Instructions: *Rough draft submitted typed, double- spaced in Arial 11 point font with final copy single spaced, except between headings. Clinic Director will provide sample reports appropriate to case as guidelines. Be sure to include page numbers at the bottom of report. Submit electronic submission to supervisor as a* ***WORD document****. Submit all test protocols used and upload them to Goggle Drive DX folder for the client.*

The following formatting is appropriate to a pediatric language assessment, but would not work for a variety of other disorders; please confirm sections with your assessment supervisor. ***Remove these Instructions prior to submission.***

CALIFORNIA STATE UNIVERSITY, EAST BAY
DEPARTMENT OF SPEECH, LANGUAGE, AND HEARING SCIENCES
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C O N F I D E N T I A L

DIAGNOSTIC EVALUATION

NAME First Last Initials*
AGE (Years/Months)
BIRTHDATE Month/Day/Year
DATE OF EXAMINATION
EXAMINER(S)
INFORMANT(S) (Initials*; relationship to client)
NATURE OF DISORDER
SUPERVISOR First Last, Degree, CCC-SLP

I. STATEMENT OF PROBLEM *(Often combined with History)*

State the initials* only, age (years; months for pediatric cases), remarkable pertinent background history or diagnosis. Include the name of the individual or agency making referral. Provide a statement of the problem in the words of the client or informant and note purpose of evaluation.

II. HISTORY *(past tense)*

Please write history and most outstanding and relevant information (e.g., CVA, ASD, SLI, speech & language delay, phonological disorder, stuttering, multi-lingual background, only if appropriate). Unless a case is extremely complex, condense and organize this section to include only relevant information related to physical development, medical history, family-social and/or education, as appropriate to this particular case that gives the reader a good sense of client's status prior to the Rees Clinic evaluation Include past treatment, response to therapy, ending with purpose of evaluation. Condensing history requires the writer to be succinct and construct meaningful transitions between paragraphs, focusing on relevant and remarkable information to present a sufficiently complete paragraphed and appropriately sequenced narrative that is easy to follow. ***(At the discretion of supervisor Statement of Problem and History sections may be combined if the latter is relatively simple for succinctness, ending section with the purpose of the evaluation, state in present tense.)***

III. GENERAL IMPRESSIONS / BEHAVIORAL OBSERVATIONS *(past tense)*

Provide general impressions of the client. This paragraph may include a description of the behavior during an initial observation period with the parent, separation from the parent for testing (only appropriate for a young or significantly impaired child), and other impressions (cooperation, attention span, engagement, etc.), client's primary means of communication. Include remarkable speech and non-speech behaviors noted outside of standardized testing that will not be highlighted later in *Evaluation Results*.

IV. EVALUATION RESULTS *(past tense)*

Use a sub-heading for each area assessed. Begin with the primary problem area and list other areas in decreasing order of severity. Group together any areas which are within normal limits in a concluding statement. When reporting results of a formal test, state and underline the full name of the test and compare client's performance to norms in test manual. Raw scores are typically not reported for most measures. If testing was invalidated, state why, providing a more qualitative description of test performance. Utilize a table to summarize assessments with multiple sections and then in your analysis don't repeat the same info, but instead comment on remarkable subtests, doing an item analysis and comparing info to other measures or observations.

A. Receptive Language

(In the event that assessment included a mixed language assessment, combine Sections A & B, into Language.)

Analyze results of testing for all receptive language tests, such as PPVT, etc., (e.g., child demonstrated difficulty following complex and lengthy directions, etc). Report results of informal testing for receptive skills when appropriate. If possible, include a general summary statement concerning child's level or receptive functioning or in the case of unremarkable, state that.

B. Expressive Language

Analyze results from all expressive language measures. Describe language performance in terms of semantics, syntax and pragmatics. If the major area of concern is social language or pragmatics, then that should be a separate sub-heading. Analyze child's spontaneous language using structured analysis or informal measure. An analysis and interpretation of tests may include: description of child's syntactic and morphological errors, level of complexity of grammatically correct sentences, including their utterances to illustrate errors, along with their response to clinician model, etc. If possible, make a general statement about child's communicative behavior (e.g. rarely initiated conversation, poor eye contact, behavior, etc.) With a nonverbal child, describe all attempts at communication, (e.g., gestures, facial expressions, laughing, crying, etc.). Describe play behavior, but consider if this should be a separate sub-heading if significantly impaired or if client is very young or non-verbal. If normal, indicate that expressive language performance appeared appropriate, with brief remarkable observations, if appropriate.

C. Articulation / Phonology*

(As appropriate; if unremarkable utilize heading Speech Parameters to capture Articulation, Voice and Fluency)

Report results of phonological/articulation testing. An analysis and interpretation of tests should include: description of error patterns (with examples from within and outside of testing), developmental levels, response to stimulation (stimulability), facilitating phonetic contexts, consistency of errors, level of intelligibility. Otherwise report as adequate or WNL.

D. Oral Mechanism and Hearing Screenings

(Screenings under a single sub-heading for most clients when oral mechanism results are not a key area. Do not combine for a client with dysarthria or apraxia in which typically a screening is insufficient.)

Describe structure, symmetry, functioning of facial, lip and tongue musculature. Describe structure of hard and soft palate, efficiency of velopharyngeal closure. Describe dental occlusion, appearance of tonsils. Report diadochokinetic rates, and describe motor sequencing and patterning skills. Describe structural deviations, strength, force, range of motion, and consistency where appropriate. **If normal indicate that an examination of the oral mechanism revealed adequate physiologic support for speech.** State results of audiometric screening, (e.g., a pure tone, air conduction audiometric screening for the frequencies 500 to 8000 Hz administered at 25 db (ISO) indicated that hearing sensitivity was

within normal limits bilaterally. Screenings are pass/no pass. Do not report a specific frequency and/or side in which client did not respond. Report tympanometric screening results as appropriate. Do not administer an audiometric screening to a client who has hearing aids or a documented hearing loss. If both screenings are unremarkable, then one sentence is sufficient report this.

V. DIAGNOSTIC IMPRESSIONS *(present tense)*

State name, using initials* only, age, and state the client's speech and language diagnosis, including severity. Describe in general (summarize) the reason for evaluation, the significant aspects of the problem(s) identified during the evaluation. In separate paragraphs, present each area of significance in order of severity as it relates to the diagnoses provided. Discuss possible contributing and maintaining factors, e.g., poor oral motor functioning, foreign language influences in the home, low intellectual functioning, etc.

This portion of the report should provide the reader with an overall picture of the client, even if the rest of the report has not been read. This section should serve as a summary that includes client's skills as well as potential problems (e.g., inattention, medical fragility, limited response to treatment, fatigue, poor responsiveness, etc.) In this section the clinician integrates and synthesizes the findings of the evaluation. It is not appropriate to restate test scores or re-present information. In fact, test scores should rarely be included. It is in this section that the clinician's hypotheses, impressions, and predictions are noted in a succinct manner in which this section reveals factors, results to build a logical case. *(For simple cases, this section may be one paragraph and it is rarely more than four or five in length.)*

VI. RECOMMENDATIONS *(present tense)*

Based on the results of the evaluation, state whether therapy is recommended and if not, why. If therapy is recommended, discuss frequency and type of therapy (group, individual, intensive), and suggest initial therapy goals that may address as appropriate, caregiver involvement, inclusion of literacy and/or multi-modalities, etc. List and discuss other recommendations (e.g., psychological evaluation, family counseling, implementation of a home program). Present balanced prognostic statement in terms of the recommendations made and your knowledge of the client's behavior, e.g., based on the child's inconsistent attention during the evaluation, it is expected that progress in therapy will be slow initially. Where relevant, make a statement concerning the client's or family's acceptance of the recommendations.

Your Name Graduate Clinician	Supervisor's Name, Degree, CCC-SLP Clinical Supervisor