Demographics and History

Pt ID/Medical Record Number:
First Name:
Middle Name:
Last Name:
Address:
Home Phone number:
Cell Phone:
Work or other number:
Emergency Contact:
   Name:
   Number:
Marital Status:
   Married, single, divorced, widow/widower
Date of birth:
Age:
Gender:  male   female
Race/Ethnicity: (select one or more)
   American Indian/Alaska Indian, Asian, Black/African American,
   Hispanic/Latino, Native Hawaiian or other Pacific Islander, White,
   Unknown

Facility admission date:

Date of SLP evaluation:

Referring physician or service:

Clinician ID:

Clinician NPI (National Provider Identifier):

Primary funding source:
   Medicare A
   Medicare B
   Medicaid (Fee for Service)
   Medicaid (Managed Care)
   Veteran’s Administration
   Commercial Fee for Service Insurance: _______________________
   Managed care plan (HMO, PPO, IPA) _______________________
   Self pay
   Unknown

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HIC number/Insurance ID number:

Name of insured:

Medical Diagnosis (select all that apply)

- Neoplasm Lip/Pharynx (140.00 – 149.99) Primary; Secondary
- Other Neoplasm (150.00 – 160.99 & 162.00 – 239.99) Primary; Secondary
- Neoplasm Larynx (161.00 – 319.00); Primary; Secondary
- Mental Disorders (290.00 – 319.00); Primary; Secondary
- Anoxia (348.10); Primary; Secondary
- Encephalopathy (348.30); Primary; Secondary
- CNS Diseases (320.00 – 348.00 & 348.40 - 359.90); Primary; Secondary
- Cerebrovascular Disease (430.00-432.99 & 436.00 – 438.99) Primary;
  left, right, bilateral, unknown;
- Occlusion/TIA (433.00 – 435.90); Primary; Secondary
- Respiratory Diseases (460.00 – 519.99); Primary; Secondary
- Hemorrhage Injury (852.00 – 852.99); Primary; Secondary
- Head Injury (854.00 – 854.99); Primary; Secondary
- Other: _________________

Onset Date of Primary Medical Diagnosis:

Communication/Swallowing Diagnosis (select all)

- Aphasia (784.3)
- Apraxia (784.69)
- Cognitive-communication disorder (438.0 – 438.10)
- Dysarthria (784.5)
- Dysphagia, unspecified, (787.20 )
- Dysphagia, oral phase (787.21)
- Dysphagia, oropharyngeal phase (787.22)
- Dysphagia, pharyngeal phase (787.23)
- Dysphagia, pharyngoesophageal phase (787.24)
- Other dysphagia (787.29)
- Fluency disorder (307.0)
- Voice disorder (784.4 – 784.49)
- Other: _________________

Other relevant medical history/diagnoses/surgery:

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Relevant Medications:

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Allergies: ______________________________________

Current Treatment Setting

- Hospital
- Inpatient rehab facility
- Subacute
- Skilled nursing facility
- Home health
- Outpatient rehab facility
- Comprehensive outpatient rehab facility
- Day treatment
- Assisted living facility
- Non physician practitioner
- Other ______________________

Setting Previous to Current Admission:

- Hospital
  - Date of admission from hospital: __________
  - Date of discharge from hospital: __________
- Inpatient rehab facility
- Subacute
- Skilled nursing facility
- Home
  - Alone
  - Living with spouse/family, caregiver, other: __________
- Assisted living facility
- Unknown
- Other: __________

Received SLP in previous setting: ___yes, ___no, ___unknown

Living Situation Prior to Onset of Medical Diagnosis:

- Home
  - Alone
  - Living with spouse/family, caregiver, other: __________
- Skilled nursing facility

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__ Assisted Living  
__ Homeless  
__ Unknown  
__ Other: ______________

**Educational background:**  
__ Did not graduate HS  
__ HS grad/GED  
__ College grad  
__ Advanced degree  
__ Currently attending: __HS, __college, __vocational  
__ Unknown

**Vocation:**  
__ Currently employed as ________________________  
__ Retired from employment as ___________________________  
__ Volunteer activities _____________________________

**Recreational Activities:**

**Is English primary language?**  
__ yes __ no;  
If no, interpreter needed?  
__ yes __ no

If no: **Language(s) spoken at home: (select all)**

__ Arabic, __ Chinese, __ English, __ French, __ German, __ Italian,  
__ Japanese, __ Korean, __ Spanish, __ Russian, __ Vietnamese,  
__ Other: ___________________

If no: **Language(s) spoken in workplace/community: (select all)**

__ Arabic, __ Chinese, __ English, __ French, __ German, __ Italian,  
__ Japanese, __ Korean, __ Spanish, __ Russian, __Vietnamese,  
__ Other: ___________________

**Cultural/linguistic considerations:** ___________________________________

**Reason for referral:**  
__ Augmentative-Alternative Communication (Speech Generating Device)  
__ Cognitive Communication  
__ Language  
__ Resonance  
__ Speech  
__ Swallowing  
__ Voice

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Overview of Related Systems

Problems or change in: (check all that apply)

__Hearing: _________________________
  Wears hearing aid(s): __no __yes

__Vision: __________________________
  Wear glasses: __no __yes

__Dentition: ____________________________
  Wears dentures __no __yes

__Resonance:

__Respiration:

Tracheostomy: __no __yes
  Type:
  Size:
    Cuffed: __yes __no
    Fenestrated: __yes __no

Mechanical ventilation: __no __yes
  Intubation history: ____________________

Hand dominance

__Right
__Left
__Ambidextrous

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