



PLACE LABEL HERE.  
  
IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

**Pediatric Speech-Language Evaluation Form (Birth to 5 Years)**

Name: \_\_\_\_\_ Chronological Age: \_\_\_\_\_ Duration: \_\_\_\_\_

Eval Date/Time: \_\_\_\_\_

Precautions: \_\_\_\_\_

Referring MD: \_\_\_\_\_

History: \_\_\_\_\_

Social history: \_\_\_\_\_

Prior level of function: \_\_\_\_\_

Hearing status: \_\_\_\_\_

Evaluation tools: \_\_\_\_\_

Subjective observations of state: \_\_\_\_\_

- awake  alert  calm  distressed/fussy  crying  impulsive  decreased initiation
- lethargic  Other: \_\_\_\_\_

Positioning: \_\_\_\_\_

Pain Assessment:  present  absent pain scale used: \_\_\_\_\_ Intervention: \_\_\_\_\_

**OBJECTIVE**

**LANGUAGE SKILLS**

Parent report of receptive/expressive language skills: \_\_\_\_\_

Observed receptive language skills: \_\_\_\_\_

Observed expressive language skills: \_\_\_\_\_

Primary method of comprehension:  verbal  sign  gestures  demonstration

Primary method of expressive language:  gestures  signs  vocalizations  verbalizations

Communicative intent:  Yes  No

**SPEECH**

Oral-motor/Motor Speech Function:  WFL  dysarthria  oral/verbal apraxia

Articulation:  Developmentally appropriate  Delayed  Disordered

Articulation errors:

Intelligibility:

- WFL  mild (75% intelligible)  moderate (50% intelligible)  severe (<50% intelligible)
- profound (<25% intelligible)

	WFL	ATYPICAL	COMMENTS
<b>VOICE</b>			
<b>FLUENCY</b>			
<b>PRAGMATICS</b>	WFL	ATYPICAL	COMMENTS
<b>SOCIAL SKILLS</b>			
Eye contact			
Taking turn			
Gestures			
Facial Expressions			
Affect			
Play Skills			

**FAMILY EDUCATION**

\* Not Completed at this time due to \_\_\_\_\_  
 \* Completed:  
 Instruction given to: \* Patient \* Caregiver/Family \_\_\_\_\_ Other: \_\_\_\_\_  
 Barriers to instructions: \* None \* Language \* Cognitive \* Educational \* Other: \_\_\_\_\_  
 Methods of teaching: \* Demonstration \* Explanation \* Handout/Video \* Other: \_\_\_\_\_  
 Response to teaching: \* Demonstrates understanding \* Needs review/reinforcement \* No evidence of learning  
 \* Other: \_\_\_\_\_

**CLINICAL FINDINGS**

**ASSESSMENT:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

DEVELOPMENT LEVELS: Language: expressive- \_\_\_\_\_ receptive- \_\_\_\_\_  
 Articulation: \_\_\_\_\_

CONSULTS REQUESTED: \_\_\_\_\_

**TREATMENT PLAN**

THERAPY RECOMMEND? \* **YES** FREQUENCY \_\_\_\_\_ X week for \_\_\_\_\_ days up to \_\_\_\_\_ minutes per week  
 \* NO-d/c date \_\_\_\_\_

PATIENT GOAL(S): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

LONG TERM GOAL(S): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

SHORT TERM GOAL(S): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 Speech-Language Pathologist

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Phone/PIC#

\* (Medicare Part B Only)  
 I approve of this plan of care signature/pic \_\_\_\_\_ date \_\_\_\_\_