ORTHONET
SPEECH-LANGUAGE PATHOLOGY EVALUATION-PEDIATRIC

Member/ID#: Insurance Company:
Provider: Provider #:
Medical Diagnosis: ICD-9 Code:
Date of Birth: Age:
Date of Onset: Date of Evaluation:

Background History:

• Reason for Referral:

• Medical History:

• Developmental Milestones:

• Hearing:

• Dominant Language in the Home:

• Family History of Speech and Language Issues:

• History of Formal Therapy Services:

Formal Assessment:

Standardized Test: __________________________________________
Results: Raw Score: ______ Standard Score: ______ %ile: _____ AE: _____

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Results: Raw Score: ______ Standard Score: ______ %ile: _____ AE: _____

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Results: Raw Score: ______ Standard Score: ______ %ile: _____ AE: _____
Clinical Observations:

Clinical Findings:

- Oral Motor Examination:
- Language Assessment:
- Vocabulary Assessment:
- Pragmatic Assessment:
- Play Assessment:
- Articulation Assessment:
- Fluency:
- Voice:
- Swallowing Concerns:

Clinical Judgment:

Clinical Summary:
Plan of Treatment:

Long Term Goals:
1. 
2. 
3. 

Short Term Goals:
1. 
2. 
3. 
4. 
5. 

Requested Visits:               Frequency/Duration of Treatment:

SLP Printed Name:________________________________________________

SLP Signature/License #:___________________________________________