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INITIAL CASE / FINAL CASE / ASSESSMENT REPORT Spring / Fall Semester 20xx

File #.

Cheff Panie.	1 110 11.
Date of Birth:	Date of Report:
Age:	-
Parents:	
Address:	
Phone:	
Graduate Clinician:	
Clinical Instructor:	
Diagnosis (-es):	
Background	
Background information should include demograthic information; referral source history	

Background information should include: demographic information; referral source; history.

Adult history — medical information (including medications); current health status; work, family and other pertinent information for treatment

Child history — birth, developmental and educational history; medical information (including medications); current health status; family and other pertinent information for treatment

Assessment

Client Name:

Voice: clinician's perception of voice; instrumental assessment data

Fluency: percent disfluent; description of disfluencies and concomitant behaviors (if any)

Baseline: Report baseline data/information for Goal 1
Goal 1:
Objective 1: Objective 2: Objective 3: Procedures and Progress
Baseline: Report baseline data/information for Goal 2
Goal 2:
Objective 1: Objective 2: Objective 3: Procedures and Progress
Baseline: Report baseline data/information for Goal 3
Goal 3:
Objective 1: Objective 2: Objective 3: Procedures and Progress
(Cont. as appropriate)
Recommendations
It is recommended that Future treatment goals may include, but are not limited to the following:
 proposed Tx Goal 1 proposed Tx Goal 2 (continue as appropriate)
First / Last Name, B.S./B.A. First / Last Name, M.A.,/M.S.,/Ph.D., CCC-SLF

Treatment Goals and Progress

Graduate Clinician

Description of previous treatment and progress (if applicable)

Clinical Instructor

Additional Guidelines:

- 1. Font type/size: Garamond / 12pt (Garamond is a Sac State authorized font)
- 2. Header: (right align) File # xxxxx and page x of y
- 3. Footer: (centered) CONFIDENTIAL STUDENT REPORT
- 4. Margins: Top = 1", Bottom = 0.5", Left = 1" and Right = 0.7"