SPAU 328

Principles of Evaluation, Diagnosis, and Report Writing in ComD

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Reporting assessment findings

Chapter 5

Information giving conferences

- After completing the assessment procedures, we conduct a meeting with the parents.
  - Introduction
  - Discussion
  - Conclusion

Information giving conferences

- **Introduction**
  - introduce the purpose of the meeting
  - indicate approximately how much time the session will take
  - Report whether adequate information was obtained during the assessment
  - If reporting to caregivers, describe the client's behavior during the assessment

Information giving conferences

- **Discussion**
  - Discuss the major findings and conclusions from the assessment
  - Keep your language easy to understand and jargon-free
  - Emphasize the major points so that the listener will be able to understand and retain the information you present
  - Provide a written report that summarizes findings
  - Use illustrations, charts, and/or diagrams as needed to help explain and clarify certain materials

Information giving conferences

- **Conclusion**
  - Summarize the major findings, conclusions, and recommendations
  - Ask if the listener has any further comments or questions
  - Thank the person for his or her help and interest
  - Describe the next steps that will need to be taken (e.g., seeing the client again, making an appointment with a physician, beginning treatment)

Evaluation/ Diagnostic Report

Evaluation/ diagnostic report

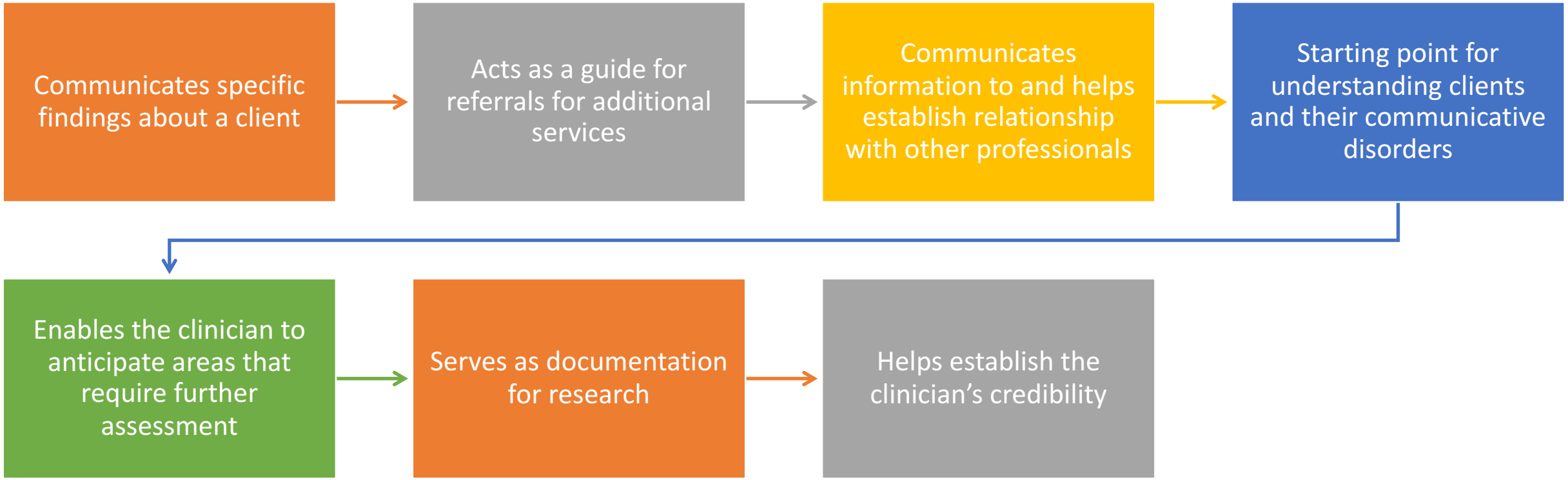
- An **Evaluation report** for SLPs is the set of information that is typically provided by the clinician when the assessment process is completed and is also called:
- Assessment Report
- Diagnostic Report

Evaluation/ diagnostic report

- **Evaluation report** should be written by a **certified clinician/SLP** (or under his/her supervision)
- **Evaluation report** should be:

- Objective (mostly)
- Accurate
- Sensitive
- Concise
- Complete
- Well organized
- Honest

The Importance of an Evaluation Report



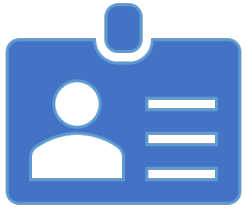
Speech and Language Assessment Protocol

(General Diagnostic Report Format)

- **Most** assessment/diagnostic **reports** have **similar format** which include the following components:

1. Identification Information
2. Description of Patient/family Concerns and Referrals
3. History or Background Information
4. Examination
5. Clinical Impressions
6. Summary
7. Prognosis
8. Recommendations
9. SLP Name and Signature

Date of Evaluation:.....
Name:.....
Date of birth:.....
Address:.....
Sex:.....
Medical History:.....
Clinician:.....
Caregivers' names(for children):.....
Siblings(for children):.....
Tel.#:.....
Referral:.....



Identification Information

Three Sample Clinical Reports

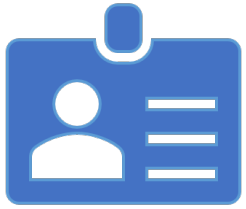
Sample Report I

University Clinic
123 Main Street
Anytown, CA 99999
(xxx)555-1529 · clinic@email.com

Diagnostic Evaluation

Name: Adam McCune
Birthdate: 4-2-20xx
Age: 7 years, 5 months
Address: 4574 E. 1st St.
Anytown, CA 99999
School Status: 2nd grade, Holt Elementary

Date: 9-14-20xx
Clinic File No.: 12345
Diagnosis: Fluency Disorder, 315.35
Phone: (xxx)555-8942



Identification Information

Description of Patient's/Family's Concerns and Referrals

Referral's source diagnosis

Patient's/caregiver's complaint

(this should be inclusive of all the details)

Nature of the problem	Time of onset	Previous intervention	Certain places or times the problem is more apparent	Possible causes

Description of Patient's/Family's Concerns and Referrals

History and Presenting Complaint

Adam, a 7-year 5-month-old male, was seen for a speech-language evaluation at the University Clinic on September 14, 20xx. He was accompanied by his mother.

Adam attended Holt Elementary School and received speech therapy two times per week for remediation of disfluent speech. Mrs. McCune reported that Adam began stuttering at approximately 3 years of age. She also stated that his stuttering fluctuated and increased during stressful situations. Mrs. McCune stated that her father also stuttered.

Background Information/History

Information obtained from the *case history*

Information regarding the *patient's development/ background :*

- Speech
- Language
- Hearing
- Social/Behavioral
- Intelligence/Cognitive
- Motor
- Educational
- Medical (including family history)

Background information should be inclusive of prenatal, perinatal and postnatal periods

Background Information/History

- Background cues:
  - Abnormal presentation, methods of delivery, Apgar* info., birth defects, jaundice*, breathing difficulties
  - Illness/disease/trauma (illnesses accompanied by high fevers, falls and accidents that involve the head and face, diseases that affect the brain, ears, face, or respiratory system)
  - Previous medical tests; neurological, psychological, hearing, C.T./MRI/EEG, Medications/reasons; and hospitalizations.

*The Apgar score, the very first test given to a newborn, occurs in the delivery or birthing room right after the baby's birth. The test was designed to quickly evaluate a newborn's physical condition and to see if there's an immediate need for extra medical or emergency care. **A**ppearance, **P**ulse, **G**rimace, **A**ctivity, and **R**espiration.

*Jaundice, also known as icterus, is a term used to describe a yellowish tinge to the skin and sclera (the white part of the eye) that is caused by an excess of bilirubin in the blood (hyperbilirubinemia). Body fluids may also be yellow.

Background Information/History

Reasons for referral

Nabeel , a 7 year , 2-month old male was seen for a speech and language evaluation at Birzeit university Speech and Hearing clinic on April, 24, 2016 . Nabeel attended the clinic with his mother who stated concerns regarding his unintelligible speech.

Background Information

Family History : Nabeel is the third of four children .He lives with his Parents , Mr. Yousef Abuawwad ,a building contractor and Mrs. Falasteen Abuawwad ,who is a housewife . Parents reported no family history of communication disorders.

Pregnancy and Birth History : Mother reported normal pregnancy and birth . Nabeel's birth weight was 3.2 Kg . No complications after birth were reported.

Motor and communication milestones : Nabeel started crawling at 6 months , walked independently at 9 months and said his first word when he was about 18 months old .

Medical History : Nabeel has hypotonic muscles of the lips and eye on the left side of his face .

Educational History : Nabeel is in the second grade in a private school .According to his mother , Nabeel has an overall good academic performance . However, he has a difficulty in performing tasks requiring memorization or concentration.

Examination

- Informal Observation
- Hearing Screening Results
- Oral Mechanism Examination
- Speech Skills (Articulation, Fluency, Voice, Prosody)
- Language Skills (Receptive, Expressive, Pragmatic Skills)
- Cognitive Skills
- Other related Factors

Examination: Informal Observation

- Observation made **by clinician** upon introduction to the client, and **continues** throughout the **interview** and **assessment**
- Report the client's **orientation**, **activity level**, **attentiveness**, **interaction with parents/ clinician**
- Report whether the client **initiated and/or responded readily** to communication
- Comment on the **type of play, response to toys** (for children)
- Comment whether **drooling** was noticed
- Comment on **anything else** that would be **helpful** in understanding the disorder and **making diagnosis**

Examination: Hearing Screening Results

- Summarize essential findings of the audiological examination
- On the basis of the audiologist's report, indicate results obtained

Examination:
Oral Mechanism Examination

- Report relevant information; listing **deviations** noted and their **possible significance** in relation **to** the client's **speech problem**
- **Facial symmetry/asymmetry**
- *Structure and function* of the **lips** - adequacy for speech
- *Structure and function* of the **teeth** - adequacy for speech
- *Structure and function* of the **tongue** - adequacy for speech
- *Structure* of **hard palate** - adequacy for speech
- *Structure and function* of the **velopharyngeal** mechanism -adequacy for speech
- *Structure and function* of the **nasal cavities** -adequacy for speech
- How did the client *perform* **voluntary oral movement**?
- How did the client *perform* **sequential oral movement**?
- State concisely the **significance of** these **findings**
- **Interpret** the result of the oral mechanism examination.

Examination:
Oral Mechanism Examination

Orofacial Integrity

An orofacial evaluation revealed a mild drooping of the left lip corner at rest and while smiling. Mild groping movements were noted during lip puckering and mandibular depression. Lingual and labial strength were within normal limits bilaterally with slight nasal emission noted during evaluation of labial strength. The tongue deviated to the left upon protrusion. Degree of mandibular range, elevation, and depression were normal, with apparent jerky movements and temporomandibular joint noises noted during depression. It was also noted that Mr. Elvi maintained an open mouth rest posture.

Asymmetrical velopharyngeal movement was observed during the production of /ɑ/ with deviation of the velum to the left. Nasality was also noted. Nasal emission was present during blowing, cheek puffing, and the production of /ɑ/. A gag reflex was not elicited.

Diadochokinetic syllable rates were slow and labored with irregular timing. Mr. Elvi produced 25 productions of /pʌ/ in 8.44 seconds and 19 productions of /bʌ/ in 9.91 seconds. He was able to produce three repetitions of both /tʌ/ and /kʌ/ in 3 seconds; 1.5 repetitions of /dɪpədɪdɪpədɪdu/, 1.5 repetitions of /lɪpədɪlɪpədɪdu/, and

(continues)

Examination: Speech Skills

Articulation:

- Through careful listening to spontaneous speech and a reading sample we can:
  - List phonological processes
  - List distortions of phonemes
  - List misarticulated phonemes
  - Indicate the position in words in which the errors were made
  - Summarize info. about the consistency of these errors
  - Summarized the client's response to stimulations
  - Indicate the general intelligibility of the client's speech
  - Report diadochokinetic rate (https://www.youtube.com/watch?v=kegQORv9CJ4)
  - State concisely the significance of these findings

Examination: Speech Skills

Assessment Findings

Speech: The *Goldman-Fristoe Test of Articulation-2* was administered to assess Adam's production of consonants in fixed positions at the word level. Adam lateralized /s/ and /z/ in all positions. He substituted /nk/ for /n/ in the medial and final positions. Adam was stimulable for /s/ and /z/ at the word level.

A 384-word conversational speech sample revealed similar errors. He also omitted /d/ and /t/ in the final position during connected speech. Adam was 100% intelligible during this sample.

Examination: Speech Skills

Fluency-Voice-Prosody:

- Through careful listening to spontaneous speech and a reading sample we can:
  - Report diadochokinetic rate
  - State concisely the significance of the findings
  - Note any deviation from the norm with regards to the normal voice parameters (breathiness, roughness, asthenia and strain)

Examination: Speech Skills

Voice: Adam exhibited a normal vocal quality. An s/z ratio of 1.0 was obtained.

Fluency: A 384-word spontaneous sample was elicited to assess Adam's fluency rate, and he was 82% fluent on a word-by-word basis. Disfluencies averaged 2 seconds in duration with a range of .8 seconds to 4 seconds. Disfluencies included:

	# Disfluencies	Percentage
Sound Interjections	28	17.3%
Word Interjections	11	10.3%
Sound Repetitions	19	15.0%
Word Repetitions	18	12.1%
Phrase Repetitions	18	12.1%
Revisions	13	10.8%
Prolongations	12	10.5%
Total	**69**	**18.1%**

Adam was stimulable for fluent speech at the 3-syllable phrase level when he was required to use an easy onset and syllable stretching.

Examination: Language Skills

Receptive and Expressive:

- Ask basic questions that are indicative of the client's receptive language skills.
- State concisely the significance of the findings
- Interpret the result of findings
- Concisely state the significance of the findings
- Interpret the result of tests and language analysis

Examination: Language Skills

Pragmatic skills:

- How did the client respond to greetings?
- What about eye contact?
- Turn taking
- Topic maintenance?
- Topic initiation?
- Concisely state the significance of the findings
- Interpret the result

Examination: Cognitive Skills

- Matching
- Association
- Sequencing
- Categorizing
- State concisely the significance of the analysis
- Interpret the results of the analysis

Examination: Other Related Factors

- These include information input that is outside the diagnostic report (i.e. information from school reports in cases of children)
  - Concisely state the significance of the information
  - Interpret the results of the findings.

Summary

- Overall summery of all the significant sections of the assessment form including basic identification information, clinical impressions in all fields and recommendations:
  - Summarize your impressions of the client and his/her communication problem
  - What is the communication disorder (diagnosis)?
  - What is the underlying cause if applicable?
  - What are the primary features of the disorder? Provide a brief summary of each area

Summary

Appendix 4-A. continued

Summary

Christopher Elvi was diagnosed with severe mixed dysarthria and concurrent verbal apraxia, severely reduced respiratory control, and moderate anomia. His speech and language were characterized by imprecise consonant productions, hypernasality, audible inhalations, monostress, a harsh and strained-strangled voice quality, and an abnormally high-pitched voice with severely reduced laryngeal control of pitch. He took frequent breaths and exhibited a significant amount of groping movements during volitional speech tasks. He also exhibited word retrieval difficulty during conversational speech and confrontational naming tasks.

Prognosis

- Explain positive and negative indicators
- Prognosis:
  - Provide directions for the treatment
  - Is based on findings
  - What is the general estimate of the predicted time frame for recovery? (If applicable)
  - Is part of the final diagnostic report and not the initial assessment

Recommendations

- Do we need further speech and language evaluation? What area (e.g. speech, language, voice) needs further comprehensive assessment?
- Is medical or other referrals necessary? Why?
- Is treatment indicated?
- What happens now?/ Where do we go from here?

Signature (Designation)

- This area of the report should include:
  - The clinician name/signature
  - The supervisor/consultant name/signature
  - The date of each signature

Recommendations & Signature

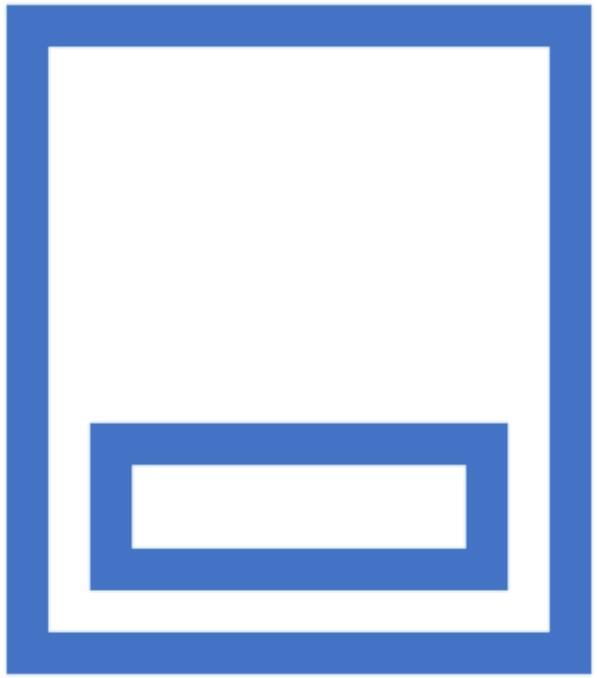
Summary and Recommendations

Adam exhibited moderate disfluency characterized by sound interjections and sound, word, and phrase repetitions. He was stimulable for fluent speech, which suggests a good prognosis for improvement with therapy. Adam also exhibited mild articulatory errors of substitutions and additions. He was stimulable for all phonemes. Expressive and receptive language abilities were age appropriate.

It was recommended that Adam receive speech therapy to train fluent speech and correct his articulation errors.

_____

Stephen D. Marshall, M.A., CCC/SLP
Speech-Language Pathologist



SOAP Notes

- Four kinds of information are part of the medical record:
  - Subjective
  - Objective
  - Assessment
  - Plan
- Each type of information is important for understanding the patient/client

S: Subjective

- Subjective information is any that is reported to the clinician about the patient OR behavior the clinician observes that impacts the outcome of a session
- May be reported by client/patient, caregivers, or family members
- Usually, cannot be confirmed by clinician
  Ex: “Miral had a cold all week and that affected her performance”

O: Objective

- Objective information is the record of what was actually done during the therapy session, including what the client achieved.
- Data and activities ONLY – no interpretation
- Ex: “The clinician supplied a picture book with no words. Miral created a story based on the picture. Miral generated 9 sentences using correct chronological transitions (first, then, next, so).”

A: Assessment

- In the assessment section, the clinician provides comment on client's progress within the session. Performance goals are specified and new problems may be noted.
- Ex: "Miral demonstrated mastery in using transition words between chronological events. She used few descriptions in her narrative."

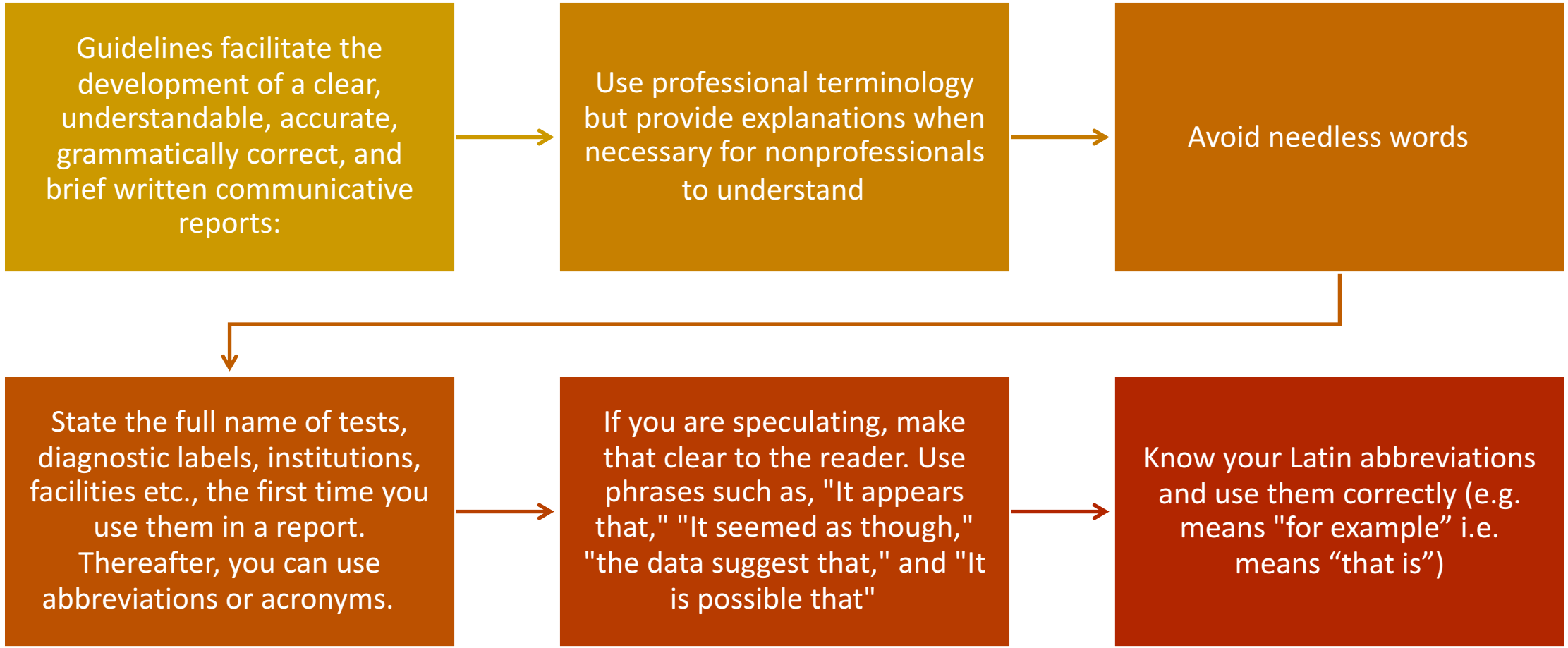
P: Plan

- The plan section is where the clinician makes specific recommendations for what the client should do next
- Use the future tense
  Ex: “Miral will start using more descriptive words and more complex sentences.”

For next time:

Sample Report #3 Page 111

Guidelines for Report Writing



USE	AVOID
Specific language	Ambiguous terms
Complete, clearly understood words	Abbreviations
Variety of language styles and words appropriate to needs of the report	Stereotypy
Specific, accurate, **brief** sentences	Verbosity and needless words
Language that conveys sincere, serious **professional** attitude	Flippancy
Complete verb forms and correct punctuation	Contractions and hyphens

USE	AVOID
Positive statements that show what testing or observations have revealed	Qualifiers (very, really) and noncommittal/ non-expressive language
Personal pronouns when they convey a clear statement in a natural manner	Awkward verbosity
Accurate descriptive language that is supported by facts	Exaggeration and overstatement
The exact words needed to express a concept or idea	Misusing words
Active word construction, when possible	Passive verb forms

Commonly Used Terms in Report Writing

TABLE 6

Commonly Used Terms in Report Writing

THE PERSON YOU WORK WITH	PROBLEMS WITH COMMUNICATIO
client	speech
patient	communication
child	articulation
youngster	language
student	voice
Suzie (child's name)	rhythm
Mr.	fluency
Ms.	hearing
	deviancy
WHAT YOU DID	deviation
therapy	problem
remediation	disorder
intervention	difficulty
speech rehabilitation	abnormality
assessment	dysfunction
examination	anomaly
testing	impairment
appraisal	defect
YOU	
the (this) clinician	
the (this) therapist	
the (this) examiner	

TERMS WITH PROFESSIONAL TONE		
ability	feedback	performed
administered	generalized	production
appeared	goals	progressive
base line	impression	projected
behavior	improved	reinforcement
carry over	increased	reported
causal	indicated	response
characteristics	informant	revealed
conducted	judgment	skill
congenital	manifests	stated
contingent	nature	status
criterion	objectives	symptomatolo
data	observation	target behavior
demonstrates	occurred	tasks
determine	onset	terminated
etiology	outlook	unremarkable
evidenced	parameter	utterance
exhibits	performance	verbalization

Preferred Terminologies

PREFERRED TERMS	TERMS TO AVOID
persons who are disabled; people with disabilities	the disabled; crippled; deformed; invalid
congenital disability	defective at birth
partially sighted; visually impaired; blind (total loss of vision)	"blind" regardless of amount of vision; sightless
partial hearing loss; hearing impaired; deaf (total loss of hearing)	"deaf" regardless of amount of hearing; deaf-mute; deaf and dumb
Down syndrome	Mongoloid
mental disorder	mentally defective; crazy
learning disabled	an academic failure
mental retardation	the retarded
nondisabled	able-bodied; normal
seizure disorder	epileptic
person who has arthritis	arthritic; victim of arthritis
uses a wheelchair	confined to a wheelchair

Recommended Guidelines for Composing Reports

1. Use simple vocabulary. Limit sentence length to 18 words or less, and paragraph length to 125 words or less.
2. Delete the words: that, by, which, who, and whom. Reconstruct the sentence without them.
3. Choose short words.
4. Write in active voice.
5. Remove qualifying adjectives (i.e. very, quite, much, rather, somewhat, and approximately)
6. Nouns ending in -ion should be changed to verbs (i.e. “Her verbalizations were short” —> “She verbalized in short utterances”.
7. Vary the length and type of sentences.
8. Make revisions. Would it make sense to others?
9. Revise with the objective of making the complex more simple and the unfamiliar more familiar.

Technical Writing Style

- Avoid writing clinical reports in a conversational style (e.g., "He just didn't get the point" versus "He did not appear to understand the task").
- Use correct spelling, grammar, and punctuation and write in complete sentences.
- Write in the third person (e.g., "The Token Test administered showed…" rather than "I administered the Token Test").
- Avoid use of contracted verb forms (e.g., isn't, can't, I've).
- Give the full names of tests when first mentioned before using acronyms and other abbreviations in the remainder of the report.
- Present information (particularly case history) in chronological sequence.
- Differentiate clearly between information reported by others versus information obtained directly through clinician observation.

Technical Writing Style

- **List all data** such as **test scores** or baseline measures **before** providing any interpretative statements. This approach **facilitates interpretation** of a client's overall profile rather than presenting unrelated descriptions of isolated communication skills.
- **Include** information about a client's **strengths as well as weaknesses** in the body of the report.
- **Avoid presenting information** in the **summary** section of any report **that was not introduced previously** in the body of the report.
- Write **reports to communicate with colleagues** using professional terminology, **but** include **simple explanations** and clear examples to make reports **meaningful** to **family members** and other **nonprofessionals**.
- Use **language** that is **specific** and **unambiguous** (e.g., "He demonstrated language skills characteristic of 4-year-old children" versus “He demonstrated poor language skills").
- Avoid exaggeration and overstatement (e.g., “completely uncooperative,” “absolutely intelligible,” “never produces /s/,” “extremely motivated”).

Proofreading

- A first draft is your first finished report:
  - It should be neat, complete and proofed. All drafts must be word- processed and printed double-spaced.
  - Completed test forms/data sheets should be turned in with your first draft.
  - All previous drafts must be given to the supervisor with each subsequent draft, revision or final copy.
  - Final copies should be single-spaced.
- Before you hand your first draft and all subsequent drafts:
  - Make sure that you have used the required report format.
  - Read the report over. (In the beginning reading aloud helps correcting).
  - Check for typos, spelling errors, and grammar errors.
- When you get your report back from the supervisor:
  - Read over the comments and ask for clarification when needed.
  - As you make each suggested change, check it off in a different color ink to make sure that you have addressed all edits.