strength: |  |  |  |  |
| Opening   | 1 | 2 | 3 | 4 |
| Closing   | 1 | 2 | 3 | 4 |

### TONGUE (XII)

Resting: Size Length Shape

| Protrusion: |  |  |  |  |
| Mobility   | 1 | 2 | 3 | 4 1 | 2 | 3 | 4 |
| Strength   | 1 | 2 | 3 | 4 1 | 2 | 3 | 4 |

| Lateralization: |  |  |  |  |
| Mobility       | 1 | 2 | 3 | 4 1 | 2 | 3 | 4 |
| Rate           | 1 | 2 | 3 | 4 1 | 2 | 3 | 4 |

| Elevation: |  |  |  |  |
| Mobility    | 1 | 2 | 3 | 4 1 | 2 | 3 | 4 |
| Strength    | 1 | 2 | 3 | 4 1 | 2 | 3 | 4 |

Sequential Movement:
- /tʌ/  Norm   Precision   Timing   Rate
- /kʌ/  Norm   Precision   Timing   Rate
- /dɪp/ Norm   Precision   Timing   Rate
- /lɪp/ Norm   Precision   Timing   Rate
- /ɡɪp/ Norm   Precision   Timing   Rate

### TEETH

Oclusion

### PALATE (XI & X)

Hard                  Soft

Length                Shape                Gag Reflex
Mobility:
Prolonged /a/ ___________________________
/i/ __________________ Repetition /a/ ________________

LARYNGEAL MECHANISM (X)
Quality: Normal _____ Breathy ______ Hoarse ______ Harsh ______ Tremor ______ Comments:

Pitch: Normal _____ High _____ Low _____ Pitch Breaks ______

Loudness: Normal _____ Excessive _____ Low _____ Variable _____

Duration: /a/ _______ seconds  /i/ _______ seconds  __________ _______

Coughing: Normal _____ Hypoadduction ______ Hyperadduction ___

Comments:

PROSODY
Normal _____ Monopitch ______ Monoloudness ______ Reduced Stress ______ Excess Stress ______

IMPRESSIONS:

Lips: WNL Mild Moderate Severe Weakness: R L Both
Mandible: WNL Mild Moderate Severe Weakness: R L Both
Tongue: WNL Mild Moderate Severe Weakness: R L Both
Palate: WNL Mild Moderate Severe Weakness: R L Both
Voice: WNL Mild Moderate Severe

RECOMMENDATIONS:
No Oral Motor recommendations Restore:

Compensate:

Adjust:
Appendix D  Structure and Function Assessment Summary

Is the face symmetric? Yes____ No ____
Are the angles of the mouth symmetric? Yes____ No ____
Is asymmetry due to drooping of the entire face on one side____, a droop at the corner of the mouth_____, or flattening of the naso-labial fold________________?  
Is the face expressionless____, masklike____, or unblinking____?  
Is it held in a fixed expression of smiling, astonishment, or perplexity? Yes____No ____ Does the upper lip appear stiff? Yes_______________No ____
Are abnormal spontaneous, involuntary movements present? Yes____No ____ Do the eyes shut tightly and uncontrollably? Yes_______________No ____
Is there quick or slow symmetric or asymmetric pursing or retraction of the lips? Yes____No __
Are there spontaneous smacking noises of the lips? Yes ____ No ____
Can the patient inhibit these movements on request? Yes __ No __ If so, do they reappear when inhibitory efforts cease? Yes ____ No ____
Are the lips tremulous or are there tremor-like rhythmic movements of the lips? Yes ____ No ____
Are fasciculation present in the face, especially around the mouth or chin? Yes ____ No ____
Are lip retraction, rounding, and puffing symmetric? Yes ____ No ____
Is their range of movement normal ____ or restricted ____?
When opening the mouth, is the configuration of the lips symmetric ____or does one side lag____?
Is the patient able to resist the examiner’s attempt to push the upper and lower lip toward the midline when the lips are retracted____ or when they are rounded____? Yes__No ____
Does air escape through the lips when the patient puffs the cheeks? Yes____No ____
Can the seal be broken with less than normal pressure when the examiner pushes in on the cheeks? Yes____No ____
Does tremulousness appear____ or disappear____ during sustained facial postures? Yes ____ No ____
Are additional movements present that distort or alter the ability to maintain the sustained posture? Yes____No ____
Can the patient maintain the posture for several seconds or does he/she stop the effort even when instructed to maintain it_______? Yes___No ____
Does the jaw hang lower than normal? Yes____No ____
Are there spontaneous, apparently involuntary quick or slow movements of the jaw (clenching, opening/pulling to one side, tremor-like up and down movements)? Yes ___ No___

Has the patient learned any postural adjustments or tricks that tend to inhibit sustained involuntary movements (i.e. clenching the jaw, holding a pipe in the mouth, touching a hand to the side of the jaw or neck)? Yes___No____

Does the jaw deviate to one side when the patient attempts to open it as widely as possible? Yes___No___

Is the patient able to open the mouth widely____or is excursion limited?

Can the patient resist the examiner’s attempt to open the jaw when told to clench the teeth? Yes____No____

Can the jaw be closed against resistance from the examiner (either by holding the midline of the jaw with the hand or by placing a tongue blade on the lower teeth and resisting closure)? Yes___No ___

Do the masseter and temporalis muscles have normal bulk and bulge when the patient bites down? Yes __No____

Can the patient resist the examiner’s attempt to close the jaw when told to hold it open? Yes ___No___

Is the tongue full and symmetric? Yes___No ____

If symmetric, is its size normal? Yes_ No___

If small, are there symmetric or unilateral grooves_____or furrowing in the tongue representing atrophy? Yes ____No____

Are fasciculations present? Yes____No____

If so, are they best observed when the tongue is at rest inside the mouth? Yes____No____

Does the tongue remain quiet on the floor of the mouth? Yes____No___

Are quick, slow, or sustained movements of large portions of the tongue apparent in the form of protrusion____, retraction___, lateralization____, or writhing____? Yes___No____

Is the tongue excessively wet___or dry____? Yes____No____

Can the patient protrude the tongue to a normal degree? Yes____No____

Does the tongue consistently deviate to one side or the other? Yes____No____

Can the patient resist the examiner’s attempt to push the tongue back into the mouth? Yes ___ No____

Does the palate hang low in the mouth? Yes____No____

Does it rest on the tongue? Yes ____ No____

Are the palatal arches symmetric_____or does one side hang lower than another___?
Are there spontaneous rhythmic or arrhythmic beating movements of the palate? Yes  No

Is the palatal movement symmetric? Yes ___ No ___

If asymmetric, does the palate elevate more strongly to the side opposite that which hung lower at rest? Yes___No___

Is there evidence of nasal airflow on a mirror held at the nares during vowel prolongation or repetitions of pressure sounds (/s/, /p/), or words or phrases with non-nasal consonants? Yes___No___

Does resonance change during vowel prolongation with the nares occluded versus un-occluded? Yes___No___

Respiration:

Is the patient’s posture normal? Yes___No___

If not, is the patient slouched in the chair or bent forward or to the side? Yes___No___

Does the patient tend to gravitate over time toward abnormal posture? Yes___No____

Does it require effort or assistance to resume a more normal posture? Yes___No____

Does the patient complain of shortness of breath at rest__, during physical exertion__, or during speech__? Yes___No____

Is breathing rapid__, shallow__, or labored__? Yes___No____

Are abdominal or chest wall movements asymmetric or limited in range during rest breathing__, speech__, or maximum inspiration__? Yes___No____

Is breathing accompanied by shoulder movement____, neck extension____, retraction of the neck just above the upper sternum on inhalation____, or flaring of the nares on inhalation? Yes___No____

Is breathing irregular? Yes___No____

Are there any abrupt or slow abdominal or chest wall movements that alter or interrupt normal cyclical breathing during rest breathing__, speech__, or maximum inspiration__? Yes___No____

Does the patient have hiccups? Yes___No____

Reference:

August 28, 2015

Jane Smith
2345 Avery Lane
Opelika, AL 36804

Dear Mrs. Smith:

Enclosed, please find a copy of the diagnostic report for John’s speech and language evaluation on August 24, 2015.

Thank you for choosing the Auburn University speech and hearing clinic. We look forward to serving you in the future, should the need arise. If you have any questions regarding this report, please do not hesitate to contact me.

Sincerely,

________________________________________
Embry Burrus, MCD, CCC/SLP
Associate Clinical Professor

________________________________________
Lydia Jackson, B. S.
Graduate Clinician
August 2, 2015

Mary Johnson
Address

Dear Ms. Johnson:

Thank you for choosing the Auburn University Speech and Hearing Clinic. Enclosed is a copy of the report from your evaluation on July 31, 2015. We enjoyed meeting you and look forward to working with you OR we look forward to speaking with you in the future, should the need arise.

If you have any questions regarding this report, please do not hesitate to contact us.

Sincerely,

____________________________________
Laura Willis, MCD, CCC/SLP
Associate Clinical Professor

____________________________________
Lydia Jackson
Graduate Clinician
Speech/Language Evaluation

Summary:
David is a 1 year, 8 month old male assessed at the Auburn University Speech and Hearing Clinic (AUSHC) for a language delay. The referral was made by David’s pediatrician, Dr. Reginald Jones, due to concerns with language development. David's results indicated a severe delay in his speech and language abilities according to percentile ranks, standard scores, and age equivalents. Based on David’s scores on the MacArthur- Bates CDI tests, his vocabulary comprehension and use, as well as his use of nonverbal gestures are below what is expected for his chronological age. David's receptive language scores were more than 3 standard deviations below the mean, indicating an age-equivalency of 5 months. His expressive language scores were more than 2 standard deviations below the mean, indicating an age equivalency of 10 months. David’s total language scores were more than 3 standard deviations below the mean, indicating an age equivalency of 7 months. Based on these scores, David’s total language abilities (receptive and expressive scores combined) were judged to be 13 months below his chronological age.

Case History:
David is a 1 year, 8 month old male assessed at the Auburn University Speech and Hearing Clinic (AUSHC) for a language delay. The referral was made by David’s pediatrician, Dr. Jones, due to concerns with language development. He was accompanied by his mother, Bridget Harris, who was concerned about his language development. Ms. Harris reported an unremarkable pregnancy and delivery with David. He was born full-term, and weighed 6.5 pounds at birth. According to her report, all developmental milestones, with the exception of speech and language, were achieved within normal limits. David’s medical history is significant for recurring ear infections. His mother reported that David has had three diagnosed ear infections, each accompanied with fluid in the middle ear. David’s most recent ear infections occurred in January and February, 2010; his mother reports that fluid has remained in the middle ear since that time; therefore, the pediatrician made the referral for tubes. She indicated on the case history that she believes the middle ear fluid is the cause of David’s language delay. Her main concerns were that David did not appear to be at the same communicative level as peers his age. She stated that he will imitate approximately three words (“DJ” for his brother’s name, “eye” and “see”) and spontaneously produces one word (“see”). She further indicated that David previously said the following words: “daddy,” “eat,” “bottle” (/baba/) and “hey,” but these are not currently words in his vocabulary.
Assessment Results:

Behavior:
David initially spent much of his time exploring the evaluation room, without engaging with people or objects. No vocalizations were noted in the first 30 minutes of the evaluation. During the evaluation, it was noted that David chewed his fingers on several occasions. Ms. Harris stated, “I think he’s teething.” It was observed that David was focused intently on the edge of the mat, as he would walk up and down edges, ignoring toys that were placed on the mat. He was also focused on the edges of a table in the room. He ignored windup toys on the table, and instead traced the edges of the table with his finger. During these instances of intense focus, it was further noted that David would not readily respond to either familiar (mother) or unfamiliar voices (supervisor and clinicians). David was observed to flap his hands with excitement when the clinician blew bubbles. Ms. Harris reported that David’s typical behavior at home includes either “wandering around the room” or lying on the floor. Reportedly, he does not spent much time sitting on floor engaged in play activities. Ms. Harris reported that David does enjoy playing with mechanical toys (toys with buttons or sounds) and cars. According to his mother, David will gesture to express his wants and needs; this action is consistently paired with crying or grunts.

Hearing Assessment:
A formal audiological screening was conducted by Dr. Martha Wilson of the Auburn University Speech and Hearing Clinic on April 9, 2010. Normal tympanograms were observed bilaterally, showing that eardrum mobility and middle ear pressure were within normal limits. Conditioned Orientated Reflex Audiometry (CORA) was administered with the child positioned on his mother’s lap. Minimal response levels were higher than what is expected for a child David’s age, suggesting a possible hearing loss including sounds within the speech frequencies. It should be noted that testing was conducted in sound field condition, which does not test ears individually. In addition, David’s active movements and fussiness during the test may have negatively affected the test results.

Pragmatics/Social:
David’s pragmatics and social skills were observed during the evaluation. In the area of social prerequisites for language development, David was able to demonstrate appropriate behaviors in several categories, including being cooperative and transitioning well between activities (switching from bubbles to tambourine). It was noted that David made eye contact with the clinicians early in the evaluation; however this behavior decreased overall as the session progressed. It was also noted that eye contact was more frequently associated with activities in which David demonstrated an interest, such as blowing bubbles and playing with cars. Joint-referencing was demonstrated minimally through play with the cars and bubbles. David also engaged in verbal imitation with his mother, imitating the words, “eye,” and “see.” Skills in this area that were not demonstrated during the evaluation include: motor imitation and turn-taking during play activities or during social games, such as peekaboo. David demonstrated two cognitive prerequisites for language: means-end behavior (walking to his mother) and rejection...
(turned away from clinician), as a form of protest. Skills that should be emerging in this area for David are symbolic play (pretend play) and functional object use (uses objects appropriate in play, such as cup, spoon, and blocks). According to Ms. Harris, David will gesture to express his wants and needs; this action is consistently paired with crying or grunts.

**NOMS Cognitive Orientation:** Level 2 – child purposely responds to single/multi-sensory input less than half the time. Even with maximum cueing, child infrequently (less than half the time), attends during familiar daily routines. Child may show negative reaction to adverse stimuli.

**NOMS Pragmatics:** Level 2 – child rarely initiates and even with consistent moderate cueing, rarely responds to communication, even in familiar settings with familiar communication partners. Child occasionally demonstrates general awareness of others by directed gaze, and gaze is occasionally associated with vocalizing or smiling.

**Play:**
*Westby’s Symbolic Play Scale* was administered by clinical observation to assess David's play skills. *Westby’s Symbolic Play Scale* is a criterion-referenced assessment of play skills in young children based on typical acquisition of play skills. David demonstrated play skills at Stage I (9-12 months), including awareness that objects exists although they are not seen and means-end behaviors (walking to get to the desired object) and not mouthing or banging all toys (David was observed to chew on his fingers throughout the evaluation). David was unable to demonstrate play skills in Stage II (15 to 17 months) and Stage III (17-19 months), which would be expected of a child his age. Skills at Stage II (15-17 months) include engaging in purposeful play with a variety of toys and handing a toy to an adult if unable to operate. Skills in Stage III (17-19 months) include auto-symbolic play (child pretends to go to sleep or pretends to drink from cup) and the ability to use most common objects appropriately.

**Receptive and Expressive Language:**

*Preschool Language Scale 4 (PLS-4)*
Clinical observation through play and formal testing were utilized to assess David’s expressive and receptive language skills. The *Preschool Language Scale 4 (PLS-4)* was administered to formally assess David’s skills in this area. The PLS-4 is a test which uses a picture book and various toys to elicit speech and measure a child’s understanding of language.

**Auditory Comprehension:**
- Raw Score: 11
- Standard Score: 51 (1st percentile)
- Age equivalent: 5 months

**Expressive Communication:**
- Raw Score: 16
- Standard Score: 60 (1st percentile)
Age equivalent: 10 months

Total Language Score:
  Raw Score: 27
  Standard Score: 51 (1st percentile)
  Age equivalent: 7 months

Summary of PLS-4:

David exhibited receptive strengths including his ability to look at a speaker and responding to both loud sounds and voices. He demonstrated the ability to anticipate social routines while playing the “tickle game.” David turned his head to locate the source of sound only when presented with loud sounds (banging wooden toys on table). During the evaluation, he was observed to search for a speaker when he was not distracted by toys or the edge of the mat and the table. David inconsistently responded to his name, and again, he only did so when not distracted by competing stimuli.

Receptive needs were identified based on behaviors that were not observed during the evaluation, such as not looking for the source of sounds with consistency. David was not observed or reported to respond to phrases such as “give me a kiss.” He was unable to demonstrate the ability to recognize common objects when named, such as a ball.

David exhibited expressive strengths including his ability to produce some consonant and vowel sounds in isolation and in combination during imitation, spontaneous speech, and/or sound play (“eyes” in imitation, “see” in spontaneous speech, and “mama” in sound play). Additional expressive strengths included behaviors that are expected of chronologically younger children. These behaviors included protests by gesture (turning away from undesired activity) and seeking attention from others (made eye contact with his mother while climbing into her lap during evaluation). Ms. Harris reported that David will babble or “talk to himself” using changing intonation.

Expressive language needs were identified during the evaluation to include David’s limited vocalization for functional communication and limited consonant productions. Other areas of concern in expressive language include David’s lack of initiating or engaging in social games and limited joint-referencing with others.

NOMS Spoken Language Comprehension: Level 1 – child understands a limited number of common object and action labels, and simple directions only in highly structured, repetitive daily routines, with consistent maximal cueing.

NOMS Spoken Language Production: Level 2 – child attempts to communicate, but, even with consistent maximal cueing, child rarely produces meaningful communication with familiar people in routine situations.
Semantics:
*The MacArthur-Bates Communicative Development Inventories* (CDI: Words and Sentences) is a formal, standardized assessment measure of a child’s use of words. The Words and Sentences Subtest is normed for ages 16-30 months. The MacArthur-Bates CDI is designed to be completed by a parent or caregiver, and then scored by a professional such as a Speech-Language Pathologist. David’s score of one spontaneous word production would rank him below the 5th percentile using normative data from the *MacArthur-Bates CDI: Words and Sentences*, which is normed for children age 16-30 months. This indicates that 95% of children his age would perform at or above his level. David did not spontaneously produce any words or phrases during the evaluation.

Articulation/Phonology:
From the data collected during the evaluation, David’s phonetic inventory was assessed.

<table>
<thead>
<tr>
<th>Vowels</th>
<th>Stops</th>
<th>Glides</th>
<th>Fricatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>a, ae, i</td>
<td>m</td>
<td>-none observed</td>
<td>s</td>
</tr>
</tbody>
</table>

Analysis of sounds produced indicates that David produced only one of the phonemes expected for his age, /m/, and one later developing phoneme, /s/. David was lacking several phonemes normally developed by his age, such as p, b, and k. Overall, he is felt to be 50% intelligible to a familiar listener.

* NOMS Articulation/Intelligibility: Level 2 – child’s production of simple words and short phrases is rarely intelligible to familiar listeners. Child’s speech is unintelligible to unfamiliar listeners.

Oral/Facial Examination:

*Facial Structure:*
Informal assessment revealed that David exhibits normal, symmetrical facial features and no signs of facial weakness.

*Lips:*
Structure: within normal limits.
Function: Deemed adequate for speech production, although opportunities for observation were limited. David was noted to pucker while attempting to blow bubbles, and retract lips while smiling.

*Tongue:*
Structure: within normal limits.
Function: Appeared to be within normal limits in that David was able to achieve lateral tongue movements, elevate his tongue and lick his lips during instructed play activities.
Summary:
Overall, external structures and function of the oral mechanism appeared adequate for speech based on limited observation of structures during speech production. More extensive evaluation is suggested during therapy sessions.

Voice and Fluency:
Formal testing was not used to assess voice and fluency. Based on informal assessments and parent report of his vocalizations, it is felt that David’s voice quality and pitch are within normal range for his age, stature and gender. No stuttering or stuttering-like behaviors were reported or observed at this time.

Prognosis:
Based on results of standardized assessments and clinical observations, prognosis for improving functional communication skills is fair based on the severity of David’s language delay. Parental involvement is a positive prognostic factor.

Recommendations:
Based on results from today’s assessment, it is recommended that David begin treatment, at a frequency of 2-3 times per week for 30 minute sessions, to focus on both receptive and expressive language.

Suggested goals for expressive language:
Increase sound inventory and word productions through informal play.

Suggested goals for receptive language:
Increase knowledge of age-appropriate words
Increase knowledge of age-appropriate phrases and simple commands

Suggested goals for hearing:
It is suggested that hearing be assessed in light of abnormal audiometric findings. David should receive additional audiological testing, pending medical intervention (child is scheduled for insertion of tympanostomy tubes) and at the discretion of the otologist.

Elizabeth Zylla-Jones  Amy Jones, B.S.
Clinical Supervisor  Graduate Clinician

Bradley Booth, B.S.
Graduate Clinician

cc: Bridget Harris
Reginald Jones, M.D.
Speech-Language Evaluation

Summary:
David is a 6.2 year-old male with a remarkable medical history. During the evaluation, he was administered the Goldman-Fristoe Test of Articulation-2 (GFTA-2) and the Clinical Evaluation of Language Fundamentals Preschool-2 (CELF-P2) to assess his articulation and receptive and expressive language skills. He presents today with a severe articulation disorder. His performance on the CELF-P2 was considered to be within normal limits for each subtest administered. David was compliant and engaged during the two hour evaluation session and was judged to put forth his best effort. It is recommended that David attend therapy twice a week for 30-minute sessions to address the aforementioned deficits.

Case History/Background Information:
David is a 6.2 year-old male who was seen at the Auburn University Speech and Hearing Clinic (AUSHC) on May 23, 2014, for a formal comprehensive speech and language evaluation. He was accompanied to the evaluation by his mother, Susan Rhodes, who served as the primary informant. There were no reported complications with regard to Mrs. Rhodes’ pregnancy or delivery. David’s medical history is remarkable for recurrent pneumonia, for which an albuterol inhaler is used as needed. He exhibited normal developmental milestones, with the exception of articulation. Mrs. Rhodes’ main concern was with regard to David’s pronunciation. She reported that he often substitutes sounds with /dʒ/ and frequently omits final consonants. David will be repeating kindergarten at Auburn Elementary School and is receiving speech services at school targeting /l/ and /z/ production. Mrs. Rhodes reported that David was being held back due to his inability to master learning the alphabet and letter-sound recognition. David currently resides with his parents and older brother, Charles (age 8), who does not exhibit any speech or language delays.

Assessment Results

Fluency and Voice
Based on informal observation, David exhibits appropriate pitch and voice quality for his age and gender. No episodes of stuttering were observed or reported.

Oral-Peripheral Exam:
Based on informal observation, the structure and function of the oral mechanism are judged to be grossly within functional limits. Overall, external structures and function of the oral mechanism appeared to be adequate for speech.

Hearing
No formal hearing screening was conducted during the evaluation. David previously received a hearing screening at the Auburn University Speech and Hearing Clinic (AUSHC) on May 19, 2014, and passed the screening at all frequency levels. Mrs. Edwards reported no concerns with regard to his hearing and stated David was able to follow directions.

Articulation
The Goldman-Fristoe Test of Articulation - 2nd Edition (GFTA-2) is a standardized assessment designed to measure articulation ability by sampling both spontaneous and imitative sound production. This assessment evaluated David’s speech sound production at the word (Sounds-in-Words subtest) and sentence (Sounds-in-Sentences subtest) level. The Sounds-in-Words subtest uses pictures to elicit multiple single target consonants across initial, medial, and final positions and consonant blends in the initial position. David was also administered the Sounds-in-Sentences and Stimulability portions of the GFTA-2. The Sounds-in-Sentences subtest provided information regarding David’s spontaneous sound production in connected speech through the use of two, simple
picture-based stories. The *Stimulability* portion was used in order to assess David’s ability to correctly produce previously misarticulated sounds by listening and repeating the clinician’s modeled production. The raw score is obtained by adding the total number of articulation errors. It is then converted to a standard score, which indicates the distance of the raw score from the mean. A standard score of 100 on the *GFTA-2* is considered to be average, with a standard deviation of 15. Results are as follows:

<table>
<thead>
<tr>
<th>Raw Score</th>
<th>Standard Score</th>
<th>Percentile Rank</th>
<th>Test-Age Equivalent</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>43</td>
<td>44</td>
<td>&lt;1</td>
<td>2-3</td>
<td>Severe</td>
</tr>
</tbody>
</table>

David earned a standard score of 43 indicating 31 articulation errors were made during the *Sounds-in-Words* section of the *GFTA-2*. As previously stated, the raw score is converted to a standard score, representing the distance the child's raw score falls from the mean or average, among children of his same age bracket. David’s standard score of 44 is approximately 4 standard deviations below the mean, indicating a severe articulation delay. Scores can also be represented as percentiles, which indicate the percentage of children within that particular age group who performed at or below David’s level. David tested in the <1 percentile, which means that he performed as well as or better than <1 percent of children his age. Test-age equivalents were also obtained, representing the average age that corresponds with David’s raw score. It is important to note that test-age equivalents only represent his articulation abilities, not his level of overall functioning. The assessment indicated that David’s test-age equivalent is that of a 2.3 year old child. The errors that David made include: deletion of final consonants (ball → ba), cluster reductions (spoon → poon), omission of medial consonants (wagon → waon), and sound substitutions (lamp → jamp). The majority of sound substitution produced by David included /tʃ/ and /dʒ/. David was able to produce a variety of sounds in all word positions some of which include /p/, /m/, and /n/.

The following table represents sounds that were deleted entirely or replaced by other sounds. Errors in articulation can be found below. Phoneme omissions (-) occurred in medial and final positions. For example, - for /s/ would be expressed as /bet bɔ l/ for /bet sbɔ l/. Substitutions refer to phonemes that were used in place of the correct phoneme; often /tʃ/ and /dʒ/ acted as replacements for other sounds. For example, /dʒ/ for /s/ would be /dʒ ık/s/ for /sık/s/. Such misarticulations occurred in all positions, the majority of which were made in the initial position.

The following phonemes and blends were substituted or omitted:

<table>
<thead>
<tr>
<th>Substitutions/Omissions</th>
<th>Initial</th>
<th>Medial</th>
<th>Final</th>
</tr>
</thead>
<tbody>
<tr>
<td>/dʒ/ for /g/</td>
<td>- for /g/</td>
<td>- for /b/</td>
<td></td>
</tr>
<tr>
<td>/tʃ/ for /k/</td>
<td>- for /k/</td>
<td>- for /g/</td>
<td></td>
</tr>
<tr>
<td>/ʃ/ / for /ʃ /,*</td>
<td>- for /d/</td>
<td>- for /k/</td>
<td></td>
</tr>
<tr>
<td>/dʒ/ / for /l/,*</td>
<td>- for /ʃ/</td>
<td>- for /d/</td>
<td></td>
</tr>
<tr>
<td>/w/ for /r/,*</td>
<td>- for /l/</td>
<td>- for /ʃ/</td>
<td></td>
</tr>
<tr>
<td>/ʃ/ for /s/,*</td>
<td>- for /r/</td>
<td>- for /ʒ/</td>
<td></td>
</tr>
<tr>
<td>/ʃ/ for /z/,*</td>
<td>- for /r/</td>
<td>- for /z/</td>
<td></td>
</tr>
<tr>
<td>/v/ for /bl/</td>
<td>- for /ʃ/</td>
<td>- for /b/</td>
<td></td>
</tr>
<tr>
<td>/b/ for /br/</td>
<td>- for /r/</td>
<td>- for /v/</td>
<td></td>
</tr>
<tr>
<td>/d/ for /dr/</td>
<td>- for /ʃ/</td>
<td>- for /ʒ/</td>
<td></td>
</tr>
<tr>
<td>/ʃ/ for /f/</td>
<td>- for /ʃ/</td>
<td>- for /ʒ/</td>
<td></td>
</tr>
<tr>
<td>/ʃ/ for /fr/</td>
<td>- for /ʃ/</td>
<td>- for /ʒ/</td>
<td></td>
</tr>
<tr>
<td>/ʃ/ for /gl/</td>
<td>- for /ʃ/</td>
<td>- for /ʒ/</td>
<td></td>
</tr>
<tr>
<td>/dʒ/ / for /g/</td>
<td>- for /ʃ/</td>
<td>- for /ʒ/</td>
<td></td>
</tr>
<tr>
<td>/ʃ/ / for /k/</td>
<td>- for /ʃ/</td>
<td>- for /ʒ/</td>
<td></td>
</tr>
<tr>
<td>/ʃ/ / for /m/</td>
<td>- for /ʃ/</td>
<td>- for /ʒ/</td>
<td></td>
</tr>
<tr>
<td>/ʃ/ / for /n/</td>
<td>- for /ʃ/</td>
<td>- for /ʒ/</td>
<td></td>
</tr>
</tbody>
</table>

105
* Indicate sounds that were produced incorrectly, but may not yet be acquired for a child of 6 years of age.

**Sounds-in-Sentence Results**
The Sound-in Sentence portion of the assessment revealed that David experienced increased difficulty when producing consonants at the conversational level. Errors made included deletion of both medial and final consonants, sound substitutions, and cluster reductions; however, David was able to produce a variety of sounds in the initial position of words. The results of the Sounds-in Sentences portion of the assessment were consistent with the results from the Sounds-in-Words portion.

<table>
<thead>
<tr>
<th>Substitutions/Omissions</th>
<th>Initial</th>
<th>Medial</th>
<th>Final</th>
</tr>
</thead>
<tbody>
<tr>
<td>/d/ for /g/</td>
<td></td>
<td>- for /g/</td>
<td>- for /g/</td>
</tr>
<tr>
<td>/tʃ/ for /k/</td>
<td></td>
<td>- for /k/</td>
<td>- for /k/</td>
</tr>
<tr>
<td>/ʃ/ for /ʃ/</td>
<td></td>
<td>- for /ʃ/</td>
<td>- for /f/</td>
</tr>
<tr>
<td>/dʒ/ for /l/*</td>
<td></td>
<td>- for /l/*</td>
<td>/n/ for /ng/</td>
</tr>
<tr>
<td>/dʒ/ for /z/*</td>
<td></td>
<td>- for /r/*</td>
<td>- for /t/</td>
</tr>
<tr>
<td>/b/ for /bl/</td>
<td></td>
<td>- for /θ/*</td>
<td>- for /v/</td>
</tr>
<tr>
<td>/b/ for /br/</td>
<td></td>
<td>- for /v/</td>
<td>- for /r/*</td>
</tr>
<tr>
<td>/f/ for /fl/</td>
<td></td>
<td>- for /s/*</td>
<td>- for /dʒ/</td>
</tr>
<tr>
<td>/ʃ/ for /fr/</td>
<td></td>
<td>- for /s/*</td>
<td>- for /θ/*</td>
</tr>
<tr>
<td>/p/ for /pl/</td>
<td></td>
<td>/d/ for /ð/*</td>
<td>- for /v/</td>
</tr>
<tr>
<td>/tʃ/ for /sl/</td>
<td></td>
<td></td>
<td>- for /s/*</td>
</tr>
</tbody>
</table>

* Indicates sounds that were produced incorrectly, but may not yet be acquired for a child of 6 years of age.

**Stimulability**
Due to time constraints, all error productions were not assessed for stimulability but only those which are considered to be early developing sounds. The results revealed that David is stimulable for the following:

<table>
<thead>
<tr>
<th>Syllable</th>
<th>Word</th>
<th>Sentence</th>
</tr>
</thead>
<tbody>
<tr>
<td>f final position</td>
<td>b final position</td>
<td>k medial position</td>
</tr>
<tr>
<td>sh initial position</td>
<td>g medial position</td>
<td>d medial position</td>
</tr>
<tr>
<td>g final position</td>
<td></td>
<td>ch final position</td>
</tr>
<tr>
<td>k initial position</td>
<td></td>
<td>th initial position</td>
</tr>
</tbody>
</table>
Intelligibility for single words was judged to be approximately 40%, while an intelligibility rating of approximately 20-30% was reported for connected speech within a known context among unfamiliar listeners. On occasion, David utilized a fast speaking rate, which also contributed to difficulty understanding his speech. The clinicians noted the following articulation patterns during conversational speech: consistent substitution of various phonemes for /tʃ/ and /dʒ/ in the initial, medial, and final positions, cluster reduction, syllable reduction, final consonant deletion and imprecise articulation.

*NOMS Articulation/Intelligibility, Level 3: Child is occasionally intelligible in connected speech to familiar listeners. Child’s production of simple words and phrases is rarely intelligible to unfamiliar listeners.*

**Language:**
The *Clinical Evaluation of Language Fundamentals Preschool - 2nd Edition (CELF-P2)* was administered to assess David’s receptive and expressive vocabulary. The CELF-P2 aims to identify, diagnose, or evaluate language deficits in children. Given David’s age, the clinicians administered six subtests, obtaining Core Language, Receptive Language, Expressive Language, Language Content and Language Structure scores and indexes. Results are as follows:

<table>
<thead>
<tr>
<th>Subtest Scaled Score</th>
<th>Core Language</th>
<th>Receptive Language</th>
<th>Expressive Language</th>
<th>Language Content</th>
<th>Language Structure</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Sentence Structure</em></td>
<td>9</td>
<td>9</td>
<td></td>
<td></td>
<td>9</td>
</tr>
<tr>
<td><em>Word Structure</em></td>
<td>7</td>
<td></td>
<td>7</td>
<td></td>
<td>7</td>
</tr>
<tr>
<td><em>Expressive Vocabulary</em></td>
<td>11</td>
<td></td>
<td>11</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Concepts &amp; Following Directions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recalling Sentences</td>
<td></td>
<td></td>
<td></td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Word Classes – Receptive</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Word Classes – Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>8</td>
</tr>
<tr>
<td><strong>Sum of Subtest Scaled Scores</strong></td>
<td>27</td>
<td>26</td>
<td>25</td>
<td>29</td>
<td>23</td>
</tr>
<tr>
<td><strong>Standard Score</strong></td>
<td>94</td>
<td>91</td>
<td>91</td>
<td>97</td>
<td>86</td>
</tr>
</tbody>
</table>
Scores for each subtest were further analyzed to obtain an age-equivalency:

<table>
<thead>
<tr>
<th>Subtest</th>
<th>Raw Score</th>
<th>Scaled Score</th>
<th>Percentile Rank</th>
<th>Age Equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sentence Structure</td>
<td>19</td>
<td>9</td>
<td>37</td>
<td>5:9</td>
</tr>
<tr>
<td>Word Structure</td>
<td>16</td>
<td>7</td>
<td>16</td>
<td>4:8</td>
</tr>
<tr>
<td>Expressive Vocabulary</td>
<td>33</td>
<td>11</td>
<td>63</td>
<td>&gt;7:0</td>
</tr>
<tr>
<td>Concepts &amp; Following Directions</td>
<td>18</td>
<td>10</td>
<td>50</td>
<td>6:3</td>
</tr>
<tr>
<td>Recalling Sentences</td>
<td>18</td>
<td>7</td>
<td>16</td>
<td>4:7</td>
</tr>
<tr>
<td>Word Classes - Receptive</td>
<td>17</td>
<td>7</td>
<td>16</td>
<td>5:3</td>
</tr>
<tr>
<td>Word Classes - Expressive</td>
<td>15</td>
<td>9</td>
<td>37</td>
<td>5:11</td>
</tr>
<tr>
<td><strong>Word Classes - Total</strong></td>
<td><strong>14</strong></td>
<td></td>
<td><strong>16</strong></td>
<td><strong>&lt;4.0</strong></td>
</tr>
</tbody>
</table>

**CELF-P2 Core Language Index**

A Core Language score is considered to be the most representative measure of David’s language skills and provides a reliable way to quantify a child’s overall language performance. The Core Language score has a mean of 100 and a standard deviation of 15. A score of 100 on this scale represents the performance of a typically developing child of a given age. For David’s Core Language score, the following subtests were administered: Sentence Structure, Word Structure, and Expressive Vocabulary. David received a Core Language standard score of 94 (confidence interval = 87 to 101, percentile rank = 34). This score is within the average range of developmental functioning.

- **Sentence Structure:** The child is asked to point to pictures in the Stimulus Book in response to oral directions presented by the clinician. David was administered this portion of the CELF-P2 in order to evaluate his ability to interpret spoken sentences of increasing length and complexity. David demonstrated strengths in the following areas: comprehension of verb conditions (e.g., is running, will find, can get); modifications (e.g., big, spotted, white, first, etc.), copulas (e.g., is sleepy, is ready), infinitives (e.g., to bake, to go); negations (e.g., not); passive voice (e.g., is being followed, is being pushed); relative clauses (e.g., who is sitting under the big tree, who is holding the baby); compound sentences (e.g., She is climbing and he is swinging); The first two children are in line, but the third child is still playing); and indirect objects (e.g., the dog). He exhibited some difficulty with prepositional phrases (e.g., toward the girl); indirect requests (e.g., Should you wear your jacket?); and subordinate clauses (e.g., before she ate the sandwich). David correctly identified 19 out of 22 items.

- **Word Structure:** The child is to complete a sentence with the targeted structure(s). David was administered this portion of the CELF-P2 in order to evaluate his ability to (a) apply word structure rules (morphology) to mark inflections, derivations, and comparison; and (b) select and use appropriate pronouns to refer to people, objects, and possessive relationships. David demonstrated strengths in the following areas: use of prepositions (e.g., in/inside the box, on the chair); regular plurals (e.g., horses); possessive nouns (e.g., king’s); and pronouns (e.g., hers, he is, she does, herself). He exhibited some difficulty with verb tenses (e.g., flies, blew, fell); copulas (e.g., it is big, she is, they are); and derivational forms (e.g, singer). David correctly identified 16 out of 24 items.
Expressive Vocabulary: The child is asked to identify an object, person, or activity portrayed in the Stimulus Book. David was administered this portion of the CELF-P2 in order to evaluate his ability to label illustrations of people, objects, and actions. David demonstrated strengths in the following areas: naming verbs (e.g., riding, pouring, wrapping); food (e.g., carrot); geography (e.g., flag); instruments (e.g., piano); communication (e.g., newspaper, stamp); sports (e.g., trophy); part/whole relationships (e.g., branch); and healthcare (e.g., wheelchair). He exhibited some difficulty with occupations (e.g., audience); science (e.g., footprint, telescope, binoculars); and math (e.g., scale). David correctly identified 33 out of 40 items.

CELF-P2 Receptive Language Index
The Receptive Language index is a cumulative measure of David’s performance on two subtests designed to best probe receptive aspects of language including comprehension and listening. The Receptive Language index has a mean of 100 and standard deviation of 15. A score of 100 on this scale represents the performance of a typically developing child of a given age. For David’s Receptive Language index, the following subtests were administered: Sentence Structure, Concepts & Following Directions, and Word Classes - Receptive. David received a Receptive Language standard score of 91 (confidence interval = 84 to 98, percentile rank = 27). This score is in the average range of developmental functioning.

- Sentence Structure: See description under CELF-P2 Core Language Index.
- Concepts & Following Directions: The child is asked to point to pictures in the Stimulus Book in response to oral directions presented by the clinician. David was administered this portion of the CELF-P2 in order to evaluate his ability to (a) interpret spoken directions of increasing length and complexity that contains concepts that require logical operations; (b) remember the names, characteristics, and order of mention of pictures; and (c) identify from among several choices that targeted objects. David demonstrated strengths with regard to the following concepts: comprehension of dimension/size (e.g., tallest, big/little); inclusion/exclusion (e.g., both, all . . . except, neither/or); equality (e.g., match); location (e.g., next to, closest to, farthest, top, bottom); and condition (unless). He exhibited some difficulty with temporal (e.g., then, after); and sequence (e.g., first/second/third). David correctly identified 18 out of 22 items.
- Word Classes - Receptive: The child is asked to choose the two words that are related. David was administered this portion of the CELF-P2 in order to evaluate his ability to perceive relationships between words that are related by semantic class features. David demonstrated strengths with regard to identifying: toys/leisure (e.g., pool/swimsuit, shovel/pail, ball/blocks); school items (e.g., crayon/pencil, slide/swing); clothing (e.g., pants/coat, shoe/sock); and food (e.g., milk/ juice, orange/grapes). He exhibited some difficulty with home items (e.g., key/door, basket/box); parts of body (e.g., foot/hand); and transportation (e.g., car/bus). David correctly identified 17 out of 20 items.

CELF-P2 Expressive Language Index
The Expressive Language index is a cumulative measure of David’s performance on the three subtests that probe oral language expression. The Expressive Language index has a mean of 100 and standard deviation of 15. A score of 100 on this scale represents the performance of a typically developing child of a given age. For David’s Receptive Language index, the following subtests were administered: Sentence Structure, Concepts & Following Directions, and Word Classes - Receptive. David received an expressive Language standard score of 91 (confidence interval = 84 to 98, percentile rank = 27). This score is in the average range of developmental functioning.

- Word Structure: See description under CELF-P2 Core Language Index.
- Expressive Vocabulary: See description under CELF-P2 Core Language Index.
- Recalling Sentences: The child is asked to imitate sentences presented by the examiner. David was administered this portion of the CELF-P2 in order to evaluate his ability to (a) listen to spoken sentences of increasing length and complexity, and (b) repeat the sentences without changing word meanings, inflections, derivations or comparisons (morphology), or sentence structure (syntax). David demonstrated strengths with regard to producing: active declaratives; active declaratives with coordination, noun...
modification and negatives; and passive interrogatives. He exhibited some difficulty with subordinate clauses; relative clauses; active interrogatives with negatives; passive declaratives with negatives and coordination. David earned 18 out of a possible 37 points.

**CELF-P2 Language Content Index**
The Language Content index is a cumulative measure of David’s performance on the two subtests to probe semantic knowledge. The Language Content index has a mean of 100 and standard deviation of 15. A score of 100 on this scale represents the performance of a typically developing child of a given age. For David’s Receptive Language index, the following subtests were administered: Expressive Vocabulary and Word Classes - Total. David received a Language Content standard score of 97 (confidence interval = 90 to 104, percentile rank = 42). This score is in the average range of developmental functioning.

- Expressive Vocabulary: See description under **CELF-P2 Core Language Index**.
- Word Classes - Total: This subtest is a continuation of the Word Classes - Receptive section. Once the child identifies the two words that are related he is asked to provide a description pertaining to their relationship. David exhibited some difficulty with home items (e.g., key/door, basket/box); parts of body (e.g., foot/hand); and transportation (e.g., car/bus). David successfully expressed a relationship between 15 of the 20 items.

**CELF-P2 Language Structure Index**
The Language Structure index is a cumulative measure of David’s performance on the two subtests to probe understanding and production of syntactical structures and morphology. The Language Structure index has a mean of 100 and standard deviation of 15. A score of 100 on this scale represents the performance of a typically developing child of a given age. For David’s Receptive Language index, the following subtests were administered: Sentence Structure, Word Structure, and Recalling Sentences. David received a Language Structure standard score of 86 (confidence interval = 79 to 93, percentile rank = 18). This score is in the average range of developmental functioning.

- Sentence Structure: See description under **CELF-P2 Core Language Index**.
- Word Structure: See description under **CELF-P2 Core Language Index**.
- Recalling Sentences: See description under **CELF-P2 Expressive Language Index**.

**NOMS Spoken Language Comprehension, Level 6:** Child understands communications of the type and length typically understood by chronologically age-matched peers but occasionally requires rephrasing and repetition. Child’s ability to participate in adult-child, peer, and group activities is sometimes limited by language comprehension.

**NOMS Spoken Language Production, Level 6:** Child usually communicates using age-appropriate sentences in most adult-child, peer, and directed group activities, but some limitations are still apparent. Minimal cueing is occasionally required from the communication partner.

**Social/Pragmatics:**
David demonstrated typical interaction skills with the clinicians and exhibited appropriate eye contact. He was cooperative, attending well to activities and remaining engaged in tasks throughout the session. David exhibited proper topic maintenance skills and initiated and participated well in conversation.
Recommendations

It is recommended that David receive therapy two times a week for 45-minutes per session. Therapy goals should include:

1. Improving articulation abilities to an age appropriate level by focusing on the production of the following sounds: /b/, /d/, /k/, /t/, /g/.
2. Improving articulation abilities to an age appropriate level by focusing on the production of consonant clusters and blends.
Speech-Language Evaluation

Summary:
Ashley Jones is a 10 year-old female with an unremarkable medical history. She presents today with deficits in reading comprehension and following complex multi-step directions. She was compliant and engaged during the evaluation session and was judged to put forth her best effort. It is recommended that Ashley attend therapy twice a week for 45-minute sessions to address the aforementioned deficits.

Case History/Background Information:
Ashley Jones is a 10 year-old female who was seen at the Auburn University Speech and Hearing Clinic (AUSHC) on February 14, 2014, for a formal comprehensive language and reading evaluation. She was accompanied to the evaluation by her mother, Leslie Jones, who served as the primary informant. There were no reported complications with regard to Ms. Jones’s pregnancy or delivery. Ashley suffers from asthma, for which she is currently taking asthma medications and steroids to combat this issue. Ms. Jones’s main concern was Ashley’s reading comprehension abilities. She reported that Ashley often gets frustrated when reading and typically has a difficult time answering questions after reading a passage. Ms. Jones also reported that Ashley often “gets lost” in conversation and experiences difficulty sounding out words when reading. Ashley is currently in the 4th grade at Auburn Elementary. Her best subjects include math and science (She typically makes As and Bs), and her poorest subject includes reading (She currently has a C). Ms. Jones also reported that Ashley has recently begun receiving special services at school with Mrs. Taylor, where she is able to receive extra time when taking tests. Ms. Jones has recently hired a tutor for Ashley, who has been helping her with reading on a weekly basis.

Assessment Results:

Voice/Fluency:
Based on informal observation, Ashley exhibits appropriate pitch and voice quality for her age and gender. No episodes of stuttering were observed or reported.

Oral-Peripheral Exam:
Based on informal observation, the structure and function of the oral mechanism are judged to be grossly within functional limits. Overall, external structures and function of the oral mechanism appeared to be adequate for speech.

Hearing:
No formal hearing screening was conducted. Ashley previously received a hearing screening at the Auburn University Speech and Hearing Clinic (AUSHC) on January 14, 2014, and passed the screening at all frequency levels. Ashley’s mother reported no concerns with regard to her hearing and stated that Ashley was able to follow directions.

Social/Pragmatics:
Ashley demonstrated typical interaction skills with the clinicians and exhibited appropriate eye contact. Ashley appeared somewhat reserved, but was very cooperative and attended well to activities and tasks presented throughout the session.
Clinical observation and formal testing were utilized to assess Ashley’s language skills. The Clinical Evaluation of Language Fundamentals -Fourth Edition (CELF-4) was administered to assess Ashley’s current receptive and expressive language skills. The CELF-4 is a comprehensive language test comprised of eleven subtests, which assess a person’s core language, receptive language, expressive language, language content, language memory, and working memory abilities. The raw scores are the total number of correct responses per subtest. The raw scores are then converted to a scaled/standard score. The standard score for each subtest is based on a mean of 10 with an average range of 7-13. The standard score for the Composite Scores are based on a mean of 100 and standard deviation of 15, with an average range of 85-115.

**Core Language:**

<table>
<thead>
<tr>
<th>Subtests:</th>
<th>Raw Score</th>
<th>Standard Score</th>
<th>Percentile</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concepts and Following Directions</td>
<td>39</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recalling Sentences</td>
<td>74</td>
<td>12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Formulated Sentences</td>
<td>48</td>
<td>12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Word Classes—Total</td>
<td>17</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Word Definitions</td>
<td>8</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>35</strong></td>
<td><strong>93</strong></td>
<td><strong>32</strong></td>
<td><strong>WNL</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Subtest:</th>
<th>Color-Shape Time Criterion</th>
<th>Color-Shape Error Criterion</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rapid Automatic Naming</td>
<td>&lt;= 90</td>
<td>&lt;= 5</td>
<td>Normal</td>
</tr>
</tbody>
</table>

Ashley’s results for the Core Language section of the test revealed her to be within normal limits overall, or where she is expected to perform for her age, with the exception of the concepts and following directions subtest. Ashley exhibited strengths in the areas of recalling sentences and formulating sentences, and she showed weakness in the area of concepts and following directions. The concepts and following directions subtest required Ashley to a) interpret spoken directions of increasing length and complexity, b) remember names, characteristics, and order of mention of objects, and c) identify pictured objects that were mentioned from several choices. Ashley was able to follow directions on a variety of concepts, but struggled interpreting concepts that expressed sequencing (first, second, third, last) and temporal relations (before, after, then). She also had a difficult time with many of the multi-level command items (particularly with three-step commands). Based on subtest scores, Ashley’s overall language abilities are within normal limits, but her ability to follow complex directions is moderately impaired.

The Test of Written Language - 4th Edition (TOWL-4) is a comprehensive diagnostic test of the expressive form of written language. The TOWL-4 was administered in order to assess the student’s ability
to perform the three components of written language: conventional (writing in compliance with orthographic standards), linguistic (proper use of grammatical and semantic elements), and cognitive (expression of ideas in creative and mature ways). The TOWL-4 assesses these three components using five contrived subtests and two spontaneous subtests. Results are as follows:

<table>
<thead>
<tr>
<th>Category</th>
<th>Subtest</th>
<th>Scaled Score</th>
<th>Percentile</th>
<th>Classification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spontaneous Writing</td>
<td>Contextual Conventions</td>
<td>11</td>
<td>63</td>
<td>Average</td>
</tr>
<tr>
<td></td>
<td>Story Composition</td>
<td>11</td>
<td>63</td>
<td>Average</td>
</tr>
<tr>
<td>Contrived Writing</td>
<td>Vocabulary</td>
<td>8</td>
<td>25</td>
<td>Average</td>
</tr>
<tr>
<td></td>
<td>Spelling</td>
<td>8</td>
<td>25</td>
<td>Average</td>
</tr>
<tr>
<td></td>
<td>Punctuation</td>
<td>10</td>
<td>50</td>
<td>Average</td>
</tr>
<tr>
<td></td>
<td>Logical Sentences</td>
<td>9</td>
<td>37</td>
<td>Average</td>
</tr>
<tr>
<td></td>
<td>Sentence Combining</td>
<td>10</td>
<td>50</td>
<td>Average</td>
</tr>
</tbody>
</table>

In order to score the TOWL-4, the examiner converts scores to normative scores (scaled scores) for one’s age group. Percentile ranks represent a value on a scale of 100 that indicates the percentage of the normative population that is equal to or below Ashley’s score. The spontaneous subtests included the Contextual Conventions and Story Composition subtests of the TOWL-4, which assess written expression. Ashley was asked to write a story based on a picture of a realistic scene involving a fire. The factors examined on this measure were her ability to write in two areas: contextual conventions (capitalization, sentence structure, punctuation, spelling, etc.) and story composition (story sequence, storyline, character, vocabulary, etc.). Ashley was shown the sample picture and read an example story before she was asked to begin writing. She was given five minutes to plan, during which she looked at the picture and drew a brainstorming chart. Then she was given 15 minutes to write the story. After seven minutes Ashley set her pencil down and stated she was finished. The clinician explained that time had not elapsed and urged her to continue writing, but she stated that she was finished with her story.

The remaining subtests were contrived subtests, each focusing on different skills. The five subtests included: Vocabulary, Spelling, Punctuation, Logical Sentences, and Sentence Combining. For the Vocabulary subtest, Ashley was given a word to use in a sentence. She was awarded a point if the sentence contained the given word and if the word was used correctly, conveying an understanding of its meaning. She was not penalized for misspellings or grammatical errors. Ashley completed the first 13 items on the subtest, ten of which were correct. The following sentences she composed received a score of zero: Do you know what aboard mean? (The vocabulary word given was “aboard”); I like to humble around. (The vocabulary word given was “humble”); I love the word though. (The vocabulary word given was “though”). Based on her scaled score of eight, Ashley’s vocabulary is considered average.

On the Spelling and Punctuation subtests the examiner dictated a sentence to Ashley and repeated the sentence once if needed. Ashley was expected to record the sentence in her booklet. She was awarded two points for each sentence that exhibited proper spelling and punctuation. A point was deducted for any spelling or any punctuation errors. She completed 16 sentences, earning ten points for spelling and 11 for punctuation. Ashley’s performance with regard to spelling and punctuation is average.
The next subtest, Logical Sentences, assessed Ashley’s ability to correct an illogical sentence by adding, removing or changing words. This subtest required her to read each sentence provided, and make necessary changes to the sentence in order to make it logical. She was not penalized for any spelling or grammatical errors. Ashley completed 14 items and earned 9 points. For this subtest, Ashley’s results equate to an average performance rating.

The last subtest, Sentence Combining, assessed Ashley’s ability to combine two sentences into one logical sentence. She was presented several items in his response booklet, each of which consisted of two or more sentences. She was scored on her ability to combine the sentences into one sentence by incorporating the important elements in the stimulus sentences using correct grammar. Spelling, punctuation, and capitalization errors were included in her score. Ashley completed 16 items and was awarded eight points. Ashley’s performance is considered average for her age.

These subtests were summed to reflect performance in three composite areas: Contrived Writing, Spontaneous Writing, and Overall Writing. The scaled scores that make up each composite are summed and recorded. Each value is converted into a standard score index where the mean is 100 and the standard deviation is 15, and a percentile rank based on age norms. The chart below summarizes Ashley’s composite scores for the TOWL-4.

<table>
<thead>
<tr>
<th>Composite</th>
<th>Sum of Scaled Scores</th>
<th>Percentile</th>
<th>Classification</th>
<th>Composite Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contrived Writing</td>
<td>44</td>
<td>39</td>
<td>Average</td>
<td>96</td>
</tr>
<tr>
<td>Spontaneous Writing</td>
<td>22</td>
<td>73</td>
<td>Average</td>
<td>109</td>
</tr>
<tr>
<td>Overall Writing</td>
<td>66</td>
<td>50</td>
<td>Average</td>
<td>100</td>
</tr>
</tbody>
</table>

The Contrived Writing composite estimates Ashley’s writing ability when given cues about how to respond. It is formed by combining the results of the Vocabulary, Spelling, Punctuation, Logical Sentences, and Sentence Combining subtests. Ashley’s Contrived Writing composite indicates that her performance is average (the 39th percentile) compared to students her age. The Spontaneous Writing composite estimates Ashley’s writing ability when measured by subtests that evaluate her spontaneously composed essay. It is formed by combining the results of the Contextual Conventions and Story Composition subtests. Ashley’s Spontaneous Writing composite indicates that her performance is average (the 73rd percentile) when compared to age-matched peers.

The Overall Writing Composite estimates Ashley’s writing ability measured by subtests that use both spontaneous and contrived formats. It is formed by combining the results of all seven subtests. Ashley wrote a 105 word story describing events in the sample picture. Her one paragraph story consisted of ten sentences. Her printing was legible; she incorporated proper spacing between words and often demonstrated appropriate usage of punctuation. Ashley received points for: sentences beginning with capital letters, the use of quotation marks, capitalizing (inconsistently) proper nouns, lack of fragmentary sentences, use of conjunctions and appropriate use of “a” at least once. Ashley did not earn any points for her usage of vocabulary words as designated by the TOWL-4 scoring criteria. In order to have received points she would have needed to produce at least four words; only three were present in her story. Ashley showed imagination and knowledge of cause and effect, but failed to comment on many of the stories details. Her writing style may be described as somewhat “matter-of-fact,” but serviceable. Results indicate Ashley’s writing ability is average given her age.
The Woodcock-Johnson III Tests of Achievement (WJ III ACH) is designed to facilitate a broad range of tailored and comprehensive assessments. The Word Attack subtest measures the student’s ability to apply structural analysis and phonic skills to the pronunciation of unfamiliar printed words. Initial items require the student to produce single letter sounds. For remaining items, the student is asked to read aloud letter combinations that are phonically consistent with typical patterns of English orthography. Test items become progressively more difficult as the complexity of the nonsense words increases. Ashley’s scores for this subtest are as follows:

<table>
<thead>
<tr>
<th>Raw Score</th>
<th>Age Equivalence (AE)</th>
<th>Percentile Rank</th>
<th>Standard Score (SS)</th>
<th>WJ III ACH Average Classification</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>9-3</td>
<td>40</td>
<td>96</td>
<td>Average</td>
</tr>
</tbody>
</table>

The raw score represents the total number of correct responses in this subtest and serves as the basis of conversion to an age/grade equivalent, relative proficiency index, and standard score. The age equivalent (AE) is similar to the GE, except it reflects performance in terms of the age level in the norming sample at which the average score is the same as the student’s score. Ashley correctly pronounced 20 out of 32 unfamiliar words, which translates to an estimated AE of 9-3. The percentile rank indicates the percentage of the population in the selected segment who had scores the same or lower than the student’s score. Thus, a percentile rank of 40 indicates that she scored higher than 40% of her peers. Classifications of standard scores are provided as a guideline for describing an individual’s relative standing among age-matched peers. Ashley’s standard score of 96 is equivalent to an average rating of performance and is within one standard deviation of a mean of 100. Ashley’s test performance establishes phonics as an area of strength.

NOMS Spoken Language Comprehension, Level 5: Child understands brief conversations. Child usually requires rephrasing and repetition to ensure understanding of the type and length of sentence typically understood by chronologically age-matched peers.

NOMS Spoken Language Production, Level 6: Child understands communications of the type and length typically understood by chronologically age-matched peers but occasionally requires rephrasing and repetition. Child’s ability to participate in adult-child, peer, and group activities is sometimes limited by language comprehension.

NOMS Writing, Level 5: The child writes sentence-level material containing some complex words. The individual occasionally requires minimal cueing to write more complex sentences and paragraph-level material. The child occasionally uses compensatory strategies.

Reading: The Gray Oral Reading Test - Fourth Edition (GORT-4) was administered to measure oral reading rate, accuracy, and comprehension. Information about rate and accuracy is important because children who read slowly take longer to complete assignments and experience difficulty understanding what they have read. On the GORT-4, after the child reads a series of passages aloud, the child’s oral reading is scored for rate and accuracy. After reading each passage, the child is asked to answer multiple choice questions that are read by the clinician. True results are as follows:
Sum of Fluency and Comprehension Standard Scores: 14
Percentile: 12
Oral Reading Quotient (ORQ): 82

For this assessment, Ashley was asked to read various stories of increasing difficulty. The clinician timed the speed of Ashley’s reading and recorded the number of errors made while reading. In addition, Ashley was asked to answer several multiple choice questions regarding each passage she read. Throughout the assessment, Ashley’s reading rate was age appropriate, but choppy. When encountering unknown words, she attempted to sound out each word. She did not ask for help, rather she continued to attempt the word until its correct production was achieved or produced a word she thought was correct. However, during administration of the *GORT-4* a basal was not initially achieved. Thus, the clinician proceeded to obtain a ceiling before revisiting earlier test items to secure a basal score. Ashley failed to answer at least three of the five questions correctly for story two. Although it is suspected fatigue played a role in her decreased performance, her true score reflects that of a lower ceiling, placing her in the below average category. Ashley’s rate, accuracy, and fluency scores were all within normal limits, earning her an average rating. Her Oral Reading Quotient of 82 equates to a percentile rank of 12. This indicates that Ashley scored as well or better than only 12 out of 100 children her age. Based on these results, Ashley exhibits a moderate deficit in reading comprehension. If the basal had been reached with item three, results would be as follows: Ashley’s overall performance on this test fell within the below average range. Results are as follows:

<table>
<thead>
<tr>
<th></th>
<th>STANDARD SCORE</th>
<th>PERCENTILE</th>
<th>AGE EQUIVALENT</th>
<th>GRADE EQUIVALENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehension Score</td>
<td>10</td>
<td>50</td>
<td>10.9</td>
<td>5.7</td>
</tr>
</tbody>
</table>

Sum of Fluency and Comprehension Standard Scores: 20
Percentile: 50
Oral Reading Quotient (ORQ): 100

The *Test of Silent Contextual Reading Fluency (TOSCRF)* was administered to assess Ashley’s silent reading skills. The *TOCSRF* is an assessment of silent reading ability normed for children ages 7-0 to 18-11. The test measures the speed that students can identify individual words in printed passages with progressing difficulty in grammar content and vocabulary. The *TOCSRF* provides raw scores, standard scores, percentiles, and age and grade equivalents.
The raw score indicates the number of words that were identified by the client in passages within a three-minute period. The standard score of the TOSCRF has a mean of 100 with a standard deviation of 15. Ashley’s standard score of 99 places her within one standard deviation of the mean. This indicates that her silent reading abilities are within normal limits for her chronological age. Ashley’s TOSCRF score reflects competence in comprehension and fluency during silent reading activities; however, parent report and scores obtained from the GORT-4 and TORC-3 indicates that reading comprehension was an area of weakness.

The Test of Reading Comprehension - Third Edition (TORC-3) was administered to assess silent reading comprehension in four general areas: Vocabulary, Syntactic Similarities, Paragraph Reading, and Sentence Sequencing. These core subtests require the reader to “construct” meaning through the development of increasingly difficult relationships. Four diagnostic supplements are used to obtain a more comprehensive evaluation of relative strengths/weaknesses in content areas of math, social studies and science. Results are as follows:

<table>
<thead>
<tr>
<th>General Reading Comprehension Core</th>
<th>Age Equivalents (AE)</th>
<th>Grade Equivalents (GE)</th>
<th>Percentile</th>
<th>Standard Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Vocabulary</td>
<td>8-0</td>
<td>3.0</td>
<td>16</td>
<td>7</td>
</tr>
<tr>
<td>Syntactic Similarities</td>
<td>9-0</td>
<td>4.0</td>
<td>25</td>
<td>8</td>
</tr>
<tr>
<td>Paragraph Reading</td>
<td>&lt; 7-3</td>
<td>&lt; 2.2</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Sentence Sequencing</td>
<td>7-3</td>
<td>2.2</td>
<td>16</td>
<td>7</td>
</tr>
<tr>
<td>Reading Comprehension Quotient (RCQ)</td>
<td></td>
<td></td>
<td></td>
<td>78</td>
</tr>
<tr>
<td><strong>Diagnostic Supplements</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mathematics Vocabulary</td>
<td>10-3</td>
<td>5.2</td>
<td>50</td>
<td>10</td>
</tr>
<tr>
<td>Social Studies Vocabulary</td>
<td>12-3</td>
<td>7.2</td>
<td>37</td>
<td>9</td>
</tr>
<tr>
<td>Science Vocabulary</td>
<td>9-9</td>
<td>4.7</td>
<td>50</td>
<td>10</td>
</tr>
<tr>
<td>Reading the Directions of Schoolwork</td>
<td>9-3</td>
<td>4.2</td>
<td>37</td>
<td>9</td>
</tr>
</tbody>
</table>
The number of correct responses, raw scores, was calculated for each of the eight subtests. Each raw score was then converted to an age/grade equivalent, percentile rank and standard score. The General Vocabulary subtest requires that the student read a list of three related words, followed by a different list comprised of four additional words. The student is asked to identify two words from the new list that are related to the original three words.

During the second subtest, entitled Syntactic Similarities, the student is asked to read five sentences and determine with two sentences “mean almost the same thing.” The Paragraph Reading subtest measures the reader’s ability to answer five questions based on short stories that become progressively more difficult. Subtest four, Sentence Sequencing, asks the student to read a list of sentences that are out of order. The reader should determine which sequence makes the most sense and rearrange the sentences accordingly.

The TORC-3 subtest standard scores use a mean of 10 and standard deviation of 3 for norm comparison. Thus, based on the Ashley’s standard scores from the General Reading Comprehension Core, her performance in three out of the four subtests is deemed below average, while her performance with regard to the Syntactic Similarities subtest is considered average.

The Reading Comprehension Quotient (RCQ) is a general index of the student’s overall reading comprehension abilities. The RCQ is arrived at by statistically transforming the combined standard scores of the four subtests in the comprehension core. The “average range” is between 90 -110. Ashley’s RCQ of 78, places her within the poor category for general reading comprehension.

The Mathematics, Social Studies and Science Vocabulary subtests all employ the same instructional procedures as the General Vocabulary subtest. Again, the student is required to read a list of three related items (numbers, symbols, words), followed by a different list comprised of four additional items. The student is asked to identify two items that are related to the original three-item list. Ashley’s standard scores from the Diagnostic Supplements section, indicate her performance in all four subtests is average. The last subtest, Reading the Directions of Schoolwork, measures the student’s ability to understand written directions commonly found in schoolwork. A standard score of nine translates to an average performance rating.

Based on subtest scores, Ashley’s understanding of words associated with specific school subject matter is within normal limits, but overall reading comprehension is moderately impaired. The following tasks presented the greatest challenge: understanding sets of vocabulary items, answering questions related to story-like paragraphs and ordering sentences into plausible paragraphs.

*NOMS Reading, Level 5: The individual reads sentence-level material containing some complex words. The individual occasionally requires minimal cueing to read more complex sentences and paragraph-level material. The individual occasionally uses compensatory strategies.*

**Articulation:**
Ashley’s overall intelligibility was assessed through informal conversation with the clinicians and was observed to be within normal limits for her age level. Based on clinician observation, it is estimated that Ashley is intelligible 98% of the time. She exhibits precise articulation, with the exception of dialectal differences of African American English, and normal speaking volume.

*NOMS Articulation/Intelligibility, Level 7: Child’s connected speech rarely calls attention to itself more than would be expected of chronological peers, and participation in adult-child, peer, and directed group activities is not limited by speech intelligibility.*
Recommendations:
It is recommended that Ashley receive therapy 2 times a week for 45-minutes per session to improve her reading comprehension and auditory comprehension skills. Therapy goals should include:

1. Improving auditory and reading comprehension and visual imagery skills through the use of a program to increase concept imagery.
Speech/Language Evaluation

Summary:

Shirley Smith is a 60 year-old female status post a left hemisphere cerebrovascular accident (CVA). She presents today with a mild/moderate auditory comprehension deficit, moderate anomia, a severe reading and writing impairment and a mild deficit in repetition ability. She was compliant and engaged during the two hour evaluation session. At this time, speech/language services are indicated for Mrs. Smith to improve aforementioned skills.

Case History

Mrs. Smith is a 60 year-old female who was given a comprehensive speech/language evaluation at the Auburn Speech and Hearing Clinic (AUSHC) on May 23, 2014. Mrs. Smith incurred a left hemisphere CVA on May 29, 2013. Mrs. Smith received speech and language therapy, physical therapy, and occupational therapy from Health South Rehab in Montgomery, Alabama in August 2013 for a short amount of time. Since the CVA, she has developed right-sided weakness and a seizure disorder. She was accompanied by two family members (her daughter and daughter-in-law) to the evaluation. In the case history completed by Mr. Smith, the following was reported to be of concern: problems expressing what she wants to say, communicating with the public, illegible writing, and difficulty swallowing depending on the type of food. Although her memory has been reported as impaired, it was determined that this may be a result of her word finding difficulties. She was reported to be able repeat words, can understand conversational speech, and uses automatic speech. Close friends and family understand her 80% of the time, and unfamiliar persons understand her 60% of the time. Mrs. Smith currently takes a mood stabilizer, blood pressure medicine, anti-seizure medicine, vitamin D, and cholesterol medicine. Both the patient and her family expressed that she enjoyed reading before the stroke, and would like to be able to return to this activity in the future. Mrs. Smith is currently not working, but previously worked in Textiles at Swift Mills. At this time, Mrs. Smith is uses a wheelchair and walker at all times. Her right arm is in a sling, as she is not able to use it at this time.

Assessment Results:

Hearing:
Mrs. Smith’s hearing was screened by the clinicians in the evaluation room using a portable audiometer. Hearing was assessed at 25 dB at 1000 Hz, 2000 Hz, and 4000 Hz. Mrs. Smith responded at each of these levels. The results of the hearing screening indicate that Mrs. Smith hearing ability is within normal limits.
Language

Both clinical observation and formal testing were used to assess Mrs. Smith’s overall language abilities.

**Informal Observation:**
During the evaluation, Mrs. Smith was observed to put forth good effort for all tasks presented to her. She would become frustrated when she was unable to successfully complete tasks. Mrs. Smith often commented, “I know the word, I just can’t say it.” On many tasks, she required repetition of directions to understand the task instructions. The clinicians observed Mrs. Smith demonstrate frequent word finding difficulties and perseverate on many occasions. At the end of the evaluation, Mrs. Smith commented that she was “very tired.” She expressed concern over her current reading skills, and commented that she would like to improve these skills in therapy.

**Formal Observation:**
*The Boston Diagnostic Aphasia Examination* (BDAE) was administered to assess Mrs. Smith’s current language skills. This assessment is a comprehensive test designed to evaluate language impairments. The BDAE standard form is comprised of ten subtests which assess fluency, conversational speech, auditory comprehension, articulation, recitation & music, repetition, naming, presence of paraphasia, reading, and writing. The raw scores are the correct responses per subtest. The raw scores are then converted to a severity rating scale that measures a person’s communicative ability. Percentile rankings are also recorded which compare an individual’s score to normative data. Severity ratings indicate a normal (85-100%), mild (70-80%), moderate (40-60%), or severe (0-30%) deficit.

1. **Conversational and Expository Speech**

The conversational speech subtest includes three sections: simple social responses, free conversation, and picture description. For simple social responses section, Mrs. Smith was asked several questions to elicit responses about herself such as, “How are you today?” She was awarded a point if the response was an appropriate social response. Mrs. Smith provided responses to all questions; however, she received a score of zero for not being able to give a response to “What is your full address?” Mrs. Smith received a score of 6/7, which correlates to a percentile rank of 50%, a moderate severity rating. For the free conversation section, Mrs. Smith engaged in conversation with the examiners. Some of the topics included her career, her family, and her communication difficulties. Though she often used short utterances, at times she used an appropriate length of utterance. She used short phrase lengths most often while encountering word retrieval difficulties, which caused variability in the phrase length. Though the clinician could understand some parts of what she was attempting to communicate, she often encountered difficulty understanding Mrs. Smith’s intended message. For example, anoma and paraphasias as were observed frequently while communicating with the clinicians, which often resulted in Mrs. Smith not being successful in her communication attempt. She seemed aggravated during much of the conversation, stating, “I know what I want to say but can’t.” However, when the clinician knew what she was trying to state, a phonemic cue often helped elicit the correct words. The next portion
of the conversational sample is the Picture Description portion. The Picture Description Subtest requires her to discuss a given picture, referred to as the ‘Cookie Theft’ picture. This assessment is a measure of assessing overall fluency and ability to communicate effectively. This sample is later evaluated in order to determine the phrase length, presence of anomia, and grammatical complexity of sentences, and overall ability to describe a given picture. This subtest assessed communication abilities in conversation. Her severity rating for conversation and expository speech was a 2, giving her a percentile rank of 50%. This correlates to a moderate severity rating. The two conversational samples are then evaluated to tally the total number of utterances, the various types of clauses included in these utterances, and an overall complexity Index, which indicates the mean number of clauses per utterance. A summary of performance for this portion of the assessment is provided below.

<table>
<thead>
<tr>
<th>Subtest</th>
<th>Percentile Rank</th>
<th>Severity Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simple Social Responses</td>
<td>50%</td>
<td>Moderate</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Conversational Speech Samples</th>
<th>Score</th>
<th>Percentile Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number of Utterances</td>
<td>38</td>
<td></td>
</tr>
<tr>
<td>Total Number of Clauses</td>
<td>32</td>
<td></td>
</tr>
<tr>
<td>Complexity Index (Clauses per utterance)</td>
<td>1.2</td>
<td>70th percentile</td>
</tr>
</tbody>
</table>

II. Auditory Comprehension

The auditory comprehension subtest includes three sections: basic word discrimination, commands, complex ideational material. For the basic word discrimination section, Mrs. Smith was asked to point to specific body parts and point to pictures (colors, letters, objects or numbers) corresponding to the spoken test word. She was awarded points depending on accuracy and responding in less than 5 seconds. She was awarded a half point for accuracy and responding in more than 5 seconds. She was awarded a zero if response was inaccurate. She responded to 37 stimulus items. She received a full point for 23 items, half point for 10 items, and zero for 4 items. She received a score of a zero for not being able to choose the correct items for ant, the letter G, spider, and iris. Her correct responses were 28.5 out of 37, which resulted in a severity rating of severe (18%).

For the commands section, Mrs. Smith was asked to follow out commands such as, “Make a fist” and “Point to the ceiling then the floor.” She was awarded points based on her ability to follow all the parts of the command. She had difficulty following the commands where she had to manipulate objects such as, “Put the watch on the other side of the pencil and turn over the card.” She was able to respond correctly to 10 portions of the commands, giving a score of 10 out of 15. Due to her responses, she received a severity rating of severe (20%).

For the
complex ideational material section, she was asked yes and no questions based on basic knowledge or short paragraphs read aloud to her. She was awarded a point for correctly answering parts A and B of the questions. She provided an answer to all questions asked and received 8 out 12 points. However, she often required the clinician to repeat the stimulus in order to answer the questions. Due to her responses, she received a severity rating of moderate (50%). A summary of overall auditory comprehension abilities are provided below.

<table>
<thead>
<tr>
<th>Subtest</th>
<th>Percentile Rank</th>
<th>Severity Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Word Discrimination</td>
<td>18%</td>
<td>Severe</td>
</tr>
<tr>
<td>Commands</td>
<td>20%</td>
<td>Severe</td>
</tr>
<tr>
<td>Complex Ideational Material</td>
<td>50%</td>
<td>Moderate</td>
</tr>
</tbody>
</table>

**III. Oral Expression**

*Articulation:*

The Oral Agility/Articulation subtest includes two parts: nonverbal agility and verbal agility. The nonverbal agility subtest required Mrs. Smith to carry out rapid mouth movements following description and demonstration. The clinician counts to determine how many repetitions of each movement she performed in 5 seconds. She demonstrated difficulty with this section, often being unable to correctly imitate the clinician’s action even with cueing. For those actions she was able to complete repeatedly, she performed the actions slowly. Because of her performance, she received as score of 3/12. This correlates to a severity rating of severe (8th percentile).

The verbal agility subtest required her to repeat given words as rapidly as possible. The clinician times the number of repetitions completed within 5 seconds. Test words include “mama, mama,” “tip-top, tip-top,” “huckleberry, huckleberry,” etc. Though the patient encountered difficulty with this portion of the test, her performance exceeded her performance on the nonverbal agility subtest. She was able to repeat some test words rapidly, such as “mama, mama” and “fifty, fifty,” but encountered difficulty on more complex words such as “huckleberry, huckleberry,” and “caterpillar, caterpillar.” On these words, she often could not articulate the words correctly when producing them rapidly. Mrs. Smith received a score of 8/14, which correlates to a percentile ranking of 40, and a severity rating of moderate in this area.

The following chart represents a summary of Mrs. Smith’s overall articulation and oral agility.
<table>
<thead>
<tr>
<th>Subtest</th>
<th>Percentile Rank</th>
<th>Severity Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nonverbal Agility</td>
<td>8%</td>
<td>Severe</td>
</tr>
<tr>
<td>Verbal Agility</td>
<td>40%</td>
<td>Moderate</td>
</tr>
<tr>
<td>Articulation Agility Rating Scale</td>
<td>40%</td>
<td>Moderate</td>
</tr>
</tbody>
</table>

**Recitation and Music**

The recitation and music subtest includes four parts: automatized sequences, recitation, melody, and rhythm. For the automatized sequences, Mrs. Smith was asked to recite common sequences including the days of the week, the months of the year, counting to 21, and the alphabet. Though she often required the first word of the sequences, she was able to accurately recite all four of the sequences, giving her a score of 8/8. This score correlates to a normal severity rating (100%). For the recitation, melody, and rhythm section, Mrs. Smith was asked to complete the line for rhymes, produce the melody for “Happy Birthday,” and repeat rhythms on the table that the examiner demonstrated. She was able to complete 4 out of the 5 rhymes, and demonstrated difficulty completing “My Country ‘Tis of Thee.” Her responses resulted in a severity rating of moderate (60%). She was able to sing the whole song of “Happy Birthday.” Her abilities awarded her a rating of a 2. In this area, she received a severity rating of normal (100%). She had little difficulty following the examiner led rhythm. Her abilities awarded her a rating of a 2 and a severity rating of normal (100%). The following chart represents a summary of Mrs. Smith’s performance in this area.

<table>
<thead>
<tr>
<th>Subtest</th>
<th>Percentile Rank</th>
<th>Severity Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Automatized Sequences</td>
<td>100%</td>
<td>Normal</td>
</tr>
<tr>
<td>Recitation</td>
<td>60%</td>
<td>Moderate</td>
</tr>
<tr>
<td>Melody</td>
<td>100%</td>
<td>Normal</td>
</tr>
<tr>
<td>Rhythm</td>
<td>100%</td>
<td>Normal</td>
</tr>
</tbody>
</table>

**Repetition:**

The repetition subtest includes two parts: single words and sentences. In the single words portion, 10 words of varying complexity are verbally presented to Mrs. Smith. She is asked to repeat a word after the clinician states it. Words included brown, chair, what, hammock, emphasize, etc. Mrs. Smith was able to repeat 9 of the 10 words presented, with the exception of “Methodist Episcopal.” Thus, Mrs. Smith received a score of 9/10, which correlates to a percentile ranking of 70, and a severity rating of mild. In regards to the sentence repetition portion, she was verbally presented with 10 sentences of varying
complexity and was asked to repeat them. Examples include “Father comes home” and “He picks up the paper from the coffee table.” Mrs. Smith was able to repeat 5 sentences back correctly. Her most common errors included omissions (deletion of words), neologisms (replacement of a word with a non-word), real word phonemically based paraphasic errors (replacement of a word with a real word), and verbal paraphasias-semantically related (replacement of a word with a word of the same class). Mrs. Smith received a score of 5/10, which correlates to a percentile rank of 55 and a severity rating of moderate. The following chart represents a summary of her performance on this portion of the test.

<table>
<thead>
<tr>
<th>Subtest</th>
<th>Percentile Rank</th>
<th>Severity Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Words</td>
<td>70%</td>
<td>Mild</td>
</tr>
<tr>
<td>Sentences</td>
<td>55%</td>
<td>Moderate</td>
</tr>
</tbody>
</table>

Naming:

The naming subtest includes three parts: responsive naming, Boston Naming test, and special categories. For the responsive naming section, Mrs. Smith was asked to give one word answers to questions the clinician asked. She was awarded points depending on accuracy and response time. She received 2 points for 5 responses, 1 point for 4 responses, and 0 points for 2 responses. She received a score of a zero for the following questions: “What do you do with soap?” and “What do we light a candle with?” During this portion of the assessment, she asked for questions to be repeated several times. She received a percentile rank of 50% for this subtest, which correlates to a moderate severity rating.

In the Boston Naming test, Mrs. Smith was asked to name 60 pictures. If an answer was not provided in 20 seconds, the clinician offered specific verbal cues to assist her. If the correct answer could not be given, the clinician moved on to the next picture. She was able to correctly identify 11 pictures. After cues were given, she was able to correctly identify 13 pictures, resulting in a severity rating of moderate (38%). Many times, she commented that “she knew the word, but the trouble was saying it.” She completed naming 60 pictures and received a score of 24/60 points. The clinicians noted that Mrs. Smith’s prevalent errors included perseverations, semantic paraphasias, circumlocutions, and non-word/real word phonemically based paraphasias.

In the screening of special categories subtest, she is shown printed letters, printed numbers, and colors using the stimulus booklet. She is asked to name each of the given stimuli. Mrs. Smith was able to name all letters, but encountered difficulty on many numbers and colors. She was not able to correctly identify the numbers 7 or 200, calling 7 “our” and 200 “20.” Additionally, the only color she was correctly able to identify was blue, presenting with semantic paraphasias on the remainder of the colors. For example, she called red “green” and green “brown.” Mrs. Smith received a score of 7/12, which correlates to a percentile rank of 20, and a severity rating of severe. The following chart represents an overall summary Mrs. Smith’s performance on the naming portion of the assessment.
### IV. Reading

The reading subtest includes nine parts: matching cases and scripts, picture-word matching, lexical decision, homophone matching, free grammatical morphemes, oral word reading, oral sentence reading, oral sentence comprehension, sentence/paragraph, and comprehension.

For the matching across cases and scripts section, Mrs. Smith was asked to identify a given symbol from a row of symbols. In this section of the assessment, she is shown a letter and is asked to choose the corresponding letter that differs only by case or script. She completed 8 items and was awarded 7 points. She could not identify “are” from the choices provided. Due to her responses, she received a severity rating of moderate (50%).

For the picture-word matching, she is shown a picture without the clinician naming it and the patient is asked to find its name among four words listed beside the picture. She was able to correctly match 7 of the 10 pictures given. She inaccurately matched “tongue,” “knight,” and “binocular.” This correlates to a percentile ranking of 20, which indicates a severe rating.

For the lexical decision section, she was asked to identify the real English word from a row of choices. She was able to correctly identify three out of five real words and received a severity rating of severe (20%).

The homophone matching subtest required Mrs. Smith to find a word that has the same sound as the target, such as “mail” and “male.” Mrs. Smith demonstrated much difficulty with this subtest, responding accurately to 0 questions. She received a percentile rank of 0, giving her a severity rating of severe in this area.

For the free grammatical morphemes section, she was asked to find the written word among five choices after the clinician stated the word. She was able to correctly identify 8 of the 10 written words and received a severity rating of severe (25%).

Mrs. Smith had difficulty on the oral word reading, oral sentence reading, oral sentence comprehension, sentence/paragraph, and comprehension sections. Though apprehensive, she attempted the oral reading section. In this section of the assessment, she was given 10

<table>
<thead>
<tr>
<th>Subtest</th>
<th>Percentile Rank</th>
<th>Severity Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsive Naming</td>
<td>50%</td>
<td>Moderate</td>
</tr>
<tr>
<td>Boston Naming Test</td>
<td>38%</td>
<td>Moderate</td>
</tr>
<tr>
<td>Screening of Special Categories</td>
<td>20%</td>
<td>Severe</td>
</tr>
</tbody>
</table>
words and is asked to read them individually, while the clinician notes the time to respond. She was able to read some words accurately, including “chair,” “purple,” “brown” and “dripping,” though sometimes with a delay. However, she often read words incorrectly or produced paraphasias including “hamburger” for “hammock,” and “six hundred seventy one” for “seven-twenty-one.” Mrs. Smith received a percentile rank of 25 in the oral word reading portion, which correlates to a severe rating. The other reading portions (oral sentence reading, oral sentence comprehension, sentence/paragraph) were not completed due to Mrs. Smith declining to participate in further reading subtests. A summary of reading performance is provided in the chart below.

<table>
<thead>
<tr>
<th>Subtest</th>
<th>Percentile Rank</th>
<th>Severity Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Matching Cases and Scripts</td>
<td>50%</td>
<td>Moderate</td>
</tr>
<tr>
<td>Picture Word Matching</td>
<td>20%</td>
<td>Severe</td>
</tr>
<tr>
<td>Lexical Decision</td>
<td>20%</td>
<td>Severe</td>
</tr>
<tr>
<td>Homophone Matching</td>
<td>0%</td>
<td>Severe</td>
</tr>
<tr>
<td>Free Grammatical Morphemes</td>
<td>25%</td>
<td>Severe</td>
</tr>
<tr>
<td>Oral Word Reading</td>
<td>25%</td>
<td>Severe</td>
</tr>
<tr>
<td>Oral Sentence Reading</td>
<td>10%</td>
<td>Severe</td>
</tr>
<tr>
<td>Oral Sentence Comprehension</td>
<td>0%</td>
<td>Severe</td>
</tr>
</tbody>
</table>

V. Writing:

Despite encouragement, Mrs. Smith was unable to complete the writing subtest of the assessment. She agreed to sign her signature. However, the writing was not indicative of her signature and contained two words (“My bad”).

Language Competency Index

The Computation of Language Competency Index estimates her expressive language and auditory comprehension abilities. It is formed by combining the results of the Boston Naming Test, Grammatical Form, Word discrimination, Commands, and Complex Ideational material sections.

Expression Component:
A. Percentile of Boston Naming Test Score | B. Percentile of Grammatical Form rating | Expression Component Score: (sum of A+B/2)
---|---|---
25 | 25 | 25

Auditory Comprehension Component:

<table>
<thead>
<tr>
<th>A. Word Discrimination percentile</th>
<th>B. Commands percentile</th>
<th>C. Complex Ideational Material percentile</th>
<th>Comprehension Component Score: (sum of A+B+C/2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>18</td>
<td>20</td>
<td>50</td>
<td>29.3</td>
</tr>
</tbody>
</table>

**NOMS Language Comprehension: Level 3:** The individual consistently responds accurately to simple yes/no questions and occasionally follows simple directions without cues. Moderate contextual support is usually needed to understand complex sentences/messages. The individual is able to understand limited conversations about routine daily activities with familiar communication partners.

**NOMS Language Expression: Level 4:** The individual is successfully able to initiate communication using spoken language in simple, structured conversation in routine daily activities with familiar communication partners. The individual usually requires moderate cueing, but is able to demonstrate use of simple sentences (i.e., semantics, syntax, and morphology) and rarely uses complex sentences/messages.

**NOMS Motor Speech: Level 5:** In simple structured conversation with familiar communication partners, the individual can produce simple words and phrases intelligibly. The individual usually requires moderate cueing in order to produce simple sentences intelligibly, although accuracy may vary.

**NOMS Pragmatics: Level 6:** Pragmatics are functional in most settings or situations with occasional minimal cues. The majority of the time, the individual is able to modify behaviors in response to subtle feedback from the environment.

**Free Conversation:**

*What kind of work were you doing before you had your stroke?*

I was in a / the first time my daddy died at the house/ and then my mama/ he died then she got sick/ and my b-brother (pause) / my brother got to the hospital/ and then we got his hips one time
He had hip surgery?

No my brother had, it’s hard to explain/1st my brother got sick/ 2 is my was he (unintelligible)/ hospital/

Did you brother get sick?

After my dad died my brother got sick and was hospital/ and my brother was Dadeville got sick/ then I got sick/ I don’t know how to smell explain it

What was your job?
My job at work/ I was a supervisor/

What did you do?
I worked at number/ I worked at number/ I don’t know it now/ I don’t know. I got moved/ they moved/ I got to move to Playtex/ it was across the road/ and I got to be same thing

Did you enjoy it?
Yes/ I enjoyed it

Picture Description:
I’ve gotta girl with a chair and the chair is falling over / and / what is this / girl / washing dishes and/ pushing/ pushing out the water/ something is I guess you say/ and water/ that’s it.

Total Number of Utterances 38
Empty Utterances 0
Subclausal Utterances 0
Single Clause Utterances 13
Multi-clause utterances 5
Agrammatic Deletions 7
Articles: 5
Omissions of auxiliary verbs: 2
Omissions of verb is SVO construction: 0

Complexity Index (Clauses per utterance):32/38-84%
Recommendations

It is recommended that Mrs. Smith receive therapy once a week for an hour per session to improve her verbal expression, auditory comprehension, reading abilities, and naming abilities. Therapy goals include:

1. Increase reading ability to a functional level
2. Increase word retrieval skills to aid in conversation ability
3. Increase auditory comprehension to a functional level
4. Increase writing ability to aid in using signatures and writing name
Name: Amanda F. Jones  
Date of Evaluation: 7-6-10  
D.O. B.: 8-12-88 (22 years)  
SSN: 123-45-6789  
Diagnosis: Intellectual Disability, LD  
Type of Identification: Driver’s License

Case History:
Amanda was seen at the Auburn University Speech and Hearing Clinic and was accompanied to the evaluation by her mother, Susie Smith. Information was also provided from Ronald King, Ph.D. in the form of a psychological evaluation dated Oct. 4, 2007. According to the aforementioned sources, Amanda is a 21 year old female who presents with reduced cognitive functioning. Dr. King reports her Full Scale IQ to be 63, which places her in the mild range of intellectual disability. According to her mother, Amanda was enrolled in special education throughout her academic career, and graduated from Jeff Davis H.S. in Montgomery with an occupational diploma. She was unsure what grade level Amanda was performing on when she graduated. Amanda stated that she has worked at Publix, and at a day care previously, but that she is no longer employed. Amanda is slow to respond when asked questions, and her mother reported that she sometimes “can’t pronounce words correctly.” She stated that Amanda was in speech therapy for an articulation disorder beginning in kindergarten and through her elementary school years. Amanda is the youngest of three children and her older siblings do not present with any speech, language or cognitive deficits. Ms. Smith denied any family history of learning disability or mental retardation.

Amanda was very pleasant and cooperative and attempted all tasks presented to her. There is no reported family history of speech or language disorders.

Assessment Results:

Language:
Clinical observation and formal testing were utilized to assess Amanda’s language skills. The following test was administered:

Test of Adolescent and Adult Language (TOAL-3)

General Language Quotient: 42 (Below 1st percentile)
Spoken Language: 43  
Written Language: 48
Based on results of today’s testing, Amanda exhibits a significant language delay (across all modalities), even when compared to her measured cognitive functioning. She has difficulty with all aspects of testing, specifically with writing vocabulary, repeating sentences, and writing grammar. She frequently did not know the meanings of words (frightened, destination, latch, horizon) and would say, “I don’t understand that.” Her response time was very slow; at times, she would hesitate up to 5 seconds before she responded. It appeared that she was attempting to process the information in order to provide an appropriate answer. Based on previous testing, and parent report, this is felt to be a valid assessment of her language abilities.

**Articulation:**
Amanda uses dialectal speech patterns of African-American English, although there was no speech errors observed. She was judged to be 90% intelligible to an unfamiliar listener.

**Voice/Fluency:**
Amanda’s voice quality, pitch and volume are age and gender appropriate. There were no stuttering or stuttering-like behaviors observed or reported.

**Hearing/Vision:**
Amanda reported that she wears eye glasses, although she did not have them with her for the evaluation. She was given a pair of reading glasses to use during the evaluation and she stated that these were adequate.

**Oral-Peripheral Exam:**
Based on cursory exam, Amanda’s structure and function appear to be adequate for speech production. She was wearing braces, which her mother reported that she had had on for 3 years, due to “financial issues.” She presents with a slight open bite, although her teeth are in alignment.

**Pragmatics:**
Amanda is a very pleasant young woman, although she exhibits noticeable difficulty participating in a conversation. She frequently took several seconds to respond to a question, and mostly provided one or two word responses.
Clinical Summary and Recommendations:
Amanda is a 21 year old female with a history of academic difficulty, enrollment in special education and intellectual disability. She presents today with a significant receptive and expressive language delay that impacts all language modalities. Articulation, voice and fluency are within normal limits at this time. Her prognosis for improvement is poor due to poor literacy skills and reduced cognitive abilities.

Clinician’s Signature: ___________________________ Date: _______________
AL. License: 2045


CLINICAL TREATMENT IN SPEECH-LANGUAGE PATHOLOGY

I. Treatment procedures at Auburn University Speech and Hearing Clinic.

A. Clinic Coordinator assigns student to case and notifies student via mailbox and/or email.
B. Student reviews client information in Practice Perfect.
C. Student calls client to confirm schedule.
D. Notify Clinic Coordinator if the client wishes to change times using a clinic form.
E. Student makes appointment to meet with supervisor to outline therapy and determine requirements for programming, reporting, conferencing, etc. Typically, two meetings are scheduled with the supervisor at the beginning of the semester to outline a treatment plan (prior to the first session).
F. When new clients are scheduled after clinic has started, the student should schedule an appointment with the case supervisor at least one day in advance of the first session.
G. During the supervisor meeting the student should be prepared to: (See supervisor meeting page for more detail).
   1. Case History:
      a. Pertinent birth history and acquisition of developmental milestones
      b. Pertinent medical history
      c. Educational and/or vocational history
      d. Evaluation results and or treatment history
   2. Outline treatment objectives and procedures.
   3. Provide a rationale for objectives and procedures based on norms, past progress, etc.
   4. Specific plan, including materials for the first day of therapy.

II. Treatment Procedures

A. The schedule of sessions is on the Practice Perfect screen in the Clinician’s room.
B. Each student is responsible for checking the schedule daily for cancellations. When a new client is assigned during the semester, the clinician will be notified via his/her mailbox in the clinicians’ room or via e-mail. A copy of the notice and/or e-mail will be provided to the clinical supervisor assigned to the case. Students are required to contact the supervisor within 24 hours of the assignment in order to schedule the client.
C. For each case assignment, the clinician should determine that the client’s folder contains all necessary forms (application, authorization, EPSDT, etc.).

D. The student is responsible for contacting the client to confirm the treatment time. The case supervisor and clinic coordinator should be notified of any changes requested by the client. Requests to change time or day should be made by completing the appropriate form. Verbal requests or request not made using the proper form will not be honored.

E. Sessions can be scheduled for 30, 45 or 60 minutes. Consider a client a “no show” if they are 10 minutes late for a 30 minute session, 5 minutes late for a 45 minute session, or 30 minutes late for a 60 minute session. If needed, check with the case supervisor before giving up the wait.

F. The clinic secretary and supervisor should be notified of client cancellations.

G. Following each session the student must return materials and equipment and sign the daily log and supervision record form.

H. SOAP notes should be completed after every treatment session.

I. If a student cannot be present for a treatment session due to a medical emergency, physician’s excused illness, contagious disease, or death in the immediate family, it is the student’s responsibility to notify immediately the secretary AND the clinical supervisor assigned to the case or another available supervisor. Once approval is given to cancel the client, it is the clinician’s responsibility to call the client to cancel. Please inform the clinic secretary if you are unable to contact your client so further attempts at contacting the client may be made. When the absence is due to illness, the student must present a written medical excuse to the clinical supervisor by the next working day.

J. Unexcused failure to attend a session will result in a reduction of the student’s final grade by one full letter grade. A second unexcused absence will result in a course grade of “F.”

K. Unexcused absence from a mandatory clinic meeting results in reduction of final grade by one full letter grade. A second unexcused absence will result in a course grade of “F.”

L. Missed treatment sessions should be rescheduled with the approval of the case supervisor. The clinic coordinator must be notified of the time change in writing. The clinic coordinator will assign a room upon notification of the change.

M. The clinic coordinator should be notified if your client no shows consistently or if the client is dismissed from treatment. Complete the Request: Send Drop or Warning Letter and place the folder labeled “Clinic Changes” in the Clinic Coordinators mail box.

N. Throughout the semester, the clinic coordinator should be notified of any changes in a clinician’s schedule. Changes should be put in writing; verbal notification will not be honored.

O. At the end of the semester clinicians should submit an updated version of courses completed and a course schedule form for the upcoming semester. These forms should be given to the Clinic Coordinator.
P. Give ample time on your schedule for client assignments. When enrolled in CMDS 7500, work should be scheduled around your clinic assignment.

Q. The clinic operates five days a week. Be prepared to be in class or clinic every day of the week. Days when you are not scheduled for therapy should be devoted to supervisor meetings and client preparation.

R. Various forms for requesting room change, warning letters to be sent, etc. are available in the clinicians’ room. These forms should be completed by the student anytime a clinical change is requested. Forms should be returned to the designated location. Forms may never be placed in the clinic coordinator’s or scheduling assistant’s desk. Once the change has been made by the clinic coordinator, a copy of the request and documented outcomes will be placed in the student’s box. All changes must be cleared by clinic coordinator:

   Notification of Client Dismissal; Request for Blue Book Addition; Request to Send Drop or Warning Letter; Request for Room or Time Change; Client Clinic schedule

S. Please remember, all requests must be made to the Clinic Coordinator on the proper form. Requests made to the scheduling GTA, verbal requests or requests made on a sticky or other note paper will not be honored. The GTA DOES NOT have authority to make changes – all changes must go through the Clinic Coordinator. Any requests made directly to the GTA will result in a reduction of your letter grade (a score of “0” or “1” for Documentation).
All students must have two meetings with their supervisor prior to seeing their client. It is expected that you read the clients’ information on Practice Perfect and complete the meeting form prior to meeting with your supervisor. Meetings will be assigned to you during the first week of class.

**First Meeting**

I. Present client to supervisor  
   A. Disorder  
   B. Evaluation history  
   C. Treatment history  
   D. Current level of functioning

II. Research Disorder  
   A. Characteristics of disorder  
   B. Research possible treatment approaches

III. Discuss treatment approaches you intend to use  
   A. Rationale (research based)  
   B. Possible procedures

IV. Discuss possibility of evaluation  
   A. Type of evaluations needed  
   B. Possible evaluation tools  
   C. Possible evaluation procedures

V. Problem-solve additional clinical issues with supervisor

VI. Additional topics as assigned by supervisor

**Second Meeting**

I. Research disorder - continued  
   (Text book, internet, assigned readings from supervisor)  
   A. Characteristics of disorder  
   B. Research possible treatment approaches

II. Refine treatment goals and procedures

III. Treatment procedures and rationale  
   A. Targets  
   B. Materials  
   C. Cuing Hierarchy  
   D. Reinforcements  
   E. Detailed Plan and Objective Procedure Sheet for First Day

IV. Additional topics as assigned by supervisor

Second Week of Clinic - Meet with supervisor and problem-solve (what worked and what did not; modify)
Request: Daily Log Book Addition

Please add the following client in the blue book:

Client: ___________________________  File # __________
Room: ___________________________  Supervisor: __________
Therapy Day(s): _________________  Student: _______________
Therapy Time: _________________

Clinic Coordinator/ Scheduling Assistant Comments:

___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
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139
Notification: Client dismissed from treatment

Client: ___________________________ File # _____________
Parent: ___________________________ Supervisor: _____________
          Student: __________________

Phone: _____________ Home Address: _____________
          _____________ Work
          _____________ Cell E-Mail: _____________

Reason for dismissal (check all that apply):
Poor attendance    Transportation    Parking    Client Moved

Achieved Maximum Potential

Other: ____________________________________________

________________________________________________________________________

Clinic Coordinator/ Scheduling Assistant Comments:

________________________________________________________________________
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________________________________________________________________________
Request: Send Drop Letter

Client: ___________________________ File # ____________

Parent: __________________________ Supervisor: ____________

Student: __________________________

Phone: ____________ Home Address: ________________

______________________ Work

______________________ Cell E-Mail: ________________

Reason for letter (circle all that apply):

Poor attendance  Achieved Maximum Potential

Other: ____________________________________________

________________________________________________________________________

Clinic Coordinator/ Scheduling Assistant Comments:

________________________________________________________________________

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________________________________________________________________________
Request: Time, Day or Room Change

Client: ___________________________  File # ______________

Parent: ___________________________  Supervisor: _____________

Student: ________________

Phone: ________________  Home  Address: ________________

_____________  Work  ________________

______________  Cell  E-Mail: ________________

Room Change Request:

Please change client’s room from ________________ to ________________

Time or Day Change Request:

Please change clients treatment day and/or time

From: _____________________________

To: _____________________________

Clinic Coordinator/ Scheduling Assistant Comments:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

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__________________________________________________________________________
Clinic Treatment Schedule

Client: ___________________________ Age: _____ File # ______________

Parent: __________________________ Supervisor: ____________________

Phone: _____________________ Home Address: ______________________

_____________________ Work ______________________________

_____________________ Cell E-Mail: ________________________

Indicate your first three choices of treatment times. Cross out any times you are not available

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**KASA Disorder Type:** Articulation, Aural Rehab., Dysphagia, Fluency, Language, Cognitive, Social, AAC, Voice, Literacy

Other (Diagnostic) Information: __________________________________________________

Individual/Group Number of Sessions:___________ Length of each session: __________

Room:  Adult Room  Child Room  Trip-Trap Chair  Computer Room

Billing: Medicaid - Expiration date: ____________, All Kids, Insurance, Private Pay, Sliding Fee

**Scheduler Use Only:**
Day/Time: ________________ Room: ______

Clinician:_________________________ Supervisor: ____________________________
# Graduate Student Summary of Hours and Experience

**Student: _______________________  Semester: ____________________**

**No. of Semesters in Grad. School: ________  Internship: __________________***

*Estimate hours (hours in areas marked with an asterisk may overlap with other areas).

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Clinical Documentation

**Treatment Plan and Treatment Reports**

1. Treatment plans are due approximately two weeks after the client is seen for treatment. The treatment plan outlines client background information and the plan for treatment including goals, targets, cues and reinforcement. The final treatment report include baseline and final data, a summary of progress achieved and recommendations for future treatment or discharge.

2. Specific information incorporated into Treatment Plan and Reports includes:
   a. Background History; Assessment information
   b. Current Objectives: Long Term Goals and Short Term Objectives (including, targets, cues, materials, reinforcement, etc.)
   c. Baseline and final data
   d. Progress summary
   e. Recommendations

**Objective/Procedures**

3. The Objectives/Procedure Form is the daily plan for treatment sessions. The Objectives/Procedures Form includes behavioral (measurable) goals to be targeted for the day and detailed procedures.

4. The objective must be a measurable goal. You must indicate how you plan to measure progress. For example, progress can be measured in terms of:
   a. A specific number (The client will spontaneously produce 10 signs to request and label)
   b. A specific time (The client will spontaneously attend to an activity for 5 minutes)
   c. A specific percentage (The client will produce /k/ final imitatively in words with 90% accuracy)

5. The procedures must include a detailed plan for the session including:
   a. Materials to be used in therapy
   b. Detailed instructions on material implementation
   c. Cueing hierarchy
   d. Reinforcement

**Progress Notes/SOAP**

6. Progress or SOAP notes are completed after every treatment session. Progress notes include detailed information on progress achieved for the treatment session.

7. Progress/SOAP notes include:
   a. Subjective information – reported or observed information pertaining to the client’s behavior
   b. Objective information – Goals and data (progress made)
   c. Assessment – An analysis of treatment outcomes based on variable such as familiarity with materials, and type and amount of cues used. Assessment should also include a description of how the targets were produced (The client’s production of /k/ initial was aspirated or the client’s production of signs were approximations).
   d. Plan – A detailed plan for the next treatment session. The plan is based on previous progress made and the assessment of progress made. Information in the plan for the next treatment session should include: goals; materials and targets; cues; and reinforcement.
DAILY THERAPY OBJECTIVE & PROCEDURE TEMPLATE

Clinician: Date:
Supervisor: Disorder:

1) Objective: Complete behavioral objective

Procedure: Materials/stimuli
Material use: read stimuli; develop sentences; name pictures
Cues: verbal; tactile; gestural
Praise & Reinforcement: verbal praise; board game; color activity

2) Objective: The client will spontaneously produce /k/ initial in words while naming picture cards with 90% accuracy.

Procedure: Using Weber /k/ articulation cards, the client will be asked to spontaneously name each picture presented by the clinician. Cues will include:

1) Verbal “try again”
2) Verbal with description “use your back sound”
3) Phonemic cue
4) Complete model

Verbal praise will be given on a continuous schedule and a sticker will be awarded on a fixed ratio schedule of every fourth correct response.
1) **Objective:** The client will produce /p/ in the initial position at the imitative word level with 90% accuracy.

**Procedure:** Using Webber articulation cards, the clinician will present a picture card and model target production encouraging the client to imitate.

**Cues:**
1. Verbal cue—“Make yours sound like mine.”
2. Phonetic Placement

**Reinforcement:** Verbal praise and a Dot-to-Dot game.

2) **Objective:** The client will imitatively produce 3 single words to request or label during a 10 minute play activity.

**Procedure:** During a play activity the clinician will model names of objects and activities pausing to wait for the client to imitate.

**Cues:**
1. Repeat model while using a different pitch
2. Tapping objects to focus attention while labeling them.

**Reinforcement:** The clinicians will reinforce client responses by repeating and expanding and providing the client with object/activity named.

3) **Objective:** The client will spontaneously identify objects by function from a field of 2 with 90% accuracy.

**Procedure:** The clinician will present two objects at a time. The clinician will ask the client for an object by function (“The baby is thirsty, what does the baby drink with?”)

**Cues:**
1. Repeat question changing pitch
2. Provide the client with a choice (i.e., “Can baby drink from a cup or a book?”)
3. Full model (“The baby drinks from a cup”)

**Reinforcement:** The clinician will reinforce the client’s responses by repeating the function and allowing the client to play with items correctly identified.
| **Subjective** | Subjective information discussing the client’s mood or behavior.  
  Something you observed or something reported. |
|-----------------|-----------------------------------------------------------------|
| **Objective**   | Behavioral objectives for the session.  
  Raw data divided according to cues. |
| **Assessment**  | Assessment of progress achieved.  
  Analyze outcome in terms of:  
  Performance (compare with previous sessions)  
  Stimuli used: consistent, changed  
  Cues: types of cues  
  Increased or decreased use of cues |
| **Plan**        | Plan for next session  
  List specific goals  
  Include:  
  Use of cues: which cues, change of cues  
  Stimuli: consistent; vary materials  
  Reinforcement |
S.O.A.P. Note - Example

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<tr>
<th>SUBJECTIVE</th>
<th>The client appeared to be somewhat tired today. His mother reported that he had missed his morning nap. She also stated, “He did real well with his home program this week.”</th>
</tr>
</thead>
</table>
| OBJECTIVE  | I. The client will produce /k/ initial at the spontaneous word level while naming pictures cards with 90% accuracy.  

- 7/10 (no cues) = 70%  
- Cue 1: 2/10=20%  
- Cue 2: 1/10=10%  

II. The client will spontaneously name pictures depicting common verbs during joint book reading with the clinician with 90% accuracy.  

- 5/10 (no cues) = 50%  
- Cue 1: 2/10=20%  
- Cue 2: 1/10=10%  

III. The client will spontaneously produce a minimum of ten 4-5 word utterances during 10 minutes of picture description.  

- Spontaneous: 3  
- Cue 1: 6  
- Cue 2: 8  

| ASSESSMENT | Charlie continues to substitute /t/ for /k/; however, he is requiring fewer cues for placement than in previous sessions. A new book was used to address verbs during today’s session and accuracy was subsequently decreased. Charlie enjoyed the pictures used during the picture description activity, most likely because they were related to baseball. He did require significant cueing to include articles. |
| **PLAN** | Due to not meeting criteria, all of the above objectives should be targeted next session, with verbal praise and stickers as reinforcement. The use of the current reinforcement appears to motivate Charlie to perform better. The same stimuli will be used for objectives 2 and 3 to determine if accuracy will be increased. The picture cards should be varied for /k/ to assess generalization. All cues are beneficial to the client’s success, so they will continue to be implemented as needed. |
THERAPY PLAN

Name: Parent Name:
Age: Diagnosis/ICD-9 Code:
D.O.B.: Physician:
Medications: Referral Source:

LTG I: The client will improve expressive language skills to an age appropriate level.

STO A: The client will increase MLU to 3.0.

Procedure: The clinician will use age appropriate toys and games to provide opportunities for the client to label, request, or describe using multiple word combinations.

Cues: The clinician will use the following hierarchy to elicit multiple word combinations:
1. Try again
2. Visual: Show multiple fingers to represent number of words to use
3. Full model

STO B: The client will spontaneously use at least 3 new semantic relations.

Procedure: The clinician will use age appropriate toys and games to provide opportunities for the client to label, request, or describe using multiple word combinations.
Cues: The clinician will use the following hierarchy to elicit multiple word combinations:
1. Try again
2. Visual: Show multiple fingers to represent number of words to use
3. Full model

LTG II: The client will improve receptive language skills to an age-appropriate level.

STO A: The client will follow two-step commands with 90% accuracy.

Procedure: During play activities, the clinician will provide the client with directions to follow.
Cues: The clinician will use the following hierarchy to elicit correct production:
1. Repeat directions
2. Repeat one direction given 2. Pointing cues
3. Model steps for client
4. HOH (hand over hand assistance)

STO B: The client will identify common objects from pictures in a field of two with 80% accuracy.

Procedure: The clinician will present the client with picture stimuli and ask the client to identify the target object.
Cues: The clinician will use the following hierarchy to elicit correct response:
1. Repeat target
2. Describe characteristic of target
3. HOH (hand over hand assistance)

____________________________________________
Supervisor’s Signature
FINAL REPORT

NAME: Malik Williams  PHYSICIAN: Pamela Nichols, M.D.
AGE: 4.1  PARENT NAME: Bridget Williams
BIRTHDATE: 09/24/10  DIAGNOSIS/ICD-9: Language/315.32
DATE OF REPORT: December, 2015  Articulation/315.39
REFERRAL SOURCE: Dr. Nichols

NUMBER OF SESSIONS ATTENDED: 18 OUT OF 22 SCHEDULED SESSIONS
SCHEDULED SESSIONS: 30 MINUTES 2 TIMES PER WEEK

CURRENT BACKGROUND INFORMATION

Malik is a 4 year old male who has been receiving services from the Auburn University Speech and Hearing Clinic (AUSHC) since the fall of 2014 for an articulation and language delay. He was referred for a speech evaluation by his pediatrician, Dr. Nichols. Mrs. Williams reported that Malik was born full-term following an unremarkable pregnancy and delivery; he weighed 7.4 pounds at birth. Malik has a history of frequent colds and ear infections and had a tonsillectomy and bilateral PE tubes inserted on 04/28/12. Malik takes Albuterol daily for asthma. He attends preschool three mornings per week at Greater Peace Baptist Church and receives no other speech/language services.

(Make sure you include: client name, age, pertinent medical history, medications and purpose, other services and educational status)

CURRENT EVALUATION RESULTS

For most recent evaluation results, please refer to the diagnostic report in the client’s permanent file dated March 12, 2014.

OBJECTIVES & PROGRESS

LTG I: The client will produce all age-appropriate phonemes at the conversation level with 90% accuracy.

STO A: The client will produce /g/ initial at the imitative word level with 90% accuracy.

Baseline Data: date: 08/29/15 results: 7/10=70%
Malik consistently substitutes /d/ for /g/ in all positions in spontaneous speech. This semester, he made significant progress within the first month of therapy and was able to advance to the spontaneous word level after meeting criteria at the imitative level. Malik enjoyed earning stickers for each trial (6) to trade in for a sticker at the end of the activity. *(NOMS: Articulation/Intelligibility: Level 4)*

Child’s connected speech is usually intelligible to familiar listeners, but only occasionally intelligible to unfamiliar listeners.

STO B: The client will produce /g/ initial at the spontaneous word level with 90% accuracy.

Baseline Data: date: 09/28/15 results: 5/10=50%
- Cue 2: 1/10=10%
- Cue 3: 2/10=20%

Final Semester Data: date: 11/28/15 results: 7/10=70%
- Cue 2: 2/10=20%

Target: golf, ghost, gate, gum, game, goat (one syllable /g/ initial words)

Materials: Worksheets, home-made articulation cards

Cues: 1. Verbal cue, “Remember your back sound.”
   2. Phonemic cue
   3. Full model

This objective was targeted initially at mid-semester after Malik met the goal for imitative words. Malik met criteria for the objective during the last 3 sessions and it is recommended that he advance to the imitative phrase level when he returns to therapy. *(NOMS: Level 4)*

STO C: The client will produce /k/ initial at the spontaneous syllable level with 90% accuracy.

Baseline Data: date: 09/28/11 results: 5/10=50%
- Cue 2: 1/10=10%
- Cue 3: 2/10=20%

Final Semester Data: date: 09/28/15 results: 9/10=90%
- Cue 1: 2/10=20%
- Cue 2: 1/10=10%
Target: cat, cable, cough, car (one syllable /k/ initial words)

Materials: Worksheets, home-made articulation cards

Cues: 1. Verbal cue, “Remember your back sound.”
2. Phonemic cue
3. Full model

Progress with this goal has been limited and variable. Although he has mastered /k/ at the imitative syllable level, he is having difficulty with consistently producing it spontaneously. During the last month of therapy, performance varied between 30-70%; however, Malik is exhibiting increased self-awareness for errors and is frequently self-correcting prior to cueing. *(NOMS: Level 4)*

**LTG II:** The client will improve receptive and expressive language skills to an age-appropriate level.

**STO A:** The client will spontaneously follow 2 step simple commands with 90% accuracy.

Baseline Data: date: 08/28/11 results: 6/10=60%
Cue 1: 4/10=40%

Final Semester Data: date: 11/28/15 results: 9/10=90%
Cue 1: 1/10=10%

Target: 2 step simple commands “Jump and then clap your hands.”

Materials: Home-made direction cards

Cues: 1. Repeat stimulus
2. Break-up commands
3. Full model

Malik made consistent progress with regard to following 2 step simple commands and met criteria the last 2 sessions. He did well when the commands were related to actions rather than when seated at the table. It was necessary to remind Malik to look at the clinician prior to providing the direction to gain his attention. He was motivated by being allowed to throw the basketball after working for 10 minutes. *(NOMS: Spoken Language Comprehension: Level 4)* Child understands simple word combinations/sentences. Child usually requires re-phrasing and repetition to ensure understanding of brief conversations.

**STO B:** The client will increase spontaneous MLU to 4.0 during play.

Baseline Data: date: 09/09/15 results: 3.0

Final Semester Data: date: 11/28/15 results: 4.0

Target: Semantic relations: object + action; agent + action; recurrence + action; location + object

Materials: A variety of toys including the farm, cars, telephone

Cues: Giving choices
Model utterances emphasizing word production
A variety of materials were used to target this goal. Malik was observed to use the longest and most variety of utterances when the farm, cars, and blocks were involved. There has been an increase in Malik commenting more about objects, actions, and imperatives. Malik has met this goal and is using an age appropriate MLU at this time.

Reinforcement: Verbal praise and sticker chart

**(NOMS: Spoken Language Production: Level 7)** Child’s ability to participate in adult-child, peer, and directed group activities is not limited by language production. Cueing is rarely required.

**SUMMARY**

Malik made consistent progress throughout the semester and met several of his goals. He currently exhibits receptive and expressive language skills that are within normal limits for his age and gender. He attended well to presented tasks during the first 15 minutes of treatment, but was then easily distracted. Malik was motivated to participate in articulation tasks when they were structured as drill/play and when was allowed time to shoot the basketball. A consistent set of stimuli was used for all targeted articulation goals. Mr. and Mrs. Williams were given a home program after the first treatment session and they report that they did activities targeting articulation and language on a weekly basis.

**RECOMMENDATIONS**

It is recommended that M. enroll in treatment at the Auburn University Speech & Hearing Clinic at a frequency of 2 times per week for 30 minute sessions. Treatment goals should focus on:

1. Improving production of /g/ initial at the spontaneous phrase level
2. Improving production of /k/ initial at the spontaneous syllable level

Jane Smith  
Undergraduate/Graduate Clinician

Amanda Clark, MCD or M.S., CCC-SLP  
Clinical Supervisor

Sarah Jones  
Undergraduate/Graduate Clinician

cc: Mr. & Mrs. Williams  
Stephanie Smith, CCC-SLP; Auburn School System
Top Ten for Therapy Plan

10. Calculate current chronological age.
9. Use client’s real name (not initials).
8. Double space background information.
7. Verify accuracy of medications, etc. with caregivers this week.
6. Only include evaluation information from this semester. If you haven’t done any, write “For previous evaluation results, please reference results from March 13, 2015. The ___________ was administered which revealed below average receptive and expressive language skills.”
5. Use baseline data that you feel is valid.
4. Ensure that your objectives are complete, regardless of what previous treatment plans say.
3. Include identifying information, background information, LTG and STO, with baseline data, targets, materials and cues.
2. Turn in to your supervisor’s box by deadline on clinic calendar.
1. Once your supervisor returns your report to your box, place it in your working file and paper clip to your final plan.

Top Ten for Final Plans

10. Calculate current chronological age.
9. Double space summaries only.
8. Verify accuracy of medications, school status, other services, etc. with caregivers.
7. Only include evaluation information from this semester. If you haven’t done any, write “For previous evaluation results, please reference results from _________(date). The ___________ (test) was administered which revealed below average receptive and expressive language skills.”
6. Use final data that you feel is valid.
5. Make changes from the first therapy plan.
4. Use appropriate and consistent tense.

Turn in to your supervisor’s box (on assigned date) along with original therapy plan. Staple the individual reports and paperclip them together. Each time you make changes, attach the most current last draft.
2. Make sure your client’s name is correct throughout the report.
1. Do not print on letterhead until your supervisor tells you to do so.
INSTRUCTIONS FOR FINAL REPORT

Once the case supervisor has instructed you to print the final report on letterhead:

1. Print a minimum of 2-3 copies on letterhead, depending on the number of copies requested by your client.

2. Type a cover letter (on letterhead) for each person to receive a copy of the client’s report. Type your name & your supervisor’s name on the bottom of the cover letter. Type the designated number of envelopes for mailing.

3. Student(s) and supervisor sign the reports and cover letters.

4. Prepare reports for mailing (fold reports and place in envelope), place envelopes in the mail basket in the faculty conference room. AUSHC will pay postage.

5. Give your supervisor one copy of your client’s report so it can be faxed to the Pediatric Clinic, Dr. Tole, or East Alabama ENT.

6. Sign the paper in the clinician’s room to indicate that you have And mailed your final report. Be sure to date when you sign your name! Failure to sign this sheet can result in an incomplete for the semester.
August 2, 2015

Mary Johnson
Address

Dear Ms. Johnson:

Enclosed is a copy of your treatment report from this past semester. We have enjoyed working with you at the Auburn University Speech & Hearing Clinic and look forward to working with you again next semester. If you have any questions regarding this report, please do not hesitate to contact us.

Sincerely,

____________________________________
Your Supervisor’s Name and credentials

____________________________________
Your name, B.S., B.A. etc.
Graduate Clinician
Letter to parent of child client

August 20, 2015

John and Nancy Smith
Address

Dear Mr. & Mrs. Smith:

Enclosed is a copy of the treatment report for Robert this past semester. We have enjoyed working with Robert at the Auburn University Speech & Hearing Clinic and look forward to working with him again next semester. If you have any questions regarding this report, please do not hesitate to contact us.

Sincerely,

_____________________________________
Your Supervisor’s Name and credentials

_____________________________________
Your name, B.S., B.A. etc.
Graduate Clinician
Letter to referral source

August 2, 2015

David Jones, M.D.
Address

Dear Dr. Jones:

Thank you for your referral of Jane Doe to the Auburn University Speech & Hearing clinic. Enclosed is a copy of his/her treatment report from this past semester. If you have any questions regarding this report, please do not hesitate to contact us.

Sincerely,

____________________________________
Your Supervisor’s Name and credentials

____________________________________
Your name, B.S., B.A. etc.
Graduate Clinician
Discharge letter

Dear Mr. or Ms.:

Enclosed is a copy of the treatment report for client’s name from this past semester. We have enjoyed working with client’s name at the Auburn University Speech & Hearing clinic and hope that he/she continues to do well in the future. If you have any questions regarding this report, please do not hesitate to contact us.

Sincerely,

____________________________________
Your Supervisor’s Name and credentials

____________________________________
Your name, B.S., B.A. etc…
Undergraduate/Graduate Clinician
Visualizing/Verbalizing Outline (supplement to the manual)

You will need to thoroughly read the manual to understand specific steps of each level. This outline is designed to provide supplemental guidance to the manual based on Lindamood-Bell training. This program is designed for age 5 children and up.

Important things to keep in mind when it comes to the philosophy of Visualizing and Verbalizing:

- Processing language is a cognitive act which requires interplay between verbal (language) and nonverbal systems (imagery connected with language).
- **Dual coding theory**: Allen Paivio; Ex: no imagery for French-no thinking/processing
  - have to do something with words
  - memory induced by mental images; imagery supports memory
  - reading fluency is supported by visual and language systems
  - amount of sensory processing available-primary factor in learning to read

3 sensory/cognitive functions

1. **Phonemic awareness** - ability to auditorily perceive the identification, number, and sequence of sounds within words
2. **Symbol imagery** - auditorily perceive and visually image sounds and letters within words
3. **Concept imagery** - create an imaged gestalt (whole) from oral or written language; Ex: make movie in your head based on what you are reading

To read successfully there are four interconnected components that require consideration. Each component relies on the acquisition specific skills.

1. **Auditory**: Phonemic awareness; word attack (sounding it out); symbol imagery
   - all of the above are required for decoding

   *Characteristics of weak phonological awareness*
   - Weak word attack, word recognition, sight words, spelling, reading fluently, monitoring and self-correcting reading and spelling errors, slow and laborious decoding

2. **Visual**: Symbol imagery (sensory ability to create mental rep for sounds and words); Word recognition (see it and know it/sight words)
   - no decoding is involved

3. **Language**: oral vocabulary developed from exposure
   - contextual reading-predicting words through context

   A fluent reader can have all of the above intact but not comprehend the material due to poor concept imagery. Imagery is sensory info that prevents language from going in one ear and out the other.

4. **Concept imagery**: ability to image what is being read or heard

   *Characteristics of weak concept imagery*: propensity to grasp “parts” not the “whole”
   - weak written language comp, oral language comp, critical, logical, abstract thinking/problem solving, following
directions, expressive language orally, expressive language in writing, humor, interpreting social situations, cause/effect, attn./focus, mental mapping (keep track of where you are), responding to a communicating world

-Concept imagery is when you can picture the story (background, setting)-not just picturing a single word (dog) at a time

*Paivio suggested that linguistic competence and performance are based on a substrate of imagery:

“Imagery includes not only static representations but also dynamic representations of action sequences and relationships between objects and events.”
“Individuals differ in the extent, manner, and efficiency of employment of each of the systems according to their verbal and nonverbal habits and skills.”

-See Chapter 2 in the manual for relationship between cognition and imagery.
“If I can’t picture it, I can’t understand it.” Albert Einstein

-Dyslexia: discrepancy between decoding and auditory comprehension. Auditory comprehension is intact.

-Symbol imagery: sensory ability to create mental representation for sounds and words
-Static form of imagery
-symbols, numerals, facts, details

-Imaged Gestalt: Higher order thinking-main idea, conclusion, inference, evaluation, prediction and extension (Chapter 11)
-can’t do critical thinking (main idea) if you are only getting parts

Concept imagery is a form of dynamic imagery.
2 sided coin of imagery: parts/wholes
-Concept: dynamic type of imagery for processing wholes
-Symbol: static type of imagery for processing parts; (names, numbers)

- Weak Concept Imagery: characteristics in chapter 4
- Many students are diagnosed with ADD/ADHD and the attention problem may be a symptom of poor language processing as a result of weak concept imagery.

Language to drive the “sensory bus”: (see chapter 5)

- Use language to directly stimulate the sensory input of imagery-the nonverbal code. Your language is vital to help them picture.
- The questions you are asking should be based on the premise of the Socratic method which is a questioning approach to stimulate thinking and learning.
- Language of “What are you picturing…” directly stimulates imagery. The language of “What are you thinking…” does not.
- Say “What do you picture will happen if…” rather than “What do you think will happen if…”
- Say “What do you picture for the word…” rather than “What is the meaning of the word…”
- Goal: sensory input---monitor---self-correct---independence

Error handling:
1. Note the student’s response.
2. Find a spot in the response to positively engage them.
3. Question to help the student analyze their response.
4. Question to help the student compare their response to the stimulus.

Imagery for Oral Vocabulary
- necessary for comprehension, but it is not sufficient—many VV students have adequate vocabulary, yet language goes in one ear and out the other
- weakness in imagery is a contributing factor in weak oral vocabulary
- Visualize first, then teach vocabulary
- VV instruction develops the underlying and necessary imagery to garner oral vocabulary

Speed of Imagery in processing language
- students need to quickly and accurately assess the meanings of words
- speed of processing is more important for oral language than written language
- V instruction develops vivid and fast concept imagery

- Encourage gesturing
- Structure words: created to develop conceptual pegs of color and movement, and other details; help them verbalize

Overview of steps:
- move through 1-4 as quickly as possible
- step 5=gestalt
- steps 6 and 7-heart of the program that will be done repeatedly
- steps 8-10 are application

Step 1: The Climate
- Keep it really short and simple!
- Should only be done during the initial session or when the client questions the purpose of the process
- Draw and talk at the same time.
- Brief explanation of what you are doing and why.
- Express that you are going to help make taking tests, etc. easier. (whatever their concern is)
- May need more specific climate for each step if necessary

Structure words:
- Structure words numbered by their relative ease and importance for imaging details and the gestalt. They may be on the table at any time.
- Explain structure words: “They will help make sure we are picturing everything we need to.”
- The process is not about memorizing the structure words but using them naturally.
- For kids that cannot read, you may use visual representations of the structure words on the cards instead. If you can only introduce steps 1-4, that is okay. Gradually introduce additional structure words.

Step 2: Picture to Picture
- “Your words make me picture ____________.”
- You need to be familiar with the pictures to be prepared to ask questions.
- Use choice and contrast questions.
- You can pair gestures with choice and contrast questions.
- Don’t trust their words! Make them describe things.
- Ensure they have addressed about 85-90% accuracy with the structure words before you bring the structure cards out for the student to review.
- Should only take about 30 seconds for you to describe what their words made you picture.
• Purposefully leave something out or describe an incorrect detail to see if they are paying attention.
• For lack of detail or incorrect description: “I was picturing ______” or “I didn’t picture.”
• 80% of session is the student describing a picture and the teacher using choice/contrast questions.
• The student needs to “own” the cards. They should be in front of the student.
• At the beginning, you may be doing a lot of the talking. Should be around 10 minutes of picture description.
• Student can look at picture while they review the structure words. They turn the cards over when they have addressed it.
• Can prompt with “what else do you see?”
• You do not want them to making inferences or doing critical thinking-just describing what is in the picture.
• Don’t make assumptions about their image-make them verbalize the details.
• When discussing perspective, turn yourself around in your chair and gesture right/left.
• After about 8 years old, only use several pictures to give the student the idea of the gestalt and then move to the next step.
• You cannot take notes-you must visualize also
• It is ok to discuss how some cards may not be pertinent (such as mood for animal or sound)

*only do Imagery Practice after picture description, Word to picture to imagery (use picture to help generate image for young kids, Personal imaging, and Object imaging if you have a severe student (1/2 steps)

Step 3: Word Imaging-Known Noun
- Make sure word is not too simple
- Animals, clown, Santa, Christmas tree, airplane, cowboy, fireman
- Do not spend a lot of time on this step
- “Your words made me picture”-summarize in about 30 seconds (fluid)
- If they need direction, you can tell them to start from their head
- Can give a point or a magic stone for each structure word
- Noun needs to be “anchored” --- not floating (background needs be to verbalized)
- Back off with your questions when you notice their detail really takes off
- Don’t focus too much on lesser details
- Make sure the student is “looking at a movie” –they are not in the movie

Step 4: Single Sentence Imaging (optional; may just do once)
- Take known noun and make a sentence
- ~5 minutes

Lesson Plan #1
-Set Climate
  1. Picture to Picture~10 minutes
  2. Word imaging~10 minutes
  3. Single Sentence ~5 minutes
  4. Sentence by Sentence
**Step 5: Sentence by Sentence Imaging**

- All previous stimulation was in preparation for this step—to develop an imaged gestalt, which is need for HOT (higher order thinking).
- Imaged parts are the sentences that form an imaged whole of a paragraph
- Need to be familiar with the paragraph
- Each colored square is equal to a sentence
- Only ask questions relevant to the whole
- Squares overlapped and moving toward the student
- Only do structure words on first sentence
- Go through squares quickly
- Encourage them to say “Here, I saw_______” while they touch each square
- Start on level that will not be challenging (2nd grade level reading—choose 1st grade material)
- Can re-read the sentence multiple times but need to focus the student’s attention on specific detail each time.
- First sentence will take significantly longer than others.
- Give verbal cue if the student forgets what matches the square.
- Goal: gestalt imaging not HOT (yet)
- Word summary: only state what paragraph said, not all of what they visualized. Make sure it is not the main idea. Need to tell everything that happened.
- Read important elements in chapter 10
- Move from subject to verb to object when questioning/guide them to describe in this order
- Do not ask “why” questions

**Lesson Plan #2**

1. Word Imaging-Known Noun (10 minutes)
   - teacher says word, student describes
   - teacher questions with choice/contrast
   - student checks structure words
   - teacher summarizes (Your words made me picture)

2. Single Sentence (5 minutes)
   - Use previous noun
   - teacher makes up sentence, student describes
   - student checks structure words
   - teacher summarizes (Your words made me picture)

3. Sentence by Sentence (15 minutes)
   - teacher reads first sentence, student describes, student checks structure words
   - teacher reads next sentence, student describes (repeat)
   - student does picture summary (Here I saw_______)
   - student does word summary (This was about_______)

**Step 6: Sentence by Sentence with HOT**

- Pull away from using structure cards when student is using them naturally
- Once gestalt is complete, now can ask to interpret
- Do not pull a paragraph from a larger passage (not a gestalt)
- Read Important elements to note in chapter 11
- Word summary—not too little/too much, did they get the gestalt from the story? Not main idea but facts from the story

Example HOT questions:
- Main idea: think about your pictures—what is consistent?
- What do you see that is the same and important in all the pictures?
- What do you picture the _____ doing next?
- From all your images, what was the main idea?
- From your pictures, why do you think______?
- From what you pictured, what do you think will happen next?
- From all your imagery, can we conclude______?
- From all your images, if….then, what can we predict about…..?
- Ask 2-3 questions for each story
- Can model some answers to save time—main thing you pictured

Step 7: Multiple Sentence Imaging with HOT
- Have increased grade levels throughout the S by S level. You do not have to go back to an easier level when you increase the language.
- Stay at the same level and add more sentences to be imaged at one time.
- Once you have started to ask HOT, you do not stop.
- Always use the imaged gestalt to help the student think and comprehend.
- Not important that they recall every single detail

Step 8: Whole Paragraph with HOT
- Start to focus on expressive language
- Take away text before word summary
- Unfamiliar words: what did you picture for ________?
- Testing imagery at this stage—not developing
- ~5 minutes after the student has read the paragraph
- if re-reading, need to focus attention on certain aspect

1. Whole Paragraph
   - student does word summary
   - teacher checks images
   - HOTS

2. Paragraph by paragraph
   - student reads/listens to first paragraph
   - student does word summary
   - teacher checks pictures
   - student reads/listens to 2nd paragraph
   - word summary
   - teacher checks pictures
   - picture summary using colored cards
   - page summary without cards
After they are doing well with last step, bring in school books that are not high in imagery.

**Vocabulary Development:**
**goal: to help your student develop the ability to image the meaning of a word, to store that imaged meaning, and to access and retrieve the meaning more rapidly**
- check images for key words in stories or from a vocab list
- student creates picture for unknown word
- look for signs of imagery as you wait for her to visualize and then ask a few questions to be sure she was imaging
- may show a picture from a picture dictionary or Google images, if needed.
- use sensory language: What do you picture for a skyscraper?
- put word in a high imagery sentence for student to image
- student uses word to create sentences that demonstrate meaning and imagery

**SxS Imaging and Writing:**
- use picture-cue on 3x5 card and place it next to the felt, numbering each card
- may reference structure cards
- after WS, place picture-cues in order and use to write a summary
- student edits and compares what she wrote to her images

**Final Thoughts:**
Alternate between you reading and student reading-focus on what they need most.

Generate positive, passionate energy in each session!!

Overlap steps.

Give small rewards immediately and constantly, for positive responses or behaviors. Use magic stones at your discretion (need auditory feedback) and let them put them in a cup during the session. If undesired behaviors persist, you may remove a stone without any verbal feedback. You may choose to use the stones in the form of conditioned generalized reinforcement and they may trade these in for a prize or privilege after meeting criteria.

**Relevant Questioning—Read this entire chapter!!**
- Think about the goal of your questioning.
- Monitor to be certain you stay on task.
- Over-questioning: Takes the imagery away from the gestalt.
- Don’t ask them to think but picture!
- Don’t say remember or memorize

<table>
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<tr>
<th>Spontaneous</th>
<th>Choice/Contrast</th>
<th>Self-correct (with structure cards)</th>
<th>Choice/Contrast (with structure cards)</th>
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<td>What</td>
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Only provide cues for structure words appropriate for each image. It is okay if they miss 1-2 structure words during the spontaneous portion. This will hopefully facilitate self-correction when they check the cards. Make a note in the “A” part of the SOAP as to whether structure cards on displayed on the table or not. Also, include subjective note as to signs the student is visualizing. Be sure to move from the what to the verb to the object in terms of your questioning.

*Appropriate for Picture to Picture, Word, Single Sentence or Sentence by Sentence imaging (first summary).

*For sentence by sentence:
1st sentence: student should address most if not all 12 words
Additional sentences: student should address all relevant words to image the gestalt.

*Use colored pens/pencils or different symbols to correspond to the sentence they address the word.

Picture summary: for each colored square note if the student recalls the most vital information spontaneously or with a verbal cue. For the word summary, note details recalled without colored squares. The picture summary is more detailed and elaborate in imagery, whereas the word summary is closer to the written text. O=teacher reads, R=student reads
S=single sentence; M=2 sentences   P=paragraph

<table>
<thead>
<tr>
<th>Picture summary</th>
<th>Word Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spontaneous</td>
<td>Verbal Cue</td>
</tr>
<tr>
<td>Spontaneous</td>
<td>Verbal Cue</td>
</tr>
</tbody>
</table>

LTG: The client will develop their higher order thinking skills from an imaged gestalt.

STO: The client will state the main idea from a 4-5 sentence paragraph read by the clinician with 100% accuracy.

This may be altered to reflect the student reading or a change in text length.

STO: The client will answer 4 higher order thinking skills questions from a 4-5 sentence paragraph read aloud by the client with 100% accuracy.

If the client does not spontaneously answer, a choice cue may be provided for higher order thinking questions.
Ex: What did you see for ______________?
LTG: The client will visualize and verbalize language from a variety of stimuli to increase auditory and reading comprehension.

Picture to Picture goal:
STO: The client will visualize and verbalize using structure cards as guide to form an image from a picture with 90% accuracy for three consecutive pictures.
(90% accuracy includes self-correction and spontaneous)

Word Imaging
STO: The client will visualize and verbalize using structure cards as guide to form an image from a known noun with 90% accuracy for three consecutive trials.
(90% accuracy includes self-correction and spontaneous)

Single Sentence (optional, bridge step):
STO: The client will visualize and verbalize using structure cards as guide to form an image from a sentence with 90% accuracy for two consecutive trials.
(90% accuracy includes self-correction and spontaneous)

Sentence by Sentence
STO: The client will visualize and verbalize using structure cards as guide to form an image from a paragraph, sentence by sentence with 90% accuracy.
(90% accuracy includes self-correction and spontaneous)

Multiple Sentence Imaging
STO: The client will visualize and verbalize using structure cards as a guide to form an image from a paragraph, in 2-3 sentence chunks with 90% accuracy.
(90% accuracy includes self-correction and spontaneous)

Whole Paragraph
STO: The client will visualize and verbalize the gestalt of a paragraph from auditory or written stimulus and provide a word summary with 90% accuracy.
(90% accuracy includes self-correction and spontaneous)

Paragraph by Paragraph
STO: The client will visualize and verbalize the gestalt of a paragraph from auditory or written stimulus and provide a picture and page summary with 90% accuracy.
(90% accuracy includes self-correction and spontaneous)

Writing
The client will write notes at the word/phrase/sentence level corresponding to the colored squares with 100% accuracy.

Note-taking
The client will write the main idea and supporting images during several pages of lecture material read by the clinician with 90% accuracy.
Important things to keep in mind when it comes to the philosophy of Seeing Stars:

- Processing language is a cognitive act which requires an interplay between verbal (language) and nonverbal systems (imagery connected with language)
- **Dual coding theory**: (Allen Paivio); Ex: no imagery for French-no thinking/processing
- have to do something with words
- memory induced by mental images; imagery supports memory
- reading fluency is supported by visual and language systems
- amount of sensory processing available is a primary factor in learning to read

### 3 sensory/cognitive functions

1. **Phonemic awareness** (PA)- ability to auditorily perceive the identification, number, and sequence of sounds within words

2. **Symbol imagery** (SI)- auditorily perceive and visually image sounds and letters within words

3. **Concept imagery** (CI)- create an imaged gestalt (whole) from oral or written language; Ex: make movie in your head based on what you have read

**PA and SI are for the mechanics of reading, CI is for comprehension.**

To read successfully there are four interconnected components that require consideration. Each component relies on the acquisition specific skills.

1. **Auditory**
   - Phonemic awareness; word attack (sounding it out); symbol imagery
   - all of the above are required for decoding
   - *Characteristics of weak phonological awareness*- Weak word attack, word recognition, sight words, spelling, reading fluently, monitoring and self-correcting reading and spelling errors, slow and laborious decoding

2. **Visual**
   - Symbol imagery (sensory ability to create mental representation for sounds and words);
   - Word recognition (see it and know it/sight words)- no decoding is involved

3. **Language**
   - oral vocabulary developed from exposure
-contextual reading-predicting words through context

A fluent reader can have all of the above intact but not comprehend the material due to poor concept imagery. Imagery is sensory info that prevents language from going in one ear and out the other.

4. **Concept imagery:**
-ability to image what is being read or heard

**Characteristics of weak concept imagery:** propensity to grasp “parts” not the “whole” -weak written language comp, oral language comp, critical, logical, abstract thinking/ problem solving, following directions, expressive language orally, expressive language in writing, humor, interpreting social situations, cause/effect, attn./focus, mental mapping (keep track of where you are), responding to a communicating world

SS uses the Socratic Method to encourage SI. You will use questions to help the student discover and correct their own errors. Mistakes are moments to learn! A basis of SS is symbol imagery and your language is vital. Therefore, you will use terms such as see, picture, image, visualize, or imagine NOT hear.

Example questions you might use are as follows:

- What are you picturing?
- What is the last letter that you see?
- What letters do you picture for the word? (not spell)
- What does the vowel say?
- Did you picture all the letters?
- Can you see it?

**Air-writing** is also used to establish SI.

**Guidelines are as follows:**

- should be done above the horizon and to the right or left (not looking at you)
- student must vocalize while writing
- writing should not take up more space than an average size of white paper
- all lowercase letters
- may ask the student to write in a certain color

**Symbol Imagery Exercises**

- **Decoding**-student reads syllable from imaged pattern (part of expectation of each trial) The following may be used to enhance SI. You will not use each one with each trial.
- **Identify**-identify specific letter from imaged pattern (what letter or sound do you see last?)
- **Manipulate**-read syllable from imagery after letters are manipulated (what do you see if you change t to d?)
• Backwards-ask student to say imaged letters backwards but don’t write them backwards.

**Only use backwards sparingly when some degree of mastery has been achieved.

Step 1: The Climate

--Briefly explain to the student what and why

1. I’m going to teach you to see letters in your imagination.

2. It will help you read and spell words better.

3. Here’s how you can picture that.

4. Diagram a head with imagery for letters. (Use their first name as an example or a single phoneme)

*should take less than 5 minutes and should only be done during the initial session or when the client questions the purpose of the process

Step 2: Letter Imagery (using letter cards)

- This is done until sound/symbol (visual and auditory) is mastered. After initial session, only target weak areas (vowels not consonants).
- You may use phoneme categories as referenced on chart.
- ~5 minutes with minimum of 10 trials of auditory and 10 visual stimuli.
- skills are considered “mastered” after 3 consecutive sessions with 100% accuracy.
- has auditory (no visual stimulus; you provide sound or letter) and visual (with card) components.
- for auditory, alternate between providing the sound and the symbol as the stimulus -present each card for 1 second.
- student responds with letter name, letter sound and air-writes after you remove the card
- student must air-write while saying corresponding letter name

Error Handling:

**Always praise for some aspect of the response prior to asking your follow-up question.

-If student responds incorrectly for the letter name, you state the correct name.

- Target is m, student says n-you say “If that said n, what sound would that be?”
- Target is oo, student says o –“If that said /ah/, what sound do you picture for /oo/?”

Step 3: Syllable Imagery (syllable books)
has visual component only

~5 minutes with minimum of 15 trials of visual stimuli

present card for one second per phoneme

student responds with letter names, letter sounds and air-writes after you remove the card

student must air-write while saying corresponding letter names

may be using more than one book at a time (remember to introduce/review rules or skip words for rules you have not addressed)

If creating your own words, make sure they include the phonemes within the levels that have been addressed. You can use letter tiles or i-Pad app-use symbol imagery exercises

Error handling:

1. Cover the syllable/word to help the student access SI. Student reads the word “spoif” as “spoil.” Teacher covers the word.

2. Errors are handled in a positive, specific manner: “Great job with the vowel sound.”

3. Question to help him analyze his response. “If it said spoil (error word), what letter do you see last?”

4. Uncover the word and help him compare response to stimulus. Teacher shows the card again and says “Let’s see if that matched.”

Step 4: Syllable Board with Chaining

- Begin with yellow side-single syllable stimuli
- Must be used in conjunction with syllable chains
- See manual for chain examples
- Chaining is an intermediate half-step to facilitate air-writing after auditory stimulus
- Use SI exercises Example: ip; change ip to it; change it to at; change at to lat; change lat to la

1. Substitution

2. Omission (Can’t omit vowel)

3. Addition

4. Repeat (ba to bab)

5. Switch (pi to ip; have to be next to each other)
**Goal:** Have student “hold and compare”---“change __________ to __________” (ALWAYS say both words).

Creating chains:

- What level? (CV/VC)
- What sounds do they know? (short vowels)
- Alter according to the client’s need
- Changing sound at the beginning is harder; final sound is easiest—focus on internal sounds
- CV: Ot---og---ag---gag---gig---ig
- CVC: pit---pite---pile---ile---ide---id---mid---did
- Write vertically in your notes to make it easier to take notes on performance

**Step 5/6: Air-writing with or without a chain**

1. Teacher says syllable (encoding) or letters (decoding/reading)
2. Student writes letters or decodes or decodes then writes
3. Stimulation moves from simple to complex syllables
4. Begin with whole and move to parts (words to letters) with teacher saying word and student imaging letters
5. Miscalling-find mistake of teacher Ex: student spells “mit” teacher says if I said “mat” what was my mistake?

*In summary, air-writing involves having the student read and spell from an auditory stimulus.

- Spell: whole apart—you say dog and they say d-o-g
- Read: parts to whole—you say d-o-g and they say dog
- They must repeat the letters back to you
- At this point, you are not using visual stimuli or visual cue (syllable board)

**Lesson Plan for early session (5 minutes for #2-5)**

1. Set climate
2. Letter imagery—always do it at the beginning of therapy—sound/symbol check
3. *Syllable cards (CV/VC); Box 1, 1 Review or introduce rules (10 min if so)
4. *Syllable board (CV, VC) teacher says word—student writes
5. Air-writing (CV/VC) student will spell some words (you give word and then say letters) -student reads words (you say p-l-i-p) and then say “plip”
- General Guidelines for Structuring Sessions:
- 80% of time with steps 2-5;
- Imaging and decoding (2-5 sounds) CV-CCVCC
- Wait a little for sight words
- Steps 6-11 is application

Decoding
1. Decode word lists
2. Student may touch, underline with pencil, and say vowel sound first, then decode the word.
3. Give the student a plus for touching, saying, and decoding. Have them verbalize what they are doing.
4. Miscall a few words to explicitly develop monitoring/self-correction.
5. Do symbol imagery exercises (no backwards) with some words, especially missed words or words with orthographic patterns that have been difficult for the student to remember.
--- Have them air-write the error words, last letter, first letter, spell
* can use decoding workbooks as guide but do not make copies or write in original book

Error handling with Decoding
1. Cover the word to help the student access symbol imagery. Student reads the word, “slap,” as “stap.” Teacher covers the word.
2. Errors are handled in a positive, specific manner. Teacher says “Great job with the vowel sound.”
3. Question to help him analyze his response. Teacher says, “If it said ‘stap,’ what is the second letter you see?” They say “t” and you say that’s right, now let’s compare that to the word I showed you.”
4. Uncover word and help him compare response to stimulus. Teacher uncovers the word and says “Let’s see if that matched.”

Step 7: Imaging Sight words
- Categorized by frequency on Star Words chart
- ~5 minutes
- 1 second presentation followed by student only saying the word
- do not let them decode
• divide into 4 categories
  o Slow: mistakes
  o Medium: correct with slight hesitation
  o Fast: know without hesitation
  o Graduate: fast on 5 consecutive sessions
• Use sentence for context for words in slow and medium piles
• Air-writing is not required but use with difficult words
• Review all slow and medium words with rapid drill with several repetitions
• As words graduate, introduce new words

**Error handling:** there are no cues for this step; you say “That says ________”

### Step 8: Imaging Spelling

• way of assessment
• use words from sight word lists
• ~5 minutes
• application of imagery
• can say out loud, air-write, then on paper
• for trouble words, use visual spelling chart (blue)

*How to use the spelling chart:*

 o Analyze (first column)-you write word, for ex. “answer”
 o Visualize (2nd column)-student re-writes with visual cue; darken/bold letter
 o Fold so you can’t see word, then air-write-say the word as it looks
 o What’s the tricky part of the word? Discuss together.
  1. You say word as it looks-show word
  2. Student says word
  3. Student air-writes
  4. Student writes on paper

*May use school spelling lists if appropriate*

### Lesson Plan #2

1. Syllable Cards (5 minutes)
   -CCV/VCC (Box 3)
2. Syllable Board (5 minutes)—half step
   - CCV/VCC, chain, spell only

3. Air-writing (5 minutes)
   - CCV/VCC—spell 5 words, read 5 words—can be chaining or not

4. Decoding practice (5 minutes)
   * Repeat above steps
   * modify according to syllable/word structure
   * take syllable board out
   * increase number of words for #3
   * air-writing more important than syllable board

Lesson Plan #3

1. Syllable cards
2. Air-writing (above and to side)
3. Decoding
4. Sight words
5. Contextual reading

--15 min for 1 and 2; 10 min for 3 and 4

Step 9: Imaging, Reading, Spelling for 2 syllables

- first, need to establish that the student understands/can distinguish the number of syllables in a word
- ask the student to feel the beat or chunk in the word—use fist to feel the beats—many need HOH
- find the vowel sound in “cat” versus “funny”—decoding workbook #5
- draw ___le flower with 10 petals (zle, kle, tle, sle, ple, gle, fle, dle, cle, ble)
- use sectioned syllable board
- can change chunk for chaining (oply to option or iply)
- have the student identify where the syllables are by where it breaks, open/closed, then what the vowel says

1. Introduction
   - counting syllables
   - vowel sounds/one per syllable
   - teach suffixes
2. Syllable cards (box 5)
3. Syllable board
4. Air-writing
   - spell
   - read
When do you move into 2 syllables? Processing at CVC-asap

**Syllable cards**

<table>
<thead>
<tr>
<th>CVCC/CCVC (box 4)</th>
<th>2 syllable words (box 5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Syllable board-with chain</td>
<td></td>
</tr>
<tr>
<td>CVCC/CCVC</td>
<td>2 syllable words</td>
</tr>
<tr>
<td>Air-write (spell and read)</td>
<td></td>
</tr>
<tr>
<td>CVCC/CCVC (random)</td>
<td>2 syllable words</td>
</tr>
</tbody>
</table>

**Decoding**

- Workbook #4, single syllable
- Workbook #5, multi-syllable

**Sight words**
categorize

*Never go for longer than 10 minutes per task
*can move vertically or horizontally
*learn prefixes and suffixes like sight words-not sounding them out
*can combine prefix and suffix cards to make additional words

**Symbol Imagery and Reading in Context**

- If sight words are not well established; if the student is needing to phonetically pronounce many words, if self-correction requires checking articulatory feedback for sensory input---- then the student may revert to guessing-causing interference in fluency, accuracy, and comprehension. (p. 216)

**Comprehension Questions:**

- Did that imagery/what you read make sense?
- Visual: I’ll read it just like you did, see if you can catch any words that don’t match. (minor error, is for if)
  
- Auditory/Visual: When you say _____, what do you picture for ________? (coral)
- Language: Is that a word you’ve heard? (vocabulary)
  
  o Does that imagery make sense compared to what you have read? (comprehension/syntax/semantic)

- Don’t focus on single word/sound
- Let them finish their sentence
- Are they reading fluently?
- Don’t re-read paragraphs

**Final thoughts:**

- Generate positive, passionate energy in each session!!
- Give small rewards immediately and constantly, for positive responses or behaviors. Use magic stones at your discretion (need auditory feedback) and let them put them in a cup during the session. If undesired behaviors persist, remove a stone without any verbal feedback. You may choose to use the stones in the form of conditioned generalized reinforcement and they may trade these in for a prize or privilege after meeting criteria
### Seeing Stars Sequence of Treatment

<table>
<thead>
<tr>
<th>Simple syllable CV: Rules</th>
<th>Simple Syllable VC: Rules</th>
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</thead>
<tbody>
<tr>
<td>Short vowels_______</td>
<td>Short vowels_______</td>
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</table>
oo _______  
ee _______  
Open syllable _______  
Two vowels _______  
ay _______  
Diphthongs _______  
y (as “ie” sound) _______  
C-rule _______  
G-rule _______  

Final e _______  
Two vowels _______  
Diphthongs _______  
Vowel + r _______  
C-rule _______  
G-rule _______  
tch _______  
dge _______  
ck _______  

Simple Syllable CVC: Rules  
Short vowels _______  
Final e _______  
Two vowels _______  
Diphthongs _______  
Vowel + r _______  
ck _______  
ke _______  
C-rule _______  
G-rule _______  
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Complex Syllable CCV: Rules  
Short vowels _______  
Two vowels _______  
Diphthongs _______  
Vowel + r _______  
y (ie sound) _______  

Complex Syllable VCC: Rules  
Common final blends _______  
Plurals _______  
Past tense _______  
ce _______  
se _______  

Complex Syllables CCVC: Rules  
Short vowels _______  
Final e _______  
Two vowels _______  
ck _______  
Diphthongs _______  
Vowel + r _______  

Complex Syllables CVCC: Rules  
Common final blends _______  
Plurals _______  

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C-rule _______  
G-rule _______  
Past tense _______  
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Complex Syllables CCVCC: Rules  
Common initial/final blends _______  
Plurals _______  

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ly _______ , le _______  
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ck/ke _______  
C-rule _______  
G-rule _______  
Past tense _______  
se _______  

Complex Syllables CCVCC: Rules  
Common initial/final blends _______  
Plurals _______  

182
Past tense ______

Prefixes:
- pre _____
- pro _____
- in _____
- ex _____
- re _____
- de _____
- un _____
- dis _____
- con _____
- mis _____
- per _____
- non _____
- sub _____
- trans _____
- tele _____

Suffixes:
- ly _____
- ple _____
- tle _____
- ble _____
- dle _____
- kle _____
- cle _____
- gle _____
- fle _____
- sle _____
- zle _____
- ing _____
- ful _____
- tion _____
- ment _____
- less _____
- ness _____
- ture _____
- al _____
- an _____
- on _____
- ent _____
- ence _____
- ance _____
- ate _____
- tive _____

Suffixes (continued)
- sive _____
- ous _____
- cious _____
- sion _____
- cial _____
- ious _____
- ial _____
- ary _____
- tial _____
- ism _____
- ian _____

Visually- short vowel Visually- final /e/ Visually- 2 vowels go walking

CV/VC | Letter | Draw | Sound
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<th>CV/VC</th>
<th>Letter</th>
<th>Draw</th>
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Guidelines for Seeing Stars Data Collection:

- You will be asking the clients to say, air-write, and decode.

- You should have different data charts for:
  1. Imaging (verbalize the individual letters with regard to each rule (may have more than one).
  2. Air-Writing (optional)
  3. Decoding (also divided by each rule)

- Separate auditory and visual data.
- Record sessions in case you are not able to capture data during the session.
- Document the date each rule is introduced.

Sight words:
- Separate words into suggested categories by Seeing Stars.
- No cues are provided for this task.

Sight word goal:
The client will identify the first 25 sight words (modify accordingly) without hesitation with 100% accuracy given 5 opportunities.

- When tracking symbol imagery exercises, separate by what you have asked them to do (omit, manipulate, etc.). No cues are provided for this task.

- The client will say and air-write given phonemes/digraphs/affixes with 100% accuracy (when using the consonant, vowel, or affix cards in isolation).
1. **Pre-Evaluation Planning**: The clinician will review the client folder and compose appropriate interview questions prior to the initial meeting with the supervisor. The clinician will be able to present the proposed assessment plan including standardized testing, material set-up and equipment to be used (if needed) to the supervisor. Test selection should be based on normative data and the reported concern. The clinician will contact the client and follow-up with any necessary questions in a professional manner.

2. **Case History**: The clinician will discuss the case history with the client and will ask additional questions during the interview when appropriate.

3. **Test Administration/Equipment Use**: The clinician will administer tests following test criteria and protocol in an efficient and organized manner. The clinician will be prepared to conduct an informal assessment in addition to the formal assessment. The clinician will be familiar with the operation of any equipment that may be necessary for the evaluation.

4. **Client Interaction**: The clinician will attempt to establish rapport with the client and caregiver, as well as demonstrating effective communication skills and counseling when needed. The clinician will conduct the evaluation in a professional yet sensitive manner with an awareness of cultural diversity. The clinician will inform the client and caregiver of the assessment procedures using clear and concise terminology.

5. **Test Scoring and Interpretation**: The clinician will score tests following test criteria and protocol while demonstrating comprehension of the results.

6. **Diagnosis/Prognosis**: Based on formal and informal assessment, the clinician is able to assess severity and type of disorder. Based on formal/informal assessment, case history information, and diagnosis, the clinician is able to make a reasonable prediction of the client’s rehabilitative potential.

7. **Client Summary and Ability to Communicate Results to Client/Caregiver**: The clinician will demonstrate the ability to relate diagnosis and prognosis to the client and or caregiver using clear and concise terminology. The clinician will attempt to respond to client/caregiver questions pertaining to the evaluation with the assistance of the supervisor as needed.

8. **Appropriate Recommendations (goals) and Referrals**: The clinician will make appropriate recommendations regarding the need for additional evaluation, treatment or a referral to other professionals. The clinician will develop appropriate goals based on assessment results. The clinician will follow-up with the client and/or caregiver education when appropriate, as well as referrals to other professionals.

9. **Report Preparation Appropriate to Facility Standards**: The clinician will compose an evaluation report and other required paperwork following the evaluation. The report should be written and submitted according to facility requirements.

10. **Utilizes Feedback**: The clinician will utilize supervisor, team member, and allied professional feedback and formulate questions regarding information that is unclear. The clinician will incorporate the supervisor’s suggestions made during the pre-evaluation planning session and during the evaluation.
OBSERVATION FORM: Evaluation

Clinician_________________________Client_________________________

Supervisor________________________Date_________________________

1. _____Pre-evaluation planning/Test Selection 6. _____Diagnosis/Prognosis
2. _____Case History 7. _____Client Summary
3. _____Test Administration/Equipment Use 8. _____Recommendations
4. _____Client Interaction 9. _____Report Preparation
5. _____Test Scoring/Interpretation 10. _____Utilizes Feedback

Professional Attributes

1. _____Meets Client on time 6. _____Maintains accurate ASHA hours/log
2. _____Appropriate attire 7. _____Attends meetings on time
3. _____Documentation submitted on time 8. _____Complies with universal precautions
4. _____Complies with billing policies 9. _____Maintains equipment
5. _____Keeps working files in order 10. _____Maintains client confidentiality

________________________

Narrative:
CLINICAL PRACTICUM
GRADING FORM
(DIAGNOSTICS)

Student _______________________________ Level _______________________________

Clinical Instructor _______________________________ Semester _______________________________

<table>
<thead>
<tr>
<th>EVALUATION</th>
<th>Unsatisfactory</th>
<th>Needs Improvement</th>
<th>Meets Expectations</th>
<th>Exceeds Expectations</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Pre-evaluation Planning/Test Selection based on history</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>NA</td>
</tr>
<tr>
<td>2. Case history: Student reviews appropriate information and formulates appropriate follow-up questions with interview executed effectively.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>NA</td>
</tr>
<tr>
<td>3. Test administration/ Equipment Use</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>NA</td>
</tr>
<tr>
<td>4. Patient Interaction</td>
<td>0</td>
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<td>5. Test Scoring /Test Interpretation</td>
<td>0</td>
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<tr>
<td>6. Diagnosis/Prognosis</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>NA</td>
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<tr>
<td>7. Client Summary and Ability to Communicate summary to Client/Caregiver</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>NA</td>
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<tr>
<td>8. Appropriate recommendations and referrals</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>• Pertinent, accurate</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>NA</td>
</tr>
<tr>
<td>• Organized</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>NA</td>
</tr>
<tr>
<td>• Professional writing style</td>
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<td>1</td>
<td>2</td>
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<tr>
<td>• Spelling, grammar</td>
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<td>2</td>
<td>3</td>
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<tr>
<td>• Appearance</td>
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<td>1</td>
<td>2</td>
<td>3</td>
<td>NA</td>
</tr>
<tr>
<td>Report Average</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>NA</td>
</tr>
<tr>
<td>10. Utilizes feedback from clinical instructor, team members and other professionals</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>NA</td>
</tr>
</tbody>
</table>

TOTAL ________________ x 2 = ________________

Please give information on any score rated less than 2 (meets expectations): ________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________
<table>
<thead>
<tr>
<th>PROFESSIONAL CHARACTERISTICS</th>
<th>Unsatisfactory</th>
<th>Needs Improvement</th>
<th>Meets Expectations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Meets client on time</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2. Appropriate attire for situation</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3. Documentation (reports, plans) submitted on time</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>4. Complies with billing policies</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>5. Keeps working files in order</td>
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<td>2</td>
</tr>
<tr>
<td>6. Maintains accurate records for ASHA hours/daily log</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>7. Attends meetings on time</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>8. Complies with Universal Precautions</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>9. Maintains equipment</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>10. Maintains client confidentiality</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

TOTAL________________________________________x2 = __________________________

Please give information for any score rated less than 2 (meets expectations)____________________________________________________________

____________________________________________________________

____________________________________________________________

GRAND TOTAL = ___________________________       GRADE____________________

Extra Credit (3 points maximum, 1 point per activity)

_____NSSLHA
_____Fund Raising
_____Attendance at the NSSLHA Symposium or other conference
_____Complex Client
_____Extra Clinical duties
_____Material Development
_____Interaction with other professionals
_____Extensive client/family education
_____Other
Explanation of Clinic Supervision Treatment and Grading Sheet

Treatment

1. **Case History:** The clinician will present the client’s pertinent medical and treatment history. The clinician will be prepared to ask the client or caregiver additional questions in order to provide a comprehensive description of the client.

2. **Provides and Modifies Cues:** The clinician will demonstrate the ability to develop a cuing hierarchy and subsequently provide appropriate and consistent cues. The clinician will modify the cueing hierarchy as necessary.

3. **Material Selection:** The clinician will select materials appropriate for the client’s age, gender, and disorder and for a home program (if necessary). The clinician will be familiar with the stimuli chosen and will demonstrate initiative in selecting interesting and stimulating therapy materials.

4. **Treatment Goal Selection:** The clinician will review normative data and current research techniques when choosing goals to target in therapy. The clinician will take the initiative to obtain additional information related to the client in addition to what is provided by the supervisor.

5. **Modifies treatment objectives according to client performance:** The clinician will be aware of consistent changes in the client’s performance that will impact progress and modify the treatment plan accordingly.

6. **Client Interaction:** The clinician will demonstrate awareness of changes in the client’s mood and motivation level during therapy activities. The clinician will be able to switch tasks when needed and understand that the client’s performance is not always indicative of the treatment outcomes.

7. **Reinforcement/Feedback:** The clinician will use specific and appropriate feedback in order to improve client performance. The clinician will use appropriate type and schedule of reinforcement to client on-task behavior.

8. **Time Management:** The clinician will demonstrate the ability to organize and implement a treatment plan effectively and to use therapy time efficiently. The clinician will be prepared to discuss client status and progress at supervisor meetings, or with other health professionals.

9. **Paperwork Requirements:** The clinician will complete Objective/Procedure sheets, SOAP notes, and data collection per session in addition to other forms required by each supervisor. The clinician will complete the Therapy Plan and end of semester Treatment Report at assigned times.

10. **Interpersonal Skills:** The clinician will demonstrate the ability to communicate effectively using appropriate language and relate to peers, allied professionals, supervisors, and family/caregivers. This includes active listening skills, empathy, and compassion while maintaining a professional demeanor.
OBSERVATION FORM: Treatment

Clinician ___________________________ Client ___________________________

Supervisor ___________________________ Date __________________________

1. _____ Materials preparation
2. _____ Treatment plan implemented
3. _____ Cueing/reinforcement
4. _____ Client Interaction
5. _____ Supervisor’s suggestions incorporated

Professional Attributes

1. _____ Meets Client on time
2. _____ Appropriate attire
3. _____ Documentation submitted on time
4. _____ Complies with billing policies
5. _____ Keeps working files in order
6. _____ Maintains accurate ASHA hours/log
7. _____ Attends meetings on time
8. _____ Complies with universal precautions
9. _____ Maintains equipment
10. _____ Maintains client confidentiality

Comments:
**CLINICAL PRACTICUM GRADING FORM (TREATMENT)**

Student  

Clinical Instructor  

Client  

Semester  

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Unsatisfactory</th>
<th>Needs Improvement</th>
<th>Meets Expectations</th>
<th>Exceeds Expectations</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Case History</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>NA</td>
</tr>
<tr>
<td>2. Provides and Modifies Cues</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>NA</td>
</tr>
<tr>
<td>3. Material Selection</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>NA</td>
</tr>
<tr>
<td>4. Treatment Goal Selection</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>NA</td>
</tr>
<tr>
<td>5. Modifies treatment objectives</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>NA</td>
</tr>
<tr>
<td>6. Client Interaction</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>NA</td>
</tr>
<tr>
<td>7. Reinforcement/Feedback</td>
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<td>1</td>
<td>2</td>
<td>3</td>
<td>NA</td>
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<tr>
<td>8. Time Management</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>NA</td>
</tr>
<tr>
<td>9. Paperwork Requirements</td>
<td>0 (6+ errors)</td>
<td>1 (3-5 errors)</td>
<td>2 (1-2 errors)</td>
<td>3 (No errors)</td>
<td>NA</td>
</tr>
<tr>
<td>10. Interpersonal skills</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>NA</td>
</tr>
</tbody>
</table>

\[ \text{TOTAL} \times 2 = \_ \_ \_ \_ \_ \_ \]

Please give information on any score rated less than 2 (meets expectations): ________________________________
<table>
<thead>
<tr>
<th>PROFESSIONAL CHARACTERISTICS</th>
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<th>Meets Expectations</th>
</tr>
</thead>
<tbody>
<tr>
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<td>2</td>
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<tr>
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<td>9. Maintains equipment</td>
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<td>2</td>
</tr>
<tr>
<td>10. Maintains client confidentiality</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

TOTAL \( \text{xi2} \) = \underline{______________}

Please give information for any score rated less than 2 (meets expectations)

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

GRAND TOTAL = \underline{______________} \hfill GRADE \underline{______________}

Extra Credit (2 points maximum, 1 point per activity)

_____ Extensive behavior management \hfill _____ Extensive client/family education

_____ Extra clinical duties \hfill _____ Extensive material development
Mid-Semester Self-Evaluation Form

Client initials: _______ Clinician: ____________________________

Date: ________________________

Based on a 7-minute video of a session, complete each of the following items using the rubric below:

3 = Area of strength  2 = Needs modification  1 = Satisfactory  N/A = Not applicable

_____ Procedures are modified as necessary during the session
_____ Appropriate type of reinforcement
_____ Client behavior managed consistently in a firm, yet nonthreatening manner
_____ Target behaviors modeled accurately
_____ Target-specific feedback provided consistently
_____ Therapy techniques appropriate for client’s age/developmental level and disorder
_____ Clear pre-instruction given for each target behavior
_____ Cues are provided in a consistent manner
_____ Communication style adapted to needs of the client (vocabulary, language level, age)
_____ Appropriate interpersonal skills (verbal and non-verbal)
_____ Poised, confident demeanor
_____ Appropriate pace and amount of target productions
_____ Creative and appropriate therapy materials
_____ Appropriate proxemics (seating arrangement)

What are two skills that you feel could be modified for the next session?

Based on this sample, identify at least two clinical strengths.

Based on this sample, write a goal for you to achieve by the end of the semester.

How have you incorporated what you have learned in your academic courses during your clinical practicum this semester?

Minimum Performance Requirements:

Undergraduate and First Semester Graduate
Level 1 The student will identify and gather specific information in client files, text books, administrative manuals and treatment materials as instructed by the supervisor.

Second Semester Graduate
Level 2 The student will identify and gather information as specified in clinical competency I (CC I). The student will prepare an analysis of treatment and/or diagnostic options relevant to the client’s needs for presentation to the supervisor and implement accordingly.

Third Semester Graduate
Level 3 Students who have not met expectations for CC I & CC II with a minimum of 75% accuracy or above will not be assigned to an off-campus clinical placement and/or diagnostics. The student will analyze, implement, and modify with assistance information and treatment options. (May be considered for off-campus and/or diagnostics assignments).

Fourth Semester Graduate
Level 4 The student will perform on-going analysis and assessment of all elements of therapy in light of client progress and recommend timely and appropriate modifications to the supervisor. Students must pass level 4 with a minimum of 75% accuracy in order to participate in an externship.

Fifth Semester Graduate (field experience)
Level 5 The student will independently implement all modifications to therapy approved by the supervisor according to established professional standards of practice. Supervision will be provided according to ASHA supervisory requirements (25% for Tx, 50% for Dx). Students must pass this level with a minimum of 75% accuracy in order to pass the externship.

Note: Students may perform functions at any level with the assistance of the clinical supervisor, but are expected to do so independently at the level described for each semester in clinic.

Ability to perform at levels that exceed or do not meet minimum requirements will be reflected in the student’s grade.

Students must pass Levels 1-3 with a minimum of 75% accuracy in order to advance levels. Students must pass Level 4 with 75% accuracy in order to be eligible for an externship. Students must pass Level 5 with 75% accuracy in order to satisfactorily pass the externship.
PROTOCOL FOR IDENTIFYING AND ASSISTING GRADUATE SLP STUDENT CLINICIANS WHO DEMONSTRATE AT-RISK CLINICAL PERFORMANCE

STATEMENT OF PURPOSE: To provide a structured and individualized experience, with intensive instructional and supervisory input, for student clinicians who are experiencing difficulty acquiring and/or demonstrating satisfactory clinical skills.

MID-SEMESTER:

• Acknowledgment of “at risk for inadequate” clinical performance: During a supervisory meeting, the clinical faculty member presents concerns regarding the student clinician’s performance in clinical practicum (CMDS 5910 or CMDS 7500). The clinical faculty may identify the student clinician as being “at risk” for unsatisfactory clinical practicum. Specifically, the faculty member identifies standards from the Knowledge and Skills Acquisition (KASA) Summary Form, which the student may not meet. “At risk for inadequate” clinical performance is defined as performing at 79 or below.

• Student Notification: The instructor notifies the student clinician in writing, indicating that the student has been identified as “at risk for inadequate” clinical performance, which may impact participation in a clinical rotation or externship the following semester.

RESPONSIBILITIES AND ACTIONS AT MID-SEMESTER:

Student Clinician:

• Self-evaluation: The student may be asked to complete a self-evaluation form regarding clinical performance.

• Clinical Improvement Plan: If the mid-semester grade is 79 or lower, the student clinician works with the clinical instructor to develop a clinical improvement plan, which would include specific objectives to improve clinical skills and behaviors as identified on the KASA form. Audio and videotaping may be used to verify these objectives have been met.
• **Weekly progress meetings:** In addition to pre-evaluation or pre-treatment meetings, the student meets with the instructor on a weekly basis at a specified time. They discuss the student’s progress toward achieving the specific objective(s) stated in the clinical improvement plan.

**Clinical Instructor:**

• **Student evaluation:** The clinical instructor evaluates the student’s clinical performance, using the Auburn University Clinical Evaluation and Grading form and/or an additional tool, such as the (W-PACC) Wisconsin Procedure for Appraisal of Clinical Competence (Shriberg, et. al. 1974).
  - Performance ratings, written commentary, and a mid-semester grade are provided by the instructor
  - The student and the clinical instructor sign the evaluation form
  - The clinical instructor places copies of the signed evaluation form in the student’s departmental file
  - The clinical instructor notifies the department chair of the student’s mid-semester grade
  - The clinical instructor notifies the student’s academic advisor of the mid-semester grade

• **Clinical Improvement Plan:** The clinical instructor assists the student in developing a Clinical Improvement Plan. A copy of the plan is placed in the student’s file.

• **Weekly meetings:** The primary clinical instructor participates in weekly meetings with the student. If necessary, the instructor’s schedule will be adjusted to accommodate these meetings.

• **Additional Clinical Instructor:** An additional clinical instructor reviews the Clinical Improvement Plan; may observe the pre-evaluation or pre-treatment meetings, the clinical sessions, and the post-evaluation or post-treatment meetings; and provides other assistance, as requested. If necessary, the additional clinical instructor’s schedule will be adjusted to accommodate these additional responsibilities.
Department Chair:

- **Student Notification:** The Chair notifies the student clinician in writing when the student’s overall mid-semester grade for CMDS 5910 or CMDS 7500 is 79 or lower. The student is informed that if the final grade for CMDS 5910 or CMDS 7500 is: (1) 79-70, the student cannot be placed at an off-campus site or (2) “C” or lower, the student cannot be placed at an off-campus site and no ASHA hours will be earned for that semester.

- **Record of Notification:** The Chair files a copy of the notification in the student’s clinical and administrative file. S/he sends a copy to the student’s academic advisor.

END OF SEMESTER:

- **PASS:** clinical practicum (final grade of 80 or better) → continue clinical practicum following semester

- **CONDITIONAL PASS:** clinical practicum (final grade of 79-70) → will not be placed in off-campus site the following semester; may continue clinical practicum at AUSHC

- **FAIL:** clinical practicum (69 or lower) →
  - Enroll in CMDS 4930 Directed Study the following semester
  - Cannot enroll in clinical practice when enrolled in directed study
  - Grade of D or lower in CMDS 5910 or 7500 will delay graduation

DIRECTED CLINICAL STUDY:

- A committee of two or three faculty (clinical and academic) is appointed by the department chair to oversee/supervise the directed clinical study.

- This committee meets during the first week of the semester to identify specific areas of concern based on the final assessment from the preceding semester and to plan the clinical experience.

- The committee will meet with the student regarding performance expectations; the nature of performance evaluation; and the roles and responsibilities of the student clinician and the instructors. The letter grade for the Directed Study will be derived from completion of assignments and fulfillment of responsibilities.
• The schedules of instructors will be adjusted to accommodate these meetings and additional responsibilities.

• A written summary is provided for all involved parties. A signed copy is placed in the student’s file.

• Outcome of Directed Clinical Study:
  o **Pass** (final grade of 80 or better) → Enroll in clinical practicum the next semester; may be placed at off-campus site
  o **Unsatisfactory** (79 or lower) → Repeat Directed Clinical Study the next semester
    ▪ May repeat Directed Clinical Study only one time
    ▪ Cannot enroll in clinical practicum when enrolled in Directed Clinical Study
    ▪ Repeating Directed Clinical Study will delay graduation
Standard IV-G:
The applicant for certification must complete a program of study that includes supervised clinical experience sufficient in breadth and depth to achieve the following skills and outcomes:

**EVALUATION**

<table>
<thead>
<tr>
<th>Student is able to:</th>
<th>Course</th>
<th>No Experience</th>
<th>Maximum Supervision</th>
<th>Minimal supervision</th>
<th>Independent</th>
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<tbody>
<tr>
<td>Conduct screening and prevention procedures *</td>
<td></td>
<td></td>
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<tr>
<td>Articulation</td>
<td></td>
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<tr>
<td>Fluency</td>
<td></td>
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<tr>
<td>Voice &amp; resonance</td>
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<tr>
<td>Receptive &amp; expressive language</td>
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<tr>
<td>Hearing</td>
<td></td>
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<tr>
<td>Swallowing</td>
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<tr>
<td>Cognitive aspects</td>
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<tr>
<td>Social aspects</td>
<td></td>
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<td>Communicative modalities</td>
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<td>Collect case history information &amp; integrate information from clients, relevant others, &amp; professionals *</td>
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<td>Select &amp; administer appropriate evaluation procedures **</td>
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<td><strong>Refer clients for appropriate services</strong> *</td>
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### INTERVENTION

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<td>Develop appropriate plans with measurable goals based on client performance; normative data; research</td>
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<td>Demonstrate the ability to implement intervention plans</td>
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<td><strong>Demonstrate the ability to measure and evaluate clients’ performance and progress</strong></td>
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<td><strong>Demonstrates the ability to modify intervention plans, strategies, materials, and/or instrumentation as appropriate to meet the needs of clients.</strong></td>
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<td>Provides appropriate reinforcement and behavior modification techniques as needed *</td>
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<td>Demonstrate the ability to complete administrative and reporting functions necessary to support intervention *</td>
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<td>Demonstrate the ability to identify and refer clients for services (including appropriate recommendations)</td>
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**INTERACTIONS AND PERSONAL QUALITIES**

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<th>Adequate w/ supervision</th>
<th>Independent</th>
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<td>Communicate effectively, recognizing the needs values, preferred mode of communication, and cultural / linguistic background of the client /patient, family, caregivers, and relevant others</td>
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<td>Collaborate with other professionals in case management</td>
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<td>Provide counseling regarding communication and swallowing disorders to clients/patients, family, caregivers, and relevant others</td>
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<td>Adhere to the ASHA Code of Ethics and behave professionally</td>
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<td><strong>Standard III –E: Knowledge of Ethical Conduct</strong></td>
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<td>*Student will identify ethical behavior</td>
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<td><strong>Standard III-G: Knowledge of Professional Issues</strong></td>
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<td>*Student will demonstrate clinical safety and infection control procedures</td>
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<td><strong>Standard IV-B: Oral and Written Skills</strong></td>
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<td>A. Student will write a complete treatment plan that is accurate in style, format, and grammar</td>
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<td>B. Student will write a complete SOAP or progress note that is accurate in style, format, and grammar</td>
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<td>C. Student will write appropriate measurable objectives that are accurate in style, format, and grammar</td>
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<td>D. Student will write a complete diagnostic report that is accurate in style, format, and grammar</td>
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## Student Strengths and Needs

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207
Summary of Client Disorders

Semester 1

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Needs: ____________________________________________________________________

Semester 2

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Needs: ____________________________________________________________________

Semester 3

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Needs: ____________________________________________________________________

Semester 4

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________________________________________________________________________

Needs: ____________________________________________________________________
KASA Remediation Plan

Students must demonstrate skills at the “minimal supervision” level to be eligible for an internship. Internship placement will be delayed until skills are mastered at the required level.

Students demonstrating the majority of their skills at the “maximum supervision level” after completing their second or third semester of clinic (summer semester) will be placed on a remediation program.

The student will be assigned approximately two cases the following semester. Cases will be assigned based on the student’s area of need.

**Student Clinician Responsibilities:**

- **Self-evaluation.** The student will be asked to complete a self-evaluation form regarding clinical performance at the beginning, mid-semester and the end of the semester. This will enable the supervisor to obtain baseline information on how the student perceives their own clinical performance.

- **Clinical Improvement Plan.** The student clinician and clinical instructor develop a clinical improvement plan, which would include specific objectives to improve clinical skills and behaviors as identified on the KASA form.

- **Audio and Videotaping.** Treatment sessions will be either audio or video taped in order to verify these objectives have been met. The student will observe the tapes and obtain data on targeted goal (i.e., cues, reinforcement; modifying treatment; etc). The clinical instructor and student will observe the tapes jointly to measure progress on targeted goals.

- **Weekly progress meetings.** In addition to pre-evaluation or pre-treatment meetings, the student meets with the instructor on a weekly basis at a specified time. They discuss the student’s progress toward achieving the specific objective(s) stated in the clinical improvement plan.

**Clinical Instructor:**

- **Student evaluation.** The clinical instructor evaluates the student’s clinical performance, using the Auburn University Clinical Evaluation and Grading form and the Auburn University Speech and Hearing Clinic KASA form.
- Performance ratings, written commentary, and will be provided by the instructor at mid-semester
- The student and the clinical instructor sign the evaluation forms
- The clinical instructor places copies of the signed evaluation form in the student’s departmental file

**Clinical Improvement Plan.** The clinical instructor assists the student in developing a Clinical Improvement Plan. A copy of the plan is placed in the student’s file.

**Weekly meetings.** The primary clinical instructor participates in weekly meetings with the student. If necessary, the instructor’s schedule will be adjusted to accommodate these meetings.

**Additional Clinical Instructor:** An additional clinical instructor reviews the Clinical Improvement Plan; may observe the pre-evaluation or pre-treatment meetings, the clinical sessions, and the post-evaluation or post-treatment meetings; and provides other assistance, as requested. If necessary, the additional clinical instructor’s schedule will be adjusted to accommodate these additional responsibilities.
CMDS 7920: SLP Clinical Internship Requirements

CMDS 7920: SLP Clinical Internship is the last course students enroll in prior to graduating with a Masters in Communication Disorders.

Criteria for enrolling in CMDS 7920:

1) Students must have completed 250 clinical clock hours (excluding observation) prior to enrolling in 7920.
2) Students must pass CMDS 7500 with a minimal grade of 80 prior to enrolling in CMDS 7920.
3) Students must have mastered academic and clinical KASA requirements. All clinical skills must be at least at the “Minimal Assistance” level with some skills at the “Independent” level.
4) Students must have completed and passed all comprehensive examinations (including re-writes and orals).
5) Students must have completed a passed all academic course work.
6) Students must be in good academic standing. Students on academic probation may not enroll in CMDS 7920.
1. Students should identify the site of choice two semesters prior to the semester in which they plan to enroll in Internship. This can be accomplished by talking with faculty, other students, visiting prospective sites, and discussing possible locations with the Internship coordinator. Sites must have an ASHA certified professional who will agree to abide by ASHA supervision guidelines, i.e., 25% supervision for treatment and diagnostics. Students should check with the site supervisor to make sure clock hours will be available in the categories needed.

2. Students should typically begin the application process by NO LATER THAN the first week two semesters prior to the semester in which they plan to enroll in CMDS 7920 (typically, this will be the first week during the summer semester.) The Official “Internship Application Form” should be completed NO LATER THAN the first week of the semester prior to the internship (typically this will be fall semester). Some sites require the agency attorney to review Affiliation Agreements and some sites have their own Affiliation Agreement for persons wishing to complete an internship at that site. This requires additional time.

3. When the site is selected, students complete Part I of the Internship Application Form and return it to the Internship coordinator.

4. The Internship coordinator will call the prospective site and discuss placement of the student with the supervisor. If the site is appropriate and the supervisor is willing, an affiliation agreement will be sent to the site, or the site will send their agreement.

5. The student will be notified when the agreement is returned with the site representative’s signature. The student can report for the Internship at the appropriate time.

6. Students can schedule the Internship to begin the first of the week when classes begin and the end the last day of classes. Internship can begin early or late, but must be adjusted to contain the same number of days as the academic semester. Students are responsible for determining the schedule with their immediate site supervisor. Auburn University does not have a set start and end date since some sites (schools require students follow their break schedule). It is the student’s responsibility to review the University Calendar to make sure the intern dates agreed upon with the site fit with the University Calendar. The
student must complete the 15 weeks by the last day of classes. Start and break days are discussed between the student and site.

7. Students will coordinate schedules and assignments with the supervisor at the Internship site, and will report start and end dates to the Internship Coordinator.

8. Students are to call the Internship Coordinator IMMEDIATELY if there is a problem at the site. Changes can ordinarily be made in the first two weeks of an assignment, but may be difficult after that time.

9. The Internship Coordinator will call the Intern site supervisor during the second week of the semester and during midterm week to discuss progress.

10. A mid-semester evaluation should be completed. The student will be given a copy of the mid-semester prior to leaving campus. If the student does not have a copy, the Internship Coordinator will send a copy. The mid-semester is to be completed by the supervisor, discussed with the student,

11. A final evaluation will either be sent to the internship supervisor prior to the end of the semester. The evaluation should be completed by the supervisor, discussed with the student, and returned to the Internship Coordinator. The student’s grade cannot be assigned until this is received.

12. Students will be asked to write a letter evaluating the experience at the site. This also must be returned to the Intern Coordinator before a grade can be assigned.

13. The final responsibility of the Internship is for the student to complete the composite summary of clock hours. While this does not have to be submitted before the grade is assigned, it MUST be presented to the Internship coordinator for approval. After being approved, it must be placed in the student’s file before ASHA certification papers can be submitted by the student.
CMDS 7920- INTERNSHIP IN SPEECH PATHOLOGY
CURRICULUM OBJECTIVES

I. Curriculum Objectives:
CMDS 7920 Field Experience in Speech Pathology was developed to provide the
graduate clinician in speech pathology with extensive of thirty (30) hours per
week at the off-campus setting.

II. Clinical Activities:
   A. It is expected the students assigned to an extern site will engage in clinical
      activities related to both diagnostics and treatment with adults. Clinical Activities may
      include:
         • Evaluations: Speech disorders
         • Evaluations: Language disorders
         • Screening: Hearing disorders
         • Treatment: Speech disorders
         • Treatment: Language disorders
         • Treatment: Hearing disorders

   B. Evaluations refer to those hours in screening, assessment and diagnosis of
      language and speech disorders that are conducted prior to the initiation of
      treatment.

   C. Screening hours for adults with hearing disorders could be included in the
      students practicum experience, however, the Speech-language pathology
      students is not expected to engage in full audiological evaluations.

   D. Treatment refers to clinical management progress in monitoring, and
      counseling.

   E. Speech disorders refer to: articulation, fluency, voice, and dysphasia.

III. Site Supervisor observation requirements:
   A. The site supervisor will hold a Certificate of Clinical Competence in
      Speech Language Pathology.

   B. Diagnostics: In accordance with the American Speech Language &
      Hearing Association (ASHA), the site supervisor is responsible for supervising
      25% of all evaluations (including screenings).

   C. Treatment: In accordance with the American Speech Language & Hearing
      Association (ASHA), the site supervisor is responsible for supervising 25% of all
      treatment sessions.
By now your supervisors should have received their intern packet. There was a letter with instructions for you in the packet. If you have not received this important information, notify me immediately. All your records must be complete for graduation.

Be aware, AUSHC must have an original of your final ASHA hours. Faxed or copies of the original document are not acceptable. If you are extending your internship for any reason, you can send all other information (grades) needed in time for graduation. A note will be placed in your file indicating we do not have an original of your hours. You will not be eligible for your CCC until we have an original. Dr. Pindzola will not sign off on any ASHA paperwork until we have all of your paperwork, including an original copy of your ASHA hours.

Several students have asked where to include the supervisors’ state license number. Your supervisor(s) can include that information on the evaluation form.

Some students have requested information about certification and state license. I hope the following information helps.

**PLEASE** remember to send AUSHC a copy of your Praxis score if we have not already done so.

**ASHA and State Requirements:**

Everyone should have an ASHA Certification and Membership Handbook. This handbook contains all of the information you will need for certification. You can call ASHA at 800-498-2071 to obtain a copy of the handbook.

You will need to contact the state in which you are working to determine each individual’s requirements for licensure. You typically do not need to be licensed while completing your CFY, but you do need to register with the state board.

To obtain information about ASHA certification and a state license, click on the ASHA web site:

- Go to [www.ASHA.org](http://www.ASHA.org)
- Click on the *Members and Professionals* heading on the top
- For State Licensure information:
  - On the left hand side click on ASHA by State
  - Click on the state in which you will be seeking licensure
  - Contact information is available.

- For ASHA Certification:
  - On the left hand side (after you have clicked on Members and Professionals) click on Membership and Certification
  - On the right side click on *Recommended Sequence* – these are great guidelines for what you need for certification.

Let me know if you have questions, Elissa Zylla-Jones, Internship Coordinator
Part I. To be completed by student and returned to the Internship Coordinator

Date ___________________________ Semester of Intern Experience ___________________________

Student _____________________________________________________________

Last                               First                     Middle

Mailing Address________________________________________________________

Participating Internship Agency or Organization:
Initial or Business Contact Information (Human resources, Student services, etc.)
Name of Site: ____________________________________________
Contact Person: ______________________________Title_________________
Address_______________________________________________________

E-mail___________________________________________________________
Telephone____________________________ Fax________________________

Intern Experience Supervisor__________________________________________
Full Name (as appears on Certificate Clinical Competence)

Title                    ASHA Account#        State License#
Address_______________________________________________________

E-mail___________________________________________________________
Telephone____________________________ Fax________________________

SUMMARY OF ASHA HOURS EARNED: (minimum hours in parenthesis)

Total number of hours ________________ (400)
Number of hours completed at graduate level ________________ (300)
Speech-Language Pathology Majors ________________ ( 20)
Hearing Majors ________________ ( 20)

Hearing Evaluation/screening of hearing disorders ________________ ( 20)
Habilitation/rehabilitation of hearing disorders ________________ ( 20)
Evaluation: Speech disorders in children ________________ ( 20)
Evaluation: Speech disorders in adults ________________ ( 20)
Evaluation: Language disorders in children ________________ ( 20)
Evaluation: Language disorders in adults ________________ ( 20)
Treatment: Speech disorders in children ________________ ( 20)
Treatment: Speech disorders in adults ________________ ( 20)
Treatment: Language disorders in children ________________ ( 20)
Treatment: Language disorders in adults ________________ ( 20)

Sites: 1. _________________________________ ________________ ( 50)
2. _________________________________ ________________ ( 50)
3. _________________________________ ________________ ( 50)
Internship Application Form and Checklist

Part II. The following will be completed by the Internship Coordinator before approving the site.

A. Has the agency informed the clinic by letter or phone of its willingness to provide field experience? __________
B. Has the student been approved for CMDS 7920 credit? __________
C. Has the student determined that the site can provide the clinical experience the student needs? __________
D. Has the department determined that the site is an acceptable placement for the student? __________
E. Have any outside contracts been approved by Auburn University? __________
F. Has outside contract been signed by both parties? __________
G. Has the department notified the sponsoring agency that the field experience has been approved? __________
H. Has the sponsoring agency submitted a signed Field Experience Agreement? __________

Approved _____________________________________________________________

Internship Coordinator, Auburn University

Part III. The following will be completed by the Internship Coordinator after the student’s completion of the intern experience.

A. Has the Department received the student’s written evaluation of the internship? ______
B. Has the department received the student’s self-evaluation? ______
C. Has the department received the site inventory? ______
D. Has the department received the supervisor’s Intern Experience Evaluation Form and student competence? ______
E. Has the department received the supervisors Evaluation of the student & ASHA Appendix? _________

F. Has a grade been assigned to the student? _________

G. Has the department received the approved practicum hours from the Intern Experience Supervisor? _________

H. Has the department received the Survey? _________
On December 6, 1991, the Occupational Safety and Health Administration (OSHA) promulgated the final rule for exposure to blood borne pathogens. The rule, referred to as the blood borne pathogen standard, was designed to eliminate or minimize occupational exposure to Hepatitis B Virus (HBV), Human Immunodeficiency Virus (HIV), and other blood borne pathogens. Although the focus of this ruling is AIDS/HIV, faculty clinicians and student clinicians must be aware there are other contagious diseases which require disease-specific precautions.

The Centers for Disease Control (CDC) have developed general infection control procedures to minimize the risk of patient acquisition of infection from contact with contaminated devices, objects, or surfaces or transmission of an infectious agent from health-care workers to patients. Such procedures also protect workers from the risk of becoming infected. In 1987, CDC published a document describing “Universal Blood and Body Fluid Precautions” or “Universal Precautions”. Universal precautions are methods of preventing disease by preventing transfer of blood and body fluids. Since medical history and examination cannot reliably identify all patients infected with HIV or other blood borne pathogens, blood and body fluids precautions should be consistently used for all patients. Universal precautions also apply to semen, vaginal secretions, tissues, and to the following fluids: cerebrospinal fluid (CSF), synovial fluid, pleural fluid, peritoneal fluid, pericardial fluid, and amniotic fluid. Universal precautions do not apply to saliva, feces, nasal secretions, sputum, sweat, tears, urine, and vomitus unless they contain visible blood.

For universal precautions, use of protective barriers reduce the risk of exposure to blood, body fluids containing visible blood, and other fluids to which universal precautions apply. Examples of protective barriers include gloves, gowns, masks, and protective eyewear. Gowns, masks, and goggles are recommended if a splash of blood or body fluid containing visible blood is anticipated; otherwise, no barrier precautions are indicated.

ASHA’s Committee on Quality Assurance has adapted CDC’s Universal Precautions to meet the needs of speech-language pathologists and audiologists in educational settings. The committee recommended that infection control procedures be implemented to: (1) prevent transmission of chronic infectious disease; (2) protect the health of clients receiving speech-language pathology and audiology services, professional providing speech-language pathology and audiology, other health workers, family members and so on; and, (3) ensure all persons’ rights to privacy.

**HANDWASHING**

Speech-language pathologists, audiologists, and student clinicians should follow the following procedures:

1. Wash hands immediately if they are potentially contaminated with blood or body fluids
containing visible blood.
2. Wash hands before and after seeing clients.
3. Wash hands after removing gloves or personal protective devices.
4. Follow the basic hand washing technique:
   a. Vigorous mechanical action whether or not a skin cleanser is used.
   b. Use of antiseptic or ordinary soap under running water.
   c. Duration of 30 seconds between clients if not grossly contaminated and in handling client devices
   d. Duration of 60 seconds when in contact with clients, devices, or equipment with gross contamination.
   e. Thorough hand drying with a paper or disposable towel to help eliminate germs.
5. When hand washing facilities are not available, use of an appropriate antiseptic hand cleanser in conjunction with clean cloth/paper towels or antiseptic towelettes. When antiseptic hand cleansers and towelettes are used, hands shall be washed with soap and running water as soon as feasible.

USE OF GLOVES
The Food and Drug Administration (FDA) has responsibility for regulating the medical glove industry. Medical gloves include those marketed as sterile surgical or non-sterile examination gloves made of vinyl or latex. General purpose utility (“rubber”) gloves are also used in the health-care setting, but they are not regulated by FDA since they are not prompted for medical use. The following general guidelines are recommended:
1. Use sterile gloves for procedures involving contact with normally sterile areas of the body.
2. Wear gloves when touching blood or other body fluids containing visible blood.
3. Wear examination gloves for procedures involving contact with mucous membranes, unless otherwise indicated, and for other patient care or diagnostic procedures that do not require the use of sterile gloves.
4. Wear gloves when performing invasive procedures on all clients. Such procedures include performing examination of the oral speech mechanism, managing tracheostomy tubes, using laryngeal mirrors, conducting intraoperative monitoring, and using needle electrodes associated with EMG testing.
5. Change gloves after contact with each client.
6. Do not wash or disinfect surgical or examination gloves for reuse.
7. If a glove is torn or a needle stick or other injury occurs, remove the glove and use a new glove as promptly as client safety permits.
8. After removing gloves, wash hands immediately.
9. Discard gloves in the client’s room or examination room before exiting. No special disposal containers are necessary unless gloves are contaminated with blood or bloody fluids.
10. Wear gloves if client has non-intact skin, or open cuts, sores, or scratches.
11. During otoscopic inspection, if the client’s skin is intact and no blood is present, gloves are not required for industrial audiometry and fitting hearing protectors. If blood or lesions are found, then one minute of vigorous hand washing followed by use of gloves is required.
12. Gloves need not be worn when feeding patients and when wiping saliva from skin.
13. Health care workers who have exudative lesions or weeping dermatitis should refrain from handling patient care equipment until the condition resolves.
14. Use general-purpose utility gloves (e.g., rubber household gloves) for housekeeping chores involving potential blood contact and for instrument cleaning and decontamination procedures. Utility gloves may be decontaminated and reused, but should be discarded if they are peeling, cracked, or discolored, or if they have
punctures, tears, or other evidence of deterioration.

PERSONAL PROTECTIVE EQUIPMENT
1. Masks and protective eyewear or face shields should be worn during procedures that are likely to generate droplets of blood or other body fluids to prevent exposure to mucous membranes of the mouth, nose, and eyes.
2. Although saliva has not been implicated in HIV transmission, to minimize the need for emergency mouth-to-mouth resuscitation, mouthpieces, resuscitation bags, or other ventilation devices should be available for use in areas in which the need for resuscitation is predictable.

MANAGEMENT OF HUMAN BITES
When human bites occur, routine medical and surgical therapy (including and assessment of tetanus vaccination status) should be implemented as soon as possible. Such bites frequently result in infection with organisms other than HIV and HBV. Victims of bites should be evaluated for exposure to blood or other infectious body fluids.

The victim should notify the safety officer as soon as possible after the incident has occurred. The safety officer will document the incident in writing and a copy of the report will be given to the biter and the victim. The safety officer will advise both the biter and the victim to seek appropriate medical follow-up.

STERILIZATION
Sterilization is the process by which all forms of microbial life are destroyed. Presently, there are five methods of sterilization which are appropriate:
1. Steam autoclave
2. Dry heat oven
3. Chemical vapor sterilizer
4. Ethylene oxide sterilizer
5. Chemical sterilant (requires immersion for a minimum of 10 hours)

Objects such as small mirrors, containers, for tongue depressors, etc., are heat stable and can be subjected to the first four methods. Immitance probe tips, otoscopic specula, and other heat sensitive instrument requiring sterilization can be immersed for a minimum of 10 hours in a chemical sterilant followed by a sterile water rinse.

Regardless of the method of sterilization, pre-cleansing is essential in protecting those handling the instruments in addition to achieving complete sterilization. Pre-cleansing is accomplished by one of the following:
1. Immersing instruments in 2% glutaraldehyde for 10 minutes
2. Scrubbing or ultrasonic cleaning with a mild detergent
3. Rinsing and drying prior to either immersing in chemical sterilant for a minimum of 10 hours or packaging for autoclave, dry heat oven, chemical vapor sterilizer, or ethylene sterilizer.

DISINFECTION
Disinfection is a process by which chemical agents are utilized to reduce pathogenic organisms, especially on environmental surfaces. In the practice of speech-language pathology and audiology, there are many objects and environmental surfaces, such as tape recorders, audiometers, tables, etc., which should be disinfected with an Environmental Protection Agency (EPA) registered germicide or a solution of sodium hypochlorite (household bleach) at a 1:10 dilution with water. When practitioners have a question regarding cleaning and maintenance of equipment, it is suggested they consult manufacturer’s instructions.

Routine testing and treatment materials and furniture should be washable with a cleaning solution of 1:100 water to household bleach. Simple soap and water is adequate for most surfaces under
most circumstances.

Surface disinfectant should be used prior to and following each patient contact, using the following procedure:
1. Spray the surface.
2. Immediately wipe surface with a strong rubbing action.
3. Lightly mist the surface and leave it moist.
INFECTION CONTROL IN SPEECH-LANGUAGE PATHOLOGY

STANDARD PRACTICES FOR ALL SPEECH-LANGUAGE TREATMENT

1. A clinician with exudative lesions or weeping dermatitis should not have direct patient contact. The clinician should notify the clinical supervisor immediately if such conditions are present.
2. Wash hands before each patient contact. Sterile cleanser is available at sink in kitchen area of clinicians’ room.
3. Wash hands after each patient contact.
4. Clinicians may use gloves, regardless of client condition, if desired. Gloves are located on shelves in each treatment room.
5. All toys, tokens, tape recorders or other equipment should be wiped with soap and water, if washable, or disinfected with disinfectant spray located on shelves in treatment rooms.
6. Disinfectant surface to be used (tables, chairs) prior to and following each patients contact using the following procedure:
   a. Spray the surface with cleanser located in spray containers on shelves in tx rooms.
   b. Immediately wipe surface with strong rubbing action using paper towels.
   c. Lightly mist surface and leave it moist.
   d. Notify supervisor if cleanser or paper towels need to be re-supplied.

ORAL PERIPHERAL

1. If visual inspection of oral mechanism reveals a sore of any type, consult with clinical supervisor before proceeding with oral peripheral examination.
2. Gloves should always be worn during an oral peripheral procedure.
3. Discard gloves after use with each client. Never re-use a pair of gloves.
4. Always use individually-wrapped sterile tongue depressors for the examination.

Discard tongue depressors, gloves, and any other disposable items used during the evaluation in a separate zip-lock plastic bag located on shelves in therapy rooms. Discard zip-loc bag containing disposed items in trash.

AUSHC procedure for sterilization:
1. Dirty tips and specula are collected from each test area
2. Items are placed in a sieve and rinsed with hot water
3. Items are placed in the ultrasonic cleaner
   * One drop of ultrasonic disinfectant concentrate is added to ultrasonic cleaner
   * Ultrasonic cleaner is filled with enough water to cover the tips and specula
   * Cleaning cycle is done twice (at least 10 minutes)
4. Clinician should put on gloves
5. With gloved hands, cleaned items from ultrasonic cleaner are poured into sieve (over sink) and rinsed with hot water for several minutes.
6. With gloved hands, cleaned and rinsed items are placed in covered metal tray.
   * Wavicide is poured into the metal tray to cover all items
   * Items are soaked in Wavicide for at least ten hours
7. With gloved hands, sterilized items from metal tray are poured into sieve (over sink) and rinsed with hot water for several minutes.
8. With gloved hands, cleaned, rinsed, sterilized and rinsed items are placed on paper towels to dry.
Emergency Procedures

Disruptive Behavior:
Maintenance of a constructive learning environment is essential in this course. Behaviors cited as disruptive will not be tolerated and will be dealt with according to university policy (see www.auburn.edu/administration/governance/senate/behavior_policy_may03.html).

Emergencies:
Situations signaled by the university fire alarm, weather siren, or other warning systems may occur during this class period. Instructions issued by the teacher or other university personnel should be followed and may include to “shelter,” to “evacuate,” or to “barricade” in the room (see www.auburn.edu/administration/rms/emergency.html).

When sheltering, clinic students are to walk themselves and their clients (and their families) calmly to the nearest Severe Weather Shelter Area (green and white mall-mounted signs) which is the hallway across from room 1159. Students should assemble there, sitting in the hallway, so that all classmates can be accounted for. Your clinical instructor will join the class after making sure other clients on the caseload have been safely evacuated.

When evacuating, clinic students are to walk themselves and their clients (and their families) calmly down the hall: exit the doors leading toward the Pharmacy building. For handicap access, exit out the class doors by the coffee shop (across from the bookstore) and assemble near the Pharmacy building.

During class time, exit out the glass exit doors heading for the Haley concourse. Cross the concourse and assemble in the grassy knoll leading to Cater Hall. Students should gather in the grassy knoll so that all classmates can be accounted for. Your clinical instructor will join the class after making sure other clients on the caseload have been safely evacuated.

When barricading in the room, turn out lights, draw blinds, turn off computers and cell phones, barricade the door, stay away from windows, and crouch behind furniture and walls. Your clinical instructor will join the class after making sure other clients on the case load have been safely evacuated.

All clinicians should have their clients contact numbers with them during an evacuation, should the clients’ therapy or diagnostic session need to be cancelled.
I. Certification

1. ASHA’s Certificate of Clinical Competence (CCC):
   a) The American Speech-Language-Hearing Association (ASHA) issues Certificates of Clinical Competence to individuals who present evidence of their ability to provide independent clinical services to persons who have disorders of communication. Individuals who meet the standards specified by the Association's Council For Clinical Certification may be awarded a Certificate of Clinical Competence in Speech-Language Pathology (CCC-SLP) or a Certificate of Clinical Competence in Audiology (CCC-A). Individuals who meet the standards in both professional areas may be awarded both certificates.
   b) Individuals must meet specific requirements in academic preparation and clinical practicum and complete a Clinical Fellowship Year (CFY).
   c) Applicants who apply for certification must successfully complete the Praxis Examination in speech language pathology.
   d) Members and individuals who hold the CCC subscribe to a Code of Ethics incorporating the highest standards of integrity and ethical principles.
   e) See the following pages for specific standards for the Certificate of Clinical Competence (CCC).
2. Please locate additional information at ASHA’s website www.asha.org.

II. State Licensure

1. State licensure is required for most states. Alabama law requires that persons providing speech-language pathology and audiology services, have a state license, except for those employed by the public schools.
2. Alabama licensure qualifications include the following:
   - Be of good moral character
   - Make application to the Board
   - Pay to the Board appropriate application fee
   - Possess evidence of at least a master's degree or equivalent
   - Evidence of successful completion of supervised clinical practicum approved by the Board
   - Evidence of successful completion of postgraduate professional experience approved by the Board
3. Clinical fellows employed in settings requiring state licensure must register their CFY with the Board of Examiners for the respective state.
4. Please locate additional information for Alabama at their website www.abespa.org or call them at (334) 269-1434 or 1-800-219-8315. Other state licensure requirements are located online as well.

III. Teacher Certification

1. Certification of teachers is required in most states.
2. Contact individual states to identify necessary requirements.
IV. Professional Organizations

1. The **National Student Speech-Language and Hearing Association (NSSLHA)** is a pre-professional membership association for students interested in the study of communication sciences and disorders. Auburn University has a local chapter of NSSLHA with meetings opening to all interested persons. Dues for the National Level are $60.00 each year. Applications and additional information may be obtained from the NSSLHA Faculty Advisor in the Department of Communication Disorders or by visiting [www.nsslha.org](http://www.nsslha.org).

2. The **American Speech Language Hearing Association (ASHA)** is the professional, scientific, and credentialing association for members and affiliates who are audiologists, speech-language pathologists, and speech, language, and hearing scientists. Further information may be located at [www.asha.org](http://www.asha.org) or by calling the ASHA Action Center at 1-800-638-8255.

   - ASHA’s mission is the following: “Empowering and supporting speech-language pathologists, audiologists, and speech, language, and hearing scientists by:
     a) Advocating on behalf of persons with communication and related disorders
     b) Advancing communication science
     c) Promoting effective human communication”

     ASHA requires that individuals who provide or supervise clinical services in speech language pathology and audiology have the appropriate CCC. Providers of services who have yet to obtain the CCC must be in the process of finalizing certification under appropriate supervision. Individuals providing services who do not meet these requirements are in violation of the Code of Ethics.

3. The **Speech and Hearing Association (SHAA)** is Alabama’s state organization. Applications for membership may be obtained by visiting [http://www.alabamashaa.org](http://www.alabamashaa.org) or calling (256) 325-8885. Benefits and requirements for membership are also located on the website.
Standards and Implementation for the Certificate of Clinical Competence in Speech-Language Pathology

Standard I: Degree

Effective January 1, 2005, the applicant for certification must have a master's or doctoral or other recognized post-baccalaureate degree. A minimum of 75 semester credit hours must be completed in a course of study addressing the knowledge and skills pertinent to the field of speech-language pathology.

Implementation:

Verification of the graduate degree is required of the applicant before the certificate is awarded. Degree verification is accomplished by submitting (a) an application signed by the director of the graduate program indicating the degree date, and (b) an official transcript showing that the degree has been awarded. Individuals educated in foreign countries must show official transcripts and evaluations of their degrees and courses to verify equivalency.

All graduate course work and graduate clinical practicum required in the professional area for which the Certificate is sought must have been initiated and completed at an institution whose program was accredited by the Council on Academic Accreditation in Audiology and Speech-Language Pathology (CAA) of the American Speech-Language-Hearing Association in the area for which the Certificate is sought.

Automatic Approval. If the graduate program of study is initiated and completed in a CAA-accredited program and if the program director or official designee verifies that all knowledge and skills requirements have been met, approval of the application is automatic provided that the application for the Certificate of Clinical Competence is received in the National Office no more than three years after the degree is awarded.

Evaluation Required. The following categories of applicants must submit a completed application for certification that includes the Knowledge and Skills Acquisition (KASA) summary form for evaluation by the Council For Clinical Certification (CFCC):

a. those who apply more than three years after the completion of the graduate degree from a CAA-accredited program
b. those who were graduate students and were continuously enrolled in a CAA-program that had its accreditation withdrawn during the applicant's enrollment
c. those who satisfactorily completed graduate course work, clinical practicum, and knowledge and skills requirements in the area for which certification is sought in a program that held candidacy status for accreditation
d. those who satisfactorily completed graduate course work, clinical practicum, and knowledge and skills requirements in speech-language pathology in a CAA-
program, but: 1) received a graduate degree from a program not accredited by CAA; 2) received a graduate degree in a related area, or 3) received a graduate degree from a non-U.S. institution of higher education

The graduate program director must verify satisfactory completion of both undergraduate and graduate academic course work, clinical practicum, and knowledge and skills requirements.

**Standard II: Institution of Higher Education**

The graduate degree must be granted by a regionally accredited institution of higher education.

Implementation:

The institution of higher education must be accredited by one of the following:
Commission of Higher Education, Middle States Association of Colleges and Schools; Commission on Institutions of Higher Education, New England Association of Schools and Colleges; Commission on Institutions of Higher Education, North Central Association of Colleges and Schools; Commission on Colleges, Northwest Association of Schools and Colleges; Commission on Colleges, Southern Association of Colleges and Schools; or Accrediting Commission for Senior Colleges and Universities, Western Association of Schools and Colleges.

Individuals educated in foreign countries must submit documentation that course work was completed in an institution of higher education that is regionally accredited or recognized by the appropriate regulatory authority for that country. In addition, applicants educated in foreign countries must meet each of the Standards that follow.

**Standard III: Program of Study – Knowledge Outcomes**

The applicant for certification must complete a program of study (a minimum of 75 semester credit hours overall, including at least 36 at the graduate level) that includes academic course work sufficient in depth and breadth to achieve the specified knowledge outcomes.

Implementation:

The program of study must address the knowledge and skills pertinent to the field of speech-language pathology. The applicant must maintain documentation of course work at both undergraduate and graduate levels demonstrating that the requirements in this standard have been met. The minimum 75 semester credit hours may include credit earned for course work, clinical practicum, research, or thesis/dissertation. Verification is accomplished by submitting an official transcript showing that the minimum credit hours have been completed.
Standard III-A: The applicant must have prerequisite knowledge of the biological sciences, physical sciences, mathematics, and the social/behavioral sciences.

Implementation:

The applicant must demonstrate through transcript credit (which could include course work, advanced placement, CLEP, or examination of equivalency) for each of the following areas: biological sciences, physical sciences, mathematics, and the social/behavioral sciences. Appropriate course work in biological sciences could include, among others, biology, general anatomy and physiology, neuro-anatomy and neurophysiology, and genetics. Course work in physical sciences could include, among others, physics and chemistry. Course work in behavioral sciences could include, among others, psychology, sociology, and cultural anthropology. Course work in math could include, among others, statistics and non-remedial mathematics. The intent of this standard is to require students to have a broad liberal arts and science background. Courses in biological and physical sciences specifically related to communication sciences and disorders (CSD) cannot be applied for certification purposes in this category. In addition to transcript credit, applicants may be required by their graduate program to provide further evidence of meeting this requirement.

Standard III-B: The applicant must demonstrate knowledge of basic human communication and swallowing processes, including their biological, neurological, acoustic, psychological, developmental, and linguistic and cultural bases.

Implementation:

This standard emphasizes the basic human communication processes. The applicant must demonstrate the ability to integrate information pertaining to normal and abnormal human development across the life span, including basic communication processes and the impact of cultural and linguistic diversity on communication. Similar knowledge must also be obtained in swallowing processes and new emerging areas of practice. Program documentation may include transcript credit and information obtained by the applicant through clinical experiences, independent studies, and research projects.

Standard III-C: The applicant must demonstrate knowledge of the nature of speech, language, hearing, and communication disorders and differences and swallowing disorders, including the etiologies, characteristics, anatomical/physiological, acoustic, psychological, developmental, and linguistic and cultural correlates. Specific knowledge must be demonstrated in the following areas:

- articulation
- fluency
- voice and resonance, including respiration and phonation
- receptive and expressive language (phonology, morphology, syntax, semantics, and pragmatics) in speaking, listening, reading, writing, and manual modalities
- hearing, including the impact on speech and language
swallowing (oral, pharyngeal, esophageal, and related functions, including oral function for feeding; orofacial myofunction)
• cognitive aspects of communication (attention, memory, sequencing, problem-solving, executive functioning)
• social aspects of communication (including challenging behavior, ineffective social skills, lack of communication opportunities)
• communication modalities (including oral, manual, augmentative, and alternative communication techniques and assistive technologies)

Implementation:

The applicant must demonstrate the ability to integrate information delineated in this standard. Program documentation may include transcript credit and information obtained by the applicant through clinical experiences, independent studies, and research projects. It is expected that course work addressing the professional knowledge specified in Standard III-C will occur primarily at the graduate level. The knowledge gained from the graduate program should include an effective balance between traditional parameters of communication (articulation/phonology, voice, fluency, language, and hearing) and additional recognized and emerging areas of practice (e.g., swallowing, upper aerodigestive functions).

Standard III-D: The applicant must possess knowledge of the principles and methods of prevention, assessment, and intervention for people with communication and swallowing disorders, including consideration of anatomical/physiological, psychological, developmental, and linguistic and cultural correlates of the disorders.

Implementation:

The applicant must demonstrate the ability to integrate information about prevention, assessment, and intervention over the range of differences and disorders specified in Standard III-C above. Program documentation may include transcript credit and information obtained by the applicant through clinical experiences, independent studies, and research projects.

Standard III-E: The applicant must demonstrate knowledge of standards of ethical conduct.

Implementation:

The applicant must demonstrate knowledge of, appreciation for, and ability to interpret the ASHA Code of Ethics. Program documentation must reflect course work, workshop participation, instructional module, clinical experiences, and independent projects.

Standard III-F: The applicant must demonstrate knowledge of processes used in research and the integration of research principles into evidence-based clinical practice.
Implementation:

The applicant must demonstrate comprehension of the principles of basic and applied research and research design. In addition, the applicant should know how to access sources of research information and have experience relating research to clinical practice. Program documentation could include information obtained through class projects, clinical experiences, independent studies, and research projects.

**Standard III-G: The applicant must demonstrate knowledge of contemporary professional issues.**

Implementation:

The applicant must demonstrate knowledge of professional issues that affect speech-language pathology as a profession. Issues typically include professional practice, academic program accreditation standards, ASHA practice policies and guidelines, and reimbursement procedures. Documentation could include information obtained through clinical experiences, workshops, and independent studies.

**Standard III-H: The applicant must demonstrate knowledge about certification, specialty recognition, licensure, and other relevant professional credentials.**

Implementation:

The applicant must demonstrate knowledge of state and federal regulations and policies related to the practice of speech-language pathology and credentials for professional practice. Documentation could include course modules and instructional workshops.

**Standard IV: Program of Study—Skills Outcomes**

**Standard IV-A: The applicant must complete a curriculum of academic and clinical education that follows an appropriate sequence of learning sufficient to achieve the skills outcomes in Standard IV-G.**

Implementation:

The applicant's program of study should follow a systematic knowledge- and skill-building sequence in which basic course work and practicum precede, insofar as possible, more advanced course work and practicum.

**Standard IV-B: The applicant must possess skill in oral and written or other forms of communication sufficient for entry into professional practice.**
Implementation:
The applicant must demonstrate communication skills sufficient to achieve effective clinical and professional interaction with clients/patients and relevant others. For oral communication, the applicant must demonstrate speech and language skills in English, which, at a minimum are consistent with ASHA's most current position statement on students and professionals who speak English with accents and nonstandard dialects. For written communication, the applicant must be able to write and comprehend technical reports, diagnostic and treatment reports, treatment plans, and professional correspondence.

Individuals educated in foreign countries must meet the criteria required by the International Commission of Healthcare Professionals (ICHP) in order to meet this standard.

Standard IV-C: The applicant for certification in speech-language pathology must complete a minimum for 400 clock hours of supervised clinical experience in the practice of speech-language pathology. Twenty-five hours must be spent in clinical observation, and 375 hours must be spent in direct client/patient contact.

Implementation:

Observation hours general precede direct contact with clients/patients. However, completion of all 25 observation hours is not a prerequisite to begin direct client/patient contact. For certification purposes, the observation and direct client/patient contact hours must be within the scope of practice of speech-language pathology.

For certification purposes, observation experiences must be under the direction of a qualified clinical supervisor who holds current ASHA certification in the appropriate practice area. Such direction may occur simultaneously with the student's observation or may be through review and approval of written reports or summaries submitted by the student. Students may use videotapes of the provision of client services for observation purposes. The applicant must maintain documentation of time spent in supervised observation, verified by the program in accordance with Standards III and IV.

Applicants should be assigned practicum only after they have acquired sufficient knowledge bases to qualify for such experience. Only direct contact with the client or the client's family in assessment, management, and/or counseling can be counted toward practicum. Although several students may observe a clinical session at one time, clinical practicum hours should be assigned only to the student who provides direct services to the client or client's family. Typically, only one student should be working with a given client. In rare circumstances, it is possible for several students working as a team to receive credit for the same session depending on the specific responsibilities each student is assigned. For example, in a diagnostic session, if one student evaluates the client and another interviews the parents, both students may receive credit for the time each spent in providing the service. However, if one student works with the client for 30 minutes and another student works with the client for the next 45 minutes, each student receives credit for the time he/she actually provided services—that is, 30 and 45 minutes respectively,
not 75 minutes. The applicant must maintain documentation of time spent in supervised practicum, verified by the program in accordance with Standards III and IV.

**Standard IV-D:** At least 325 of the 400 clock hours must be completed while the applicant is engaged in graduate study in a program accredited in speech-language pathology by the Council on Academic Accreditation in Audiology and Speech-Language Pathology.

Implementation:

A minimum of 325 clock hours of clinical practicum must be completed at the graduate level. The remaining required hours may have been completed at the undergraduate level, at the discretion of the graduate program.

**Standard IV-E:** Supervision must be provided by individuals who hold the Certificate of Clinical Competence in the appropriate area of practice. The amount of supervision must be appropriate to the student's level of knowledge, experience, and competence. Supervision must be sufficient to ensure the welfare of the client/patient.

Implementation:

Direct supervision must be in real time and must never be less than 25% of the student's total contact with each client/patient and must take place periodically throughout the practicum. These are minimum requirements and should be adjusted upward if the student's level of knowledge, experience, and competence warrants. A supervisor must be available to consult as appropriate for the client's/patient's disorder with a student providing clinical services as part of the student's clinical education. Supervision of clinical practicum must include direct observation, guidance, and feedback to permit the student to monitor, evaluate, and improve performance and to develop clinical competence.

All observation and clinical practicum hours used to meet Standard IV-C must be supervised by individuals who hold a current CCC in the professional area in which the observation and practicum hours are being obtained. Only the supervisor who actually observes the student in a clinical session is permitted to verify the credit given to the student for the clinical practicum hours.

**Standard IV-F:** Supervised practicum must include experience with client/patient populations across the life span and from culturally/linguistically diverse backgrounds. Practicum must include experience with client/patient populations with various types and severities of communication and/or related disorders, differences, and disabilities.
Implementation:
The applicant must demonstrate direct client/patient clinical experiences in both
diagnosis and treatment with both children and adults from the range of disorders and
differences named in Standard III-C.

Standard IV-G: The applicant for certification must complete a program of study
that includes supervised clinical experiences sufficient in breadth and depth to
achieve the following skills outcomes:

1. Evaluation
   a. Conduct screening and prevention procedures (including prevention activities).
   b. Collect case history information and integrate information from clients/patients,
      family, caregivers, teachers, relevant others, and other professionals.
   c. Select and administer appropriate evaluation procedures, such as behavioral
      observations, non-standardized and standardized tests, and instrumental
      procedures.
   d. Adapt evaluation procedures to meet client/patient needs.
   e. Interpret, integrate, and synthesize all information to develop diagnoses and make
      appropriate recommendations for intervention.
   f. Complete administrative and reporting functions necessary to support evaluation.
   g. Refer clients/patients for appropriate services.

2. Intervention
   a. Develop setting-appropriate intervention plans with measurable and achievable
      goals that meet clients'/patients' needs. Collaborate with clients/patients and
      relevant others in the planning process.
   b. Implement intervention plans (involve clients/patients and relevant others in the
      intervention process).
   c. Select or develop and use appropriate materials and instrumentation for
      prevention and intervention.
   d. Measure and evaluate clients'/patients' performance and progress.
   e. Modify intervention plans, strategies, materials, or instrumentation as appropriate
      to meet the needs of clients/patients.
   f. Complete administrative and reporting functions necessary to support
      intervention.
   g. Identify and refer clients/patients for services as appropriate.

3. Interaction and Personal Qualities
   a. Communicate effectively, recognizing the needs, values, preferred mode of
      communication, and cultural/linguistic background of the client/patient, family,
      caregivers, and relevant others.
   b. Collaborate with other professionals in case management.
   c. Provide counseling regarding communication and swallowing disorders to
      clients/patients, family, caregivers, and relevant others.
d. Adhere to the ASHA Code of Ethics and behave professionally.

Implementation:

The applicant must document the acquisition of the skills referred to in this Standard applicable across the nine major areas listed in Standard III-C. Clinical skills may be developed and demonstrated by means other than direct client/patient contact in clinical practicum experiences, such as academic course work, labs, simulations, examinations, and completion of independent projects. This documentation must be maintained and verified by the program director or official designee.

For certification purposes, only direct client/patient contact may be applied toward the required minimum of 375 clock hours of supervised clinical experience.

**Standard V: Assessment**

The applicant for certification must demonstrate successful achievement of the knowledge and skills delineated in Standard III and Standard IV by means of both formative and summative assessment.

**Standard V-A: Formative Assessment**

The applicant must meet the education program's requirements for demonstrating satisfactory performance through on-going formative assessment of knowledge and skills.

Implementation:

Formative assessment yields critical information for monitoring an individual's acquisition of knowledge and skills. Therefore, to ensure that the applicant pursues the outcomes stipulated in Standard III and Standard IV in a systematic manner, academic and clinical educators must have assessed developing knowledge and skills throughout the applicant's program of graduate study. Applicants may also be part of the process through self-assessment. Applicants and program faculties should use the on-going assessment to help the applicant achieve requisite knowledge and skills. Thus, assessments should be followed by implementation of strategies for acquisition of knowledge and skills.

The applicant must adhere to the academic program's formative assessment process and must maintain records verifying on-going formative assessment. The applicant shall make these records available to the Council for Clinical Certification upon its request. Documentation of formative assessment may take a variety of forms, such as checklists of skills records of progress in clinical skill development, portfolios, and statements of achievement of academic and practicum course objectives, among others.

**Standard V-B: Summative Assessment**
The applicant must pass the national examination adopted by ASHA for purposes of certification in speech-language pathology.

Implementation:

Summative assessment is a comprehensive examination of learning outcomes at the culmination of professional preparation. Evidence of a passing score on the ASHA-approved national examination in speech-language pathology must be submitted to the National Office by the testing agency administering the examination.

**Standard VI: Speech-Language Pathology Clinical Fellowship**

After completion of academic coursework and practicum (Standard IV), the applicant then must successfully complete a Speech-Language Pathology Clinical Fellowship (SLPCF).

Implementation:

The Clinical Fellow may be engaged in clinical service delivery or clinical research that fosters the continued growth and integration of the knowledge, skills, and tasks of clinical practice in speech-language pathology consistent with ASHA's current Scope of Practice. At least 80% of the Clinical Fellow's major responsibilities during the CF experience must be in direct client/patient contact, consultations, record keeping, and administrative duties. For example, in a 5-hour work week, at least 4 hours must consist of direct clinical activities; in a 15-hour work week, at least 12 hours must consist of direct clinical activities; in a 35-hour work week, at least 28 hours must consist of direct clinical activities.

The SLPCF may not be initiated until completion of the graduate course work and graduate clinical practicum required for ASHA certification.

It is the Clinical Fellow's responsibility to identify a mentoring speech-language pathologist (SLP) who holds a current Certificate of Clinical Competence in Speech-Language Pathology to provide the requisite on-site and other monitoring activities mandated during the SLPCF experience. Before beginning the SLPCF, the Clinical Fellow must contact the ASHA National office to verify the mentoring SLP's certification status. The mentoring SLP must hold ASHA certification throughout the SLPCF period. Should the certification status of the mentoring SLP change during the experience, the Clinical Fellow will be awarded credit only for that portion of time during which the mentoring SLP held certification. It is, therefore, incumbent on the Fellow to verify the mentoring SLP's status not only at the beginning of the experience but also at the beginning of each new year.

A family member or individual related in any way to the clinical fellow may not serve as a mentoring SLP.
Standard VI-A: The mentoring speech-language pathologist and Speech-Language Pathology Clinical Fellow will establish outcomes and performance levels to be achieved during the Speech-Language Pathology Fellowship (SLPCF), based on the Clinical Fellow's academic experiences, setting-specific requirements, and professional interests/goals.

Implementation:

The Clinical Fellow and mentoring SLP will determine outcomes and performance levels in a goal-setting conference within four weeks of initiating the SLPCF. It is the Clinical Fellow's and the mentoring SLP's responsibility to each retain documentation of agreed-upon outcomes and performance levels. The mentoring SLP's guidance should be adequate throughout the SLPCF to permit the CF to achieve the stated outcomes, and to ensure that the Clinical Fellow can function independently by the completion of the SLPCF. At the conclusion of the experience, the Clinical Fellow will submit the Clinical Fellowship Report and Rating Form to the Council For Clinical Certification (CFCC). Prior to submitting documentation to the CFCC, the Clinical Fellow and mentoring SLP should make copies of all forms for their files.

Standard VI-B: The Clinical Fellow and mentoring SLP must engage in periodic assessment of the Clinical Fellow's performance, evaluating the Clinical Fellow's progress toward meeting the established goals and achievement of the clinical skills necessary for independent practice.

Implementation:

Assessment of performance may be both formal and informal means. The Clinical Fellow and mentoring SLP should keep a written record of assessment processes and recommendations. One means of assessment must be the Clinical Fellowship Report and Rating Form.

The mentoring SLP must engage in no fewer than 36 supervisory activities during the clinical fellowship experience. This supervision must include 18 on-site observations of direct client contact at the clinical fellow's work site (1 hour = 1 on-site observation; a maximum of 6 on-site observations may be accrued in one day). At least six on-site observations must be conducted during each third of the CF experience. On-site observations must consist of the clinical fellow engaged in screening, evaluation, assessment, and/or habilitation/rehabilitation activities.

Additionally, supervision must also include 18 other monitoring activities. At least six other monitoring activities must be conducted during each third of the CF experience. Other monitoring activities are defined as evaluation of reports written by the Clinical Fellow, conferences between the mentoring SLP and the Clinical Fellow, discussions with professional colleagues of the Fellow, etc., and may be executed by correspondence, telephone, or reviewing of video and/or audio tapes.
On very rare occasions the CFCC may allow the supervisory process to be conducted in other ways. However, a request for other supervisory mechanisms must be submitted in written form to the CFCC before the CF is initiated. The request must include the reason for the alternative supervision and a description of the supervision that would be provided. At a minimum, such a request must outline the type, length, and frequency of the supervision that would be provided. If the request is to use videotapes instead of direct observations, the outline must indicate how many hours will be videotaped, how often the tapes will be made, and how feedback from the mentoring SLP will be provided. Whenever possible, the mentoring SLP and the Clinical Fellow should make arrangements to view the tapes together so that communication about the feedback being provided is immediate.

Standard VI-C: The Speech-Language Pathology Clinical Fellowship (SLPCF) will consist of the equivalent of 36 weeks of full-time clinical practice.

Implementation:

Full-time clinical practice is defined as a minimum of 35 hours per week in direct client/patient contact, consultations, record keeping, and administrative duties relevant to a bona fide program of clinical work. The Clinical Fellowship experience must total no less than 1,260 hours, accumulated within 48 months of the beginning date of the experience.

Professional experience of less than five hours per week does not meet the requirement and may not be counted toward the SLPCF. Similarly, experience of more than 35 hours per week cannot be used to shorten the SLPCF to less than 36 weeks. NOTE: Clinical Fellows are strongly urged to contact their state regulatory agency/state licensing board to determine licensure requirements for the Clinical Fellowship. State licensure requirements may differ from those for ASHA certification. Failure to comply with state requirements may lead to fellowship experience that is considered invalid for licensure.

Once initiated, the Clinical Fellowship experience must be completed within four years (48 months). Clinical Fellows working less than full-time should be aware that they will need to extend their experience for a longer period of time to meet the CF requirement of 1,260 hours. If the CF is not completed within 48 months of initiation, the Clinical Fellow will be required to reapply for certification and must meet the standards in effect at the time of reapplication.

Standard VI-D: The Clinical Fellow must submit evidence of successful completion of the Speech-Language Pathology Clinical Fellowship (SLPCF) to the Council For Clinical Certification.

Implementation:

Once the Clinical Fellow has accumulated the requisite 1,260 hours, the SLPCF Report and Rating Form [PDF], which includes the Clinical Fellowship Skills Inventory (CFSI),
must be submitted. This report must be completed by both the Clinical Fellow and mentoring speech-language pathologist.

**Standard VII: Maintenance of Certification**

**Demonstration of continued professional development is mandated for maintenance of the Certificate of Clinical Competence in Speech-Language Pathology. The renewal period will be three years. This standard will apply to all certificate holders, regardless of the date of initial certification.**

**Implementation:**

Individuals who hold the Certificate of Clinical Competence (CCC) in Speech-Language Pathology must accumulate 30 contact hours of professional development over the 3-year period in order to meet this standard. Individuals will be subject to a random review of their professional development activities.

If renewal of certification is not accomplished within the 3-year period, certification will lapse. Reinstatement of certification will be required, and certification standards in effect at the time of submission of the reinstatement application must be met.

In preparation, accrual and submission of the professional development activities during the certification maintenance interval, all activities must be guided by adherence to the ASHA Code of Ethics.

Continued professional development may be demonstrated through one or more of the following options:

- Accumulation of 3 Continuing Education Units (CEUs) (30 contact hours) from continuing education providers approved by ASHA. ASHA CEUs may be earned through group activities (e.g., workshops, conferences), independent study (e.g., course development, research projects, internships, attendance at educational programs offered by non-ASHA CE providers), and self-study (e.g., videotapes, audiotapes, journals).
- Accumulation of 3 CEUs (30 contact hours) from a provider authorized by the International Association for Continuing Education and Training (IACET).
- Accumulation of 2 semester credit hours (3 quarter-hours) from a college or university that holds regional accreditation or accreditation from an equivalent nationally recognized or governmental accreditation authority.
- Accumulation of 30 contact hours from employer-sponsored in-service or other continuing education activities that contribute to professional development.

The ASHA Clinical Certification Standards define professional development as an instructional activity

- where the certificate holder is the learner;
• that is related to the science or contemporary practice of speech-language pathology, audiology, and/or the speech/language/hearing sciences;
• that results in the acquisition of new knowledge and skills or the enhancement of current knowledge and skills necessary for independent practice in any practice setting and area of practice;
• where the certificate holder is responsible for determining that the professional development activity is appropriate, relevant and meaningful to any practice setting and area of practice;
• in which the certificate holder's attendance can be documented by a third party such as an employer, educational institution, or sponsoring organization.
Preamble

The preservation of the highest standards of integrity and ethical principles is vital to the responsible discharge of obligations by speech-language pathologists, audiologists, and speech, language, and hearing scientists. This Code of Ethics sets forth the fundamental principles and rules considered essential to this purpose.

Every individual who is (a) a member of the American Speech-Language-Hearing Association, whether certified or not, (b) a nonmember holding the Certificate of Clinical Competence from the Association, (c) an applicant for membership or certification, or (d) a Clinical Fellow seeking to fulfill standards for certification shall abide by this Code of Ethics.

Any violation of the spirit and purpose of this Code shall be considered unethical. Failure to specify any particular responsibility or practice in this Code of Ethics shall not be construed as denial of the existence of such responsibilities or practices.

The fundamentals of ethical conduct are described by Principles of Ethics and by Rules of Ethics as they relate to the responsibility to persons served, the public, speech-language pathologists, audiologists, and speech, language, and hearing scientists, and to the conduct of research and scholarly activities.

Principles of Ethics, aspirational and inspirational in nature, form the underlying moral basis for the Code of Ethics. Individuals shall observe these principles as affirmative obligations under all conditions of professional activity.

Rules of Ethics are specific statements of minimally acceptable professional conduct or of prohibitions and are applicable to all individuals.

Principle of Ethics I

Individuals shall honor their responsibility to hold paramount the welfare of persons they serve professionally or who are participants in research and scholarly activities, and they shall treat animals involved in research in a humane manner.
Rules of Ethics

1. Individuals shall provide all services competently.
2. Individuals shall use every resource, including referral when appropriate, to ensure that high-quality service is provided.
3. Individuals shall not discriminate in the delivery of professional services or the conduct of research and scholarly activities on the basis of race or ethnicity, gender, gender identity/gender expression, age, religion, national origin, sexual orientation, or disability.
4. Individuals shall not misrepresent the credentials of assistants, technicians, support personnel, students, Clinical Fellows, or any others under their supervision, and they shall inform those they serve professionally of the name and professional credentials of persons providing services.
5. Individuals who hold the Certificate of Clinical Competence shall not delegate tasks that require the unique skills, knowledge, and judgment that are within the scope of their profession to assistants, technicians, support personnel, or any nonprofessionals over whom they have supervisory responsibility.
6. Individuals who hold the Certificate of Clinical Competence may delegate tasks related to provision of clinical services to assistants, technicians, support personnel, or any other persons only if those services are appropriately supervised, realizing that the responsibility for client welfare remains with the certified individual.
7. Individuals who hold the Certificate of Clinical Competence may delegate tasks related to provision of clinical services that require the unique skills, knowledge, and judgment that are within the scope of practice of their profession to students only if those services are appropriately supervised. The responsibility for client welfare remains with the certified individual.
8. Individuals shall fully inform the persons they serve of the nature and possible effects of services rendered and products dispensed, and they shall inform participants in research about the possible effects of their participation in research conducted.
9. Individuals shall evaluate the effectiveness of services rendered and of products dispensed, and they shall provide services or dispense products only when benefit can reasonably be expected.
10. Individuals shall not guarantee the results of any treatment or procedure, directly or by implication; however, they may make a reasonable statement of prognosis.
11. Individuals shall not provide clinical services solely by correspondence.
12. Individuals may practice by telecommunication (e.g., telehealth/e-health), where not prohibited by law.
13. Individuals shall adequately maintain and appropriately secure records of professional services rendered, research and scholarly activities conducted, and products dispensed, and they shall allow access to these records only when authorized or when required by law.
14. Individuals shall not reveal, without authorization, any professional or personal information about identified persons served professionally or identified participants involved in research and scholarly activities unless doing so is necessary to protect the welfare of the person or of the community or is otherwise required by law.
15. Individuals shall not charge for services not rendered, nor shall they misrepresent services rendered, products dispensed, or research and scholarly activities conducted.
16. Individuals shall enroll and include persons as participants in research or teaching demonstrations only if their participation is voluntary, without coercion, and with their informed consent.
17. Individuals whose professional services are adversely affected by substance abuse or other health-related conditions shall seek professional assistance and, where appropriate, withdraw from the affected areas of practice.
18. Individuals shall not discontinue service to those they are serving without providing reasonable notice.
Principle of Ethics II

Individuals shall honor their responsibility to achieve and maintain the highest level of professional competence and performance.
Rules of Ethics

1. Individuals shall engage in the provision of clinical services only when they hold the appropriate Certificate of Clinical Competence or when they are in the certification process and are supervised by an individual who holds the appropriate Certificate of Clinical Competence.
2. Individuals shall engage in only those aspects of the professions that are within the scope of their professional practice and competence, considering their level of education, training, and experience.
3. Individuals shall engage in lifelong learning to maintain and enhance professional competence and performance.
4. Individuals shall not require or permit their professional staff to provide services or conduct research activities that exceed the staff member's competence, level of education, training, and experience.
5. Individuals shall ensure that all equipment used to provide services or to conduct research and scholarly activities is in proper working order and is properly calibrated.

Principle of Ethics III

Individuals shall honor their responsibility to the public by promoting public understanding of the professions, by supporting the development of services designed to fulfill the unmet needs of the public, and by providing accurate information in all communications involving any aspect of the professions, including the dissemination of research findings and scholarly activities, and the promotion, marketing, and advertising of products and services.

Rules of Ethics

1. Individuals shall not misrepresent their credentials, competence, education, training, experience, or scholarly research contributions.
2. Individuals shall not participate in professional activities that constitute a conflict of interest.
3. Individuals shall refer those served professionally solely on the basis of the interest of those being referred and not on any personal interest, financial or otherwise.
4. Individuals shall not misrepresent research, diagnostic information, services rendered, results of services rendered, products dispensed, or the effects of products dispensed.
5. Individuals shall not defraud or engage in any scheme to defraud in connection with obtaining payment, reimbursement, or grants for services rendered, research conducted, or products dispensed.
6. Individuals' statements to the public shall provide accurate information about the nature and management of communication disorders, about the professions, about professional services, about products for sale, and about research and scholarly activities.
7. Individuals' statements to the public when advertising, announcing, and marketing their professional services; reporting research results; and promoting products shall adhere to professional standards and shall not contain misrepresentations.

Principle of Ethics IV

Individuals shall honor their responsibilities to the professions and their relationships with colleagues, students, and members of other professions and disciplines.
Rules of Ethics

1. Individuals shall uphold the dignity and autonomy of the professions, maintain harmonious interprofessional and intraprofessional relationships, and accept the professions' self-imposed standards.
2. Individuals shall prohibit anyone under their supervision from engaging in any practice that violates the Code of Ethics.
3. Individuals shall not engage in dishonesty, fraud, deceit, or misrepresentation.
4. Individuals shall not engage in any form of unlawful harassment, including sexual harassment or power abuse.
5. Individuals shall not engage in any other form of conduct that adversely reflects on the professions or on the individual's fitness to serve persons professionally.
6. Individuals shall not engage in sexual activities with clients, students, or research participants over whom they exercise professional authority or power.
7. Individuals shall assign credit only to those who have contributed to a publication, presentation, or product. Credit shall be assigned in proportion to the contribution and only with the contributor's consent.
8. Individuals shall reference the source when using other persons' ideas, research, presentations, or products in written, oral, or any other media presentation or summary.
9. Individuals' statements to colleagues about professional services, research results, and products shall adhere to prevailing professional standards and shall contain no misrepresentations.
10. Individuals shall not provide professional services without exercising independent professional judgment, regardless of referral source or prescription.
11. Individuals shall not discriminate in their relationships with colleagues, students, and members of other professions and disciplines on the basis of race or ethnicity, gender, gender identity/gender expression, age, religion, national origin, sexual orientation, or disability.
12. Individuals shall not file or encourage others to file complaints that disregard or ignore facts that would disprove the allegation, nor should the Code of Ethics be used for personal reprisal, as a means of addressing personal animosity, or as a vehicle for retaliation.
13. Individuals who have reason to believe that the Code of Ethics has been violated shall inform the Board of Ethics.
14. Individuals shall comply fully with the policies of the Board of Ethics in its consideration and adjudication of complaints of violations of the Code of Ethics.


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