For all reports, student clinicians are required to use this format:

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

Client Name:         File#: 
Date of Birth:        Date of Report:
Age:                  
Parents:             
Address:             
Phone:               
Graduate Clinician:
Clinical Instructor: 

Diagnoses:

- **Fonts:** Please use Garamond as this is a Sac State authorized font.

- **Footer:** You must have a footer which indicates STUDENT REPORT (centered).

- **Header:** You must have a header which indicates File # and page x of y (right alignment).

- **Margins:**
  - Left and top @ 1”
  - Right @ 0.7”
  - Bottom @ 0.5”
The following is an example of report content. Be sure to use the report structure, as indicated above. All students in on-campus clinics are required to use the same format.

**Background History and Information**
This section includes referral source, prior speech therapy, diagnosis and onset date, past medical history, prior level of function (e.g., employment, educational level, communication abilities), and current status (e.g., living environment, employment, physical abilities, medications).

**Assessment**
This will be a statement describing the testing environment, dates of testing, and overall performance (attention, cooperation, etc.).

**Receptive Language**

**Auditory Comprehension**
Include results of formal tests (please follow the appropriate format), as well as informal impressions (e.g., ability to follow conversation, ability to understand depending on length and complexity, etc.).

**Visual Comprehension**
Include results of formal tests, as well as clinician-derived reading tasks. Be sure to discuss visual neglect and vision correction, if applicable. Comment on comprehension of gestures and other non-verbal cues.

**Expressive Language**

**Verbal Expression**
Include results of formal tests, as well as spontaneous productions. Describe the quality of utterances (e.g., fluent, non-fluent, jargon, phonemic paraphasic errors) and provide examples. Also include spontaneous use of gestures, or ability to use an alternative or augmentative communication device (which could be as simple as pointing to a word from a choice of three).

**Written Expression**
This section includes writing, which may be as minimal as a signature, or as complex as a consumer complaint letter.

**Speech**

**Oral-Motor Function**
Comment on the structure and function of the oral periphery. Include results of formal tests, and description of the quality of speech (e.g., spastic dysarthria, oral and verbal dyspraxia).

**Speech Intelligibility**

**Impressions/Summary of Assessment**
This section should be brief, and includes the type and severity of aphasia, as well as overall communicative abilities and prognosis. You should then follow with a brief analysis that discusses the functional problems that are a result of the speech-language deficit.
Plan of Care/Recommendations
Make recommendations for frequency and duration of therapy, as well as participants (spouse, children), and any applicable home program. You can also discuss recommendations for outside of therapy, such as whether or not your client should manage his/her own checkbook, and community referrals (e.g., support groups, audiological evaluation).

Goals
Long-term goals
These should be broad, functional, achievable, and measurable, and include an assistance level.

Short-term goals
These should be more specific, achievable, and measurable, and include an assistance level.
Goals which you think can be achieved by the end of the semester. These goals should be set with the client’s input and feed into the broad, functional, long-term goals. These are part of the plan of care.

Signatures
Check with your supervisor how his/her name should be written. One example:
Darla K. Hagge Ph.D., CCC-SLP
CA License# SP15430
Final Case Report Sample Content

**Summary of History and Assessment:** You should be able to summarize the first two sections of your initial case report here; most likely we will place just this (the final) report in the client’s chart, so this section is very important. No more than two paragraphs, ideally just one. (Picture yourself as a busy physician; what information do you care about? Now picture yourself as an insurance reviewer; same question. Finally, picture yourself as the speech pathologist at the next level of care; same question).

**Result of Treatment:** The easiest way to structure this section is to begin with a brief summary (e.g., was seen for a total of 22 fifty minute sessions, the majority of which were conducted in a group of two; he made excellent progress and was an extremely hard worker, etc.). Then, simply restate your initial goals and respond. For example:

1) In a structured setting, Mr. H will successfully convey novel thoughts using a combination of speech, gestures, and picture board, three times per session.

**Goal exceeded.** Mr. H was able to express a multitude of ideas at least five times per session, after an initial reminder by the clinician to use his picture board. You can then address any new goals that were established after the initial case report was written. OR, since we probably won’t file the initial case report, simply list any and all goals that came up in the course of therapy. Be sure they are the functional, long-term goals, and not the “baby-step” objectives from each individual therapy session.

**Recommendations:** Here is where you can recommend not only continued therapy (or not), but also community resources and referrals that you have made (including NeuroService Alliance), as well as strategies for your client to continue using.

Signatures...