

SPEECH THERAPY ASSESSMENT AND TREATMENT FORM

1. PATIENT DETAILS

Neonatal >> BABY CLINIC

Name and Surname	Baby:	Mother:		NHCU /PICU /PNU /KMC Cubicle:	
Patient ID/DOB:		Age:	M	F	H 0 1 2 3 4
Address:		Tel No:		Account No:	
Closest Hospital/Clinic:		Language:		Younger than 6 (ECD) ☒ N	
Patient receives Governmental Grant	Yes	No	☐ CSG Other:	☐ CDG	Date:
PATIENT CONSENT I confirm that I understand: - Proposed treatment, including Treatment benefits & risks - I have the right to refuse treatment - I take responsibility to reschedule follow up appointments if I am unable to attend or have missed scheduled session(s) - Financial implications I freely & voluntarily agree to the required speech therapy assessment & treatment (An interpreter was required and used: Yes /No)					SIGNED CONSENT NOT REQUIRED FOR IN-PATIENTS: HOSPITAL ADMISSION CONSENT COVERS OT
					Signature:
					Date:

1.1 CLINICAL INFORMATION

DIAGNOSIS	BIRTH HISTORY: Born @ Born @ ___/40 weeks NVD // C/S // Assisted Birth weight _____g ☐ NBW [SGA/AGA] APGAR __, __, __ BL: _____ HC: _____ Thompson: Complications: ☐ NNE ☐ HIE ☐ IVH Grade 1/2/3 ☐ Asphyxia ☐ Seizures ☐ MSL ☐ Fetal distress ☐ EONS ☐ LONS ☐ MAS ☐ RDS ☐ CPAP/BIPAP ☐ Aspiration pneumonia ☐ Meningitis ☐ Syndromic					
Medication	Surgeries/Investigations: OAE: Pass ☐ Refer ☐ Date: _____ F/U: _____ CTB: MRI: Ba Swallow:				Mother: Age: _____ G__P__ Lodging/Visiting/Admitted	
TREATMENT REQUIRED:	PRECAUTIONS:		Reason for Termination of Therapy: ☐ Milestones on par ☐ Down Referred ☐ Defaulted ☐ Deceased Date:			
Additional allied health care professionals	HCW ☐ Physio ☐ OT	Name _____	Date _____	HCW ☐ Diet ☐ Audio	Name _____	Date _____
ASSISTIVE DEVICE ISSUED	Device Type _____	Order & issue date _____	Device Type _____	Order & issue date _____		
Referral received from: Hospital/Clinic: ☐ Other: ☐ Ward: _____ OPD: ☐ Firm:						
Name: _____			Date sent: _____		Contact: _____	
Profession: ☐ DR ☐ PT ☐ OT ☐ DT ☐ AUD:			Date received: _____		Rec by: _____	

2. OPD ATTENDANCE/DATES:

Rehab	YEAR J F M A M J J A S O N D YEAR J F M A M J J A S O N D YEAR J F M A M J J A S O N D YEAR J F M A M J J A S O N D
POPD TCB:	
Other	

3. ASSESSMENTS AND OBSERVATIONS:

3.1 Problem Identified in: Indicate: ✓ = Intact X = Not Intact												
Physical function	Neuro-motor function	Mental function	Respiratory function	ADLS	Sensory Function	Vision		Hearing		Speech	Pain	Skin
							Tested:		Tested:			
Mother and Child ☐		School Health ☐		RVD ☐ Exp ☐ Unexp ☐ PCR:		Mental Health ☐		TB ☐		Non-comm Diseases ☐		

3.2 SPEECH THERAPY INITIAL ASSESSMENT

Home Environment	Structure	Brick	RDP	Shack	Care Facility	Other:			Rooms:			
	Water	Y	N	Electricity	Y	N	Toilet	Inside	Outside	Pit	Potty	Nappy
Family / Social	Adults: Children: Primary caregiver:											
Work/School/ Crèche	Child	At Home	Crèche:	Work		U/E	Piece Jobs	Employed: PT/FT	Scholar			
						U/E	Piece Jobs	Employed: PT/FT	Scholar			

3.3 SCREENING

Other:

Assessment Forms Attached	Date	Assessment Forms Attached	Date
Patient / Caregiver / Family Concerns:		ST Treatment Goals:	
ST Print name:		ST Signature:	Date:

4. INITIAL EDUCATION RECORD

Date	Education Topic	Patient/ Caregiver Signature

5. DETAILED TREATMENT RECORD

Patient:

[illegible]

Patient:

[illegible]

5. DETAILED TREATMENT RECORD

Patient: _____
PM

Abbreviations:		ST – Speech Therapy	Tx – Therapist	Ex – Exercise	Ax – Assessment
		Pt – Patient	Rx – Treatment	Ed – Educate/education	Ref – refer / referral
		HE – Home Exercises	FU – Follow up	Dev – development	Corr - Corrected

Date & Time	Treatment Record and Reassessment							
	S:	Arrived on time	Arrived late	New Pt	FU	Accompanied by:		Weight:
		Current age:		Corr Age:		Mother	Gran	Other
O:	Healthy	Unwell	Irritable /Crying	Sleepy	Playful	Cooperative	Passive	
General: Development: ☐ See Ax form [☐ Delays evident ☐ Slight delay ☐ No delays currently] Comment:								
A: ☐ Developmental Ax ☐ General Ax ☐ Ax of: ☐ Rx offered: ☐ Parent education: ☐ Condition ☐ Dev stim ☐ Other: ☐ Home exercise: ☐ Prepared pamphlet ☐ Other								
P: FU @Baby clinic: _____. FU other: _____. D/C or Down-ref: _____. Prepare/ref: _____						Units	ST Sign	
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