

**Department of Audiology and Speech Therapy**

**Clinical Observation Record for Speech –Language and Hearing Disorders**

Student’s Name:………………………………………..……………………………………………………………………………………………………

Semester/Year:……………………………………………….………………………………………………………………………………………

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| No. | Name of Institution | Clients name | Age | Date | Disorder | Minutes of obser. | Clinician name | Supervisor sign. |
| 1 |  |  |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |  |  |
| 4 |  |  |  |  |  |  |  |  |
| 5 |  |  |  |  |  |  |  |  |
| 6 |  |  |  |  |  |  |  |  |
| 7 |  |  |  |  |  |  |  |  |
| 8 |  |  |  |  |  |  |  |  |
| 9 |  |  |  |  |  |  |  |  |
| 10 |  |  |  |  |  |  |  |  |

***AUD:*** Hearing test/specify ***HL:*** Hearing loss ***Art:*** Articulation ***St:*** Stuttering

***VD:*** Voice Disorder ***Aph:*** Aphasia ***SwD:*** Swalloing Disorder ***Nas:*** Nasality

***Dyslex:*** Dyslexia ***MSD:*** Motor Speech Disorder ***Eval:*** Evaluation