Speech Therapy Treatment Plan

eviCore healthcare
FAX (888) 565-4225

Date of this Request___/___/___
Please check type of care:
☐Initial care ☐Continuing care

INSURED

Patient Last Name	Patient First Name	M.I.	Gender ☐ M ☐ F	Age	Date of Birth (MM/DD/YYYY) ______/_____/_______
Insured I.D. or SSN	Insured Last Name	M.I.	First Name		Patient Phone (area code first)
Patient Address	City			State	Zip Code

PAYOR

Employer Name	Insurance Company	Group Plan # or Union Local (Submit Copy of Patient's Insurance I.D. Card)	
Injury or illness is related to: ☐ Work ☐ Auto ☐ Other	Referring Physician/Practitioner	Doctor License #	Date of Referral ______/_____/_______

ST

Therapist Last Name	Therapist First Name	M.I.	Group Name		Provider/Group ID#
Provider/Group Address	City		State	Zip Code	Phone # ( ) Fax # ( )

PATIENT'S CURRENT MEDICAL HISTORY

Previous Speech Therapy History
1st Visit ___/___/______ Discharge Date___/___/______ # of Visits _________

Subjective Complaints:

(Circle one) Immediate pt. safety issue *or* Functional decline/improvement in ADLs

Mechanism of Onset for Primary Diagnosis
Date of Onset ___/___/______ *Date of Initial Evaluation* ___/___/______
☐ Acute Onset ☐ Developmental
☐ Congenital ☐ Neuro/CV/Cerebral Event
☐ Chronic ☐ Other
Description:

Objective Findings *(note any deficits)*	Date obtained ____/____/______	Mild	Moderate	Severe
Attention/orientation				
Initiation/follow-through				
Problem solving/judgment				
Sequencing/organization				
Following directions	1-step			
	2-step			
	multi-step			
Verbal expression	word level			
	sentence level			
	Conversational			
	basic needs			
Motor speech				
Voice				
Fluency/prosody				
Pragmatics				
Swallow dysfunction	Preparatory			
	Oral			
	Pharyngeal (suspected)			
	Esophageal (suspected)			
Other				

Current condition
Date of onset __/__/____ Date of initial evaluation __/__/____
New condition ☐
Gradual onset ☐
Behavioral change ☐
Worsening of prior illness/trauma ☐
Trauma ☐
Pt/family request ☐
Other ☐

Summary of Clinical Findings

Date of first tx at this office for this condition _____/_____/______
Anticipated Release Date _____/_____/______

DIAGNOSES

ICD Code:	Description:
1. Primary ____________________	____________________
2. Secondary ____________________	____________________
3. Additional ____________________	____________________
4. Additional ____________________	____________________

Additional Diagnostic Info
Videofluroscopy ☐
Endoscopy ☐
CXR results ☐
Other (describe) ☐
Summary:

Prognostic Indicators
Motivation ☐
Cueing Responsiveness ☐
Active Caregiver Participation ☐
Safety Awareness ☐

TREATMENT PLAN

Treatment Plan (MM/DD/YYYY)
From ________/_______/__________
To _______/_______/___________
No. of Visits Requested ___________

Treatment Goals (Functional Improvement and Outcomes Expected)

Special Considerations:
Alternate nutritional delivery
Augmentive devices
Tracheostomy/Ventilator
Other:

I declare that the above information is true and correct to the best of my knowledge. Further, it is my professional judgment that speech therapy is not contraindicated for this patient. If I am required under state law to obtain a prescription prior to rendering this treatment, I have obtained such a prescription in compliance with state law.

Signature____Date____________________