

**NORTHCOAST HEALTH CARE MANAGEMENT SERVICES  
SPEECH THERAPY UPDATE FORM**

Provider: \_\_\_\_\_ Payor: \_\_\_\_\_

**PATIENT:** \_\_\_\_\_ Dates of Visits Since Last Auth: \_\_\_\_\_

Visit Classification:  Assessment  Ongoing  Discharge

Initial Status Date: _____	GOALS	Updated Status Date _____
<b>COGNITION:</b>		
<b>AUDITORY COMPREHENSION:</b>		
<b>PHONATION:</b>		
<b>VERBAL EXPRESSION:</b>		
<b>ARTICULATION:</b>		
<b>ORAL MOTOR:</b>		
<b>SWALLOWING:</b>		
<b>READING COMPREHENSION:</b>		

Current Progress / Medical Update: \_\_\_\_\_

**\*\*HOMEBOUND STATUS:** \_\_\_\_\_

**PROJECTED PLAN OF CARE** # of Visits \_\_\_\_\_ wk \_\_\_\_\_  No further needs

Reason for visits: \_\_\_\_\_

**STATUS AT DISCHARGE**

- Goals Met \_\_\_\_\_  Goals not met due to: \_\_\_\_\_  
 Patient aware of discharge  MD notified of discharge

Signature: \_\_\_\_\_ Date: \_\_\_\_\_