Initial Case/Final Case/Assessment Report
Spring/Fall Semester (year)

Client Name: Initials only until final draft
Date of Birth: Blank until FCR final draft
Age: blank until FCR final draft

Parents: blank until FCR final draft
Address: blank until FCR final draft
Phone: blank until FCR final draft

Graduate Clinician: include name and degree
Clinical Instructor: include name and degree (e.g., Kris Courtwright, MS, CCC-SLP)

Diagnoses:

REFERRAL AND COMMUNICATION CONCERNS
1-3 sentences that tell when the referral was made, who made it, and why. Then clearly state the communication concerns of the client and/or family.

PERTINENT HISTORY

Pregnancy and Birth: Describe pregnancy and birth. Include any complications that are relevant to speech and language and/or overall development.

Medial: Describe relevant medical history.
Motor Development: Describe relevant history related to gross and fine motor. Discuss major milestones and any other information pertinent to motor concerns.

Vision and Hearing Acuity: Tell when the client was tested, where, and who did the testing. Describe the results. Describe follow-up and recommendations.

Speech and Language: Discuss speech and language developmental milestones. Assessment, therapy and/or progress toward goals should be summarized here as well.

Education/Employment: For children discuss education. For adults discuss work and school. Strength and weaknesses should be addressed here.

Family/Social/Behavioral: Describe any pertinent info.

ASSESSMENT AND OBSERVATIONS

Initial Observations: Describe what you observed upon your first meeting. Describe how they presented, any behaviors, and/or anything you noticed that may have impacted testing.

For all assessments: a) provide the name of the assessment b) tell what the test assessed in a few sentences or a brief summary c) state what the client was asked to do d) provide an example test item to clarify if needed e) report scores f) discuss the results

Speech

Articulation/Phonology: report standardized scores and/or any informal testing

Voice: discuss fundamental frequency, jitter, shimmer, observations as necessary.

Fluency: discuss type and frequency of dysfluencies. Indicate whether your findings are within normal limits or fell outside of normal limits.

Oral Mechanism: discuss the oral mech exam and DDK.

Language

Expressive Language: discuss any standardized tests, MLU, number of words used, type of expressive communication etc.

Receptive Language: discuss standardized testing and any other informal assessments

Pragmatics: discuss your informal or standardized assessment of pragmatics. Provide specifics.

Literacy: describe literacy and pre-literacy skills.

Phonological Awareness: describe phonological awareness skills.
Hearing: state location the client was tested, thresholds, dB assessed and results. State whether they passed and not follow up is needed or refer for a follow up if needed.

Assessment Summary

Your CI may prefer this section is titled Diagnostic Summary. Please discuss with your CI their specific requirements for its title and contents.

In this section discuss a) diagnosis b) prognosis

TREATMENT PLAN

Make a statement indicating that the information from your assessment has resulted in the goals you have created.

Goal 1: goals must be specific, measurable, attainable, results oriented and within an established time.

Baseline: state the date that the data was taken and then provide measurable data.

Final Data: this is part of the FCR only. Provide date and data.

Objective: list 1 or more objectives in your ICR. Your CI may not require objectives be listed in your FCR.

Methods: Part of the FCR only. Tell how you collected the baseline data. Describe what you did to target the goal. Talk about reinforcement and specific challenges to working on the goal.

RECOMMENDATIONS discuss any recommendations you may have for this client.

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Ima Student,BS                                                                         First Last, MS, CCC-SLP
Gradaute Clinician                                                                    Clinical Instructor

CA License:

NOTE: Your CI may have different or additional requirements for your FCRs and ICRs. Please discuss with them their specific expectations and/or see the clinic handbook. This report template is only a guide and your CI and the Clinic Supervisor may make adjustments as they see fit.