

Treatment

Receipt of Patient Notification/Assignment

Contact patient to confirm initial day of therapy attendance. The clinician is responsible for confirming the patient's first therapy day. You need to make this call as soon as you receive your caseload. Your clinic assignments will be made during the first weeks of classes. Meet with each of your supervisors to discuss treatment of each client (be sure you check the room schedule in the SLP graduate lab to ensure sure space is available). Telephone the client and identify yourself ("I'm _____ assigned to work with _____ this semester. I'm calling to arrange therapy"). Clients or parents/guardians of clients are expecting your call. If you must leave a message, simply indicate that you are calling from Lamar University. To say you are calling from the Lamar University Speech and Hearing Clinic could violate the client's confidentiality. If your client cannot come for therapy at the requested time, ask the client what times he/she could come and inform him/her that you will get back to him/her after checking with your supervisor. Talk to your supervisor. We try to be flexible within reason. It is the clinician's responsibility to inform the client of the confirmed therapy time. Any conversation the clinician has with the client or parent/guardian is to be summarized and signed on the chronology sheet in the client's folder. If you have any problems or concerns, please seek out a faculty member.

Supervision of Clients

Student clinicians will be assigned to one or more supervisors during each semester of practicum. A supervisor who holds the CCC in the appropriate area directly observes at least 50% of each evaluation session, including screening and identification, and at least 25% of each student's total treatment time with each client. More frequent supervision will be dependent upon clinician needs as determined by the supervisor. Each supervisor will be directly involved with client assessment and treatment planning. Periodically throughout the semester, each supervisor will conduct session audits during supervision of therapy. These audits will be averaged and configured into the final clinic grade for the semester.

Supervisor Conferences

Initial supervisor/clinician conferences will be used to define the responsibilities of each person in regard to lesson plans, evaluations, videotaping, observations, reports, and other clinical matters. Throughout the semester meetings will be conducted weekly through one or more of the following: Formal meeting time in supervisor's office, informal meeting (i.e. open door policy), online during session, before or after session, telephone, email. These meetings can be used to evaluate past therapy sessions for areas of strengths and weaknesses, discuss proposed plans for future sessions, communicate upcoming responsibilities, and/or jointly work on personal goals established by the clinician.

Upon receipt of patient notification the clinician will checkout the patient's folder from the clinic office (complete the "out form" for folder removal located at the front window). Familiarize yourself with all folder material and previous treatment plan information (this means you will have to read the file). Each supervisor may be supervising 25 to 30 students and be responsible for 40 to 50 clients. Therefore, go into the meeting prepared to discuss your thoughts regarding treatment of the client and bring forth a preliminary treatment plan that you have put together through utilization of all the resources available to you. Refer to the [Case Study Worksheet](#) and the [Guide to Self Evaluation of Therapy](#), especially the section on [Planning, organization, & Management of Therapy](#). Some of the items are listed in past tense (occurring after the session has ended); however, they can still help you with preliminary planning of future treatment sessions.

Each clinical supervisor has a unique, individual supervisory style; therefore, uniformity of approach is the exception rather than the rule in the clinic. The clinical faculty views diversity as a program strength, thus affording the clinician exposure to differing philosophies, theories, and therapy techniques.

Supervisor Approaches

The LUSHC faculty has compiled a list of possible supervisor approaches that clinicians may want to discuss with their supervisors during their clinical experience at Lamar University. The following options may be available:

Samples: The supervisor may provide examples of lesson plans, session analysis, SOAP notes, or reports.

Joint Planning: The supervisor and clinician may write a lesson plans and/or objectives together. They may formulate step by step strategies for conducting the therapy activities.

Role Playing: The supervisor and clinician may role play therapy procedures as each one assumes the client or clinician stance.

Demonstration Therapy: A part of, or an entire therapy session may be planned to be modeled by the supervisor while the clinician observes.

Structured Observations: The clinician may arrange to observe other clinicians who demonstrate strong clinical skills in specific areas, particularly those in which he/she is experiencing some difficulty. During the observation, the clinician should gather ideas and strategies that may be implemented in his/her therapy sessions. Data collection may be practiced as well.

Videotape and/or Audiotape: Reviewing of video and audio taped sessions may be completed by the clinician and/or supervisor in order to identify the strengths and weaknesses of the session. In addition, the supervisor and the clinician can view tapes together. They can jointly find concrete solutions and strategies for the identified areas of weakness.

Script Taping: The supervisor and/or clinician may transcribe the clinician's directions and models given during the therapy session. Those may further be analyzed and evaluated. The supervisor may provide specific feedback regarding alternative to the clinician's choice or implementation of strategies.

Observation of Clinician's Therapy By Other Supervisors: Other supervisors may observe the clinician in order to provide additional specific feedback based on the data collected during the observation.

Joint Evaluation: The supervisor and clinician may evaluate the clinician's session through written analysis. These evaluations would be shared and compared to obtain supervisor-clinician accuracy and agreement.

Videotaping

Students may be expected to videotape or audio record and evaluate his/her therapy sessions. The student and supervisor will decide frequency and extent of the evaluation needed. Students are responsible for keeping the videotapes and making them available to supervisors as requested. Video cameras are available for checkout in the front office from the academic secretary, Alex Bernard. Please have your student ID for checkout.

Treatment Planning

Treatment plans are prepared and maintained throughout the semester for each patient enrolled in therapy. The clinician will prepare daily plans and submit them to the supervisor for approval. The clinician is to confer with the supervisor for additional specifics on treatment plan submission deadlines and data collection requirements.

Treatment plans for the coming week are due by 11:00 AM on Thursdays (that is Thursday on the week before) for Monday/Wednesday clients. Treatment plans for the coming week are due by 11:00 AM on Friday for Tuesday/Thursday clients (that is Friday on the week before). Each supervisor handles treatment planning in his/her own style. Some supervisors may accept e-mailed copies. Others may want you to place your plans in their mailbox. Check with your supervisor for specific directions. Plans are checked and returned to the clinician prior to the scheduled therapy session. Supervisor suggestions and/or comments are indicated and the clinician is to make the necessary adjustments prior to the scheduled session. Sessions held **WITHOUT** an **approved** treatment plan will not be counted towards total clock hours of practicum (this means you will be working for free with no clock hour accumulation). ☺

THERAPY SESSION PLAN

Date: _____ Day of Week _____ Clinician: _____

Supervisor: _____ Client Initials _____ Room Numbers: _____

Short-Term Goal #1Type of Data

Script to introduce objective:

Activity/materials to elicit targets:

Teaching Strategies:

SAMPLE

Step Up:

Step Down:

Comments:

Short-Term Goal # 2Type of Data

Script to introduce objective:

Activity/materials to elicit targets:

Teaching Strategies:

Step Up:

Step Down:

Comments:

Data Collection

In order to determine the rate and degree of patient progress over the semester, the student clinician is expected to collect baseline data on each assigned patient during the initial therapy sessions. Following the initial data collection measures, ongoing data should be collected throughout the treatment sessions during the semester. Consult with your individual supervisor regarding expectations for data collection. Data Collection Sheet may be a useful tool for collecting data. The data sheets are to be submitted to the supervisor each week (with Treatment Plans) for approval and accuracy check. Additionally, you may refer to the data collection packet given to you at initial clinic orientation.

Case Study Worksheet

Phase 1: Learning About the Client

1. What was the initial referral question?
2. What is the primary presenting problem?
3. What are the characteristics of the client's speech and language (strengths and weaknesses)?
4. What are the significant findings of the diagnostic? What are the recommendations?
5. Has there been past treatment? If so, what did they work on and what were the results?
6. How does this case confirm or contradict what I have learned up to this point?
7. What did I see in my first session? (include behavior observations as well as data analyses)

Phase 2: Constructing the Treatment Plan

Based on the Above:

1. What do I know from my education and experience?
2. Factors I need to consider as I construct my treatment plan: (age, disorder, behavior, physical, auditory, etc.) What do I not know?
3. Where could I look for answers? (e.g., journals, texts, professors, file, materials)
4. What approaches might be applicable to this case?
5. What resources do I have?

Following the First Session:

1. What do I believe is most hindering the client's communication?
2. Task analysis: What do I want the client to be able to do? How can I get him/her there?
3. Where is he/she now?
4. How will I know the client is making progress?
5. How can I elicit the behaviors I want?

Phase 3: Practical Application

Before the Session:

1. What behavioral objectives will lead me to my goals? [i.e., What do I want the client to do today?]
2. How can I elicit target behaviors in a meaningful, functional, and/or powerful way? How can I measure quantitative and qualitative behaviors?

After the Session:

1. Are my behavioral objectives moving me toward my goals?
2. Are my measurements meaningful?
3. Did my activities effectively elicit target behaviors? Why or why not?
4. Did I get important data? If not, why not?
5. When my client was successful, why?
6. When my client was unsuccessful, why?
7. How did client behavior affect client performance?
8. How did clinician behavior affect client performance?
9. How did client behavior affect clinician performance?
10. How did clinician behavior affect clinician performance?
11. What other factors affected client performance?
12. What did I learn from this session about my client?
13. What did I learn from this session about myself? (characteristics and/or clinical skills)
14. What did I learn from this session about the approach?
15. What did I learn from this session about the procedures used?
16. What did I learn from this session about rationales for my plan/approach/procedures?

Phase 4: Clinical Development

As I Approach Treatment:

1. What skills do I have?
2. What skills do I need to develop?
3. What factors about myself do I need to consider? (e.g., fear, being overwhelmed)

As I Search:

1. What key words describe my client and/or therapy approach and/or procedures? What do I want to know?
2. Where can I search for further information?

As I Read:

1. REMEMBER: Just because it's published doesn't mean it's good.
2. What is the research question/topic of this source?
3. Who were the subjects and what were their characteristics? (as applicable)
4. What did the authors do to answer their question or address their topic?
5. What were the results/conclusions?
6. What were weakness and strengths of this source?
7. What are the theoretical and/or clinical implications?

Phase 5: Evaluation of Therapy

1. Did my client make gains? To what degree? Why or why not?
2. How did these facilitate/hinder:
 - a. Client behaviors (incl. attendance, motivation)
 - b. Parent/spouse/family behaviors
 - c. Clinician behaviors
 - d. Approach/procedures characteristics
 - e. Home assignments
 - f. Other factors?
3. What should the client do next? (i.e., what are my recommendations for future therapy)?
4. What have I done to develop my skills/knowledge and what have I learned over the course of the semester?

MID-TERM THROUGH END OF SEMESTER:

Operations and Activities

Clinic operation aspects which must be addressed during this phase of programming are: (1) evaluation and progress report writing, (2) mid-term and end of semester evaluations for both clinician and supervisor, (3) final patient and parent conferences, (4) conference summary reports, (5) final clinician/supervisor conference, (6) identification of returning patients for the upcoming semester utilizing client disposition form, (7) preparation of interim therapy home programs, (8) submission of daily and master clock hour logs and supervisor verification form (9) completion of caseload request form (10) return of borrowed materials, (11) clinician room clean up and (12) locker clean up. **PLEASE NOTE: GRADES CANNOT BE ADMINISTERED UNTIL ALL OF THE ABOVE ITEMS HAVE BEEN COMPLETED IN FULL. NO EXCEPTIONS.**

Report Writing

Preparation of numerous reports by clinicians is required throughout the semester, (e.g., speech-language diagnostic reports, semester progress reports (SPR), letters, treatment plans, etc.). Therefore, development of efficient report writing skills is essential. Numerous handouts are prepared and distributed to clinicians to facilitate emergence of professional report writing ability. Materials obtained from workshops and research is made available to students as needed. Students are encouraged to refer to helpful resources to facilitate writing skill improvement.

Semester Progress Reports

Semester Progress reports are written on every patient seen for therapy in the LU clinic regardless of the number of sessions attended during the semester. The purpose of the report is to record pertinent information regarding the patient's disorder type and characteristics, therapy goals, degree of progress achieved, and future treatment recommendations. These reports also serve as useful guides for clinicians when outlining therapy goals in future semesters. In addition a copy of this report may be sent to or requested by outside agencies.

Goals for each client are due two weeks after the first day of the client's therapy. By mid-term (or midway through the client's treatment for the semester) the first half of the Semester Progress Report is prepared (including all information through Semester Objectives) in rough draft by the clinician and submitted to the supervisor for correction (check with your supervisor for preferred mode of submission – email or mailbox). Some supervisors may require an addendum page to be attached to the Semester Progress Report that lists specific information not covered in the formal report (e.g., stimulus practice material utilized with the patient including: target phonemes, drill words, vocabulary items, sentence structure patterns, etc.). Statements regarding effective motivational activities and reinforcers are also to be indicated on the addendum. The supervisor indicates corrections and suggestions and a corrected copy is then prepared by the clinician. The clinician then submits the corrected copy. **PRINT TWO COPIES ON LETTERHEAD.** When the supervisor judges the final report complete and accurate, obtain signatures of both the clinician and supervisor. The completed and signed reports are given to the Clinic Secretary who mails one copy to client/parent and places the other copy in the client's file.

On occasion, within the semester, a clinician may undergo schedule changes affecting client caseload. In this instance, the initially assigned clinician submits the first half of the progress report to the supervisor.

Below is a guide for formatting the Semester Progress Report:

SEMESTER PROGRESS REPORT

Client:	Disorder & ICD9 Code:
D.O.B.:	Etiology:
C.A.:	Initial Evaluation Date:
Address:	Initial Therapy Date:
Phone:	Current Semester & Year:
Therapy scheduled:	Total days present:
Parents/Caregivers:	Total days absent:
Clinician:	

Background information

- Use paragraph form
- State client's name and exact age in yrs/months
- State referral source to Lamar U. Speech & Hearing Clinic
- State original diagnosis to include severity and date
- Report pertinent patient history to date
 - *Anthony Taylor is a 3-year-old boy with a speech delay. His mother reported that he has PE tubes in his ears, however, due to thickness of fluid in the ear, tubes are ineffective. Additionally, his hearing has been tested, and revealed that he is not hearing below 40 decibels. He had surgery at the beginning of summer 2010 to remove his adenoids. At this time, fluid was drained from the middle ear that was contributing to conductive hearing loss. His speech has mostly been unintelligible. He received a speech and language evaluation in February 2010 at Houston Elementary School and began receiving speech therapy during the summer semester of the same year at the Lamar University Speech and Hearing Clinic.*

Beginning of Semester Status

- Diagnostics Completed this semester, prior to treatment: Date
- List all tests administered and include hearing screens
- Write out full name of test and include common abbreviations in parentheses (ex: GFTA-2)
- Description of speech and language characteristics including any diagnostic results and interpretations, prior to treatment this semester, may be done in table or narrative format
- Description of behavioral characteristics at the beginning of the semester, summarize general behavior, including attention span, level of structure needed, motivation, beneficial reinforcement and re-directions
 - *Anthony appeared shy and reluctant to go back to therapy room with clinician. He would normally cry for the first 5 minutes of the session. His mother reported that he associated speech therapy with his ear surgery. He exhibits persistence and determination to produce the target sounds throughout the session. At times he is difficult to understand out of context. His phonetic inventory did not include the sounds s, sh, f, v, l, r, and th. Speech errors observed included consonant deletion and cluster reduction.*

Long Term Goal(s):

- This is the broad, overall goal (ex: produce developmentally appropriate articulation and language skills)
 - *Anthony will demonstrate age appropriate articulation skills*

Short Term Goals:

- Short-term goals MUST be measurable (refer to goal writing document on LU clinic website)
- Include baseline measures (% accuracy)
- Report procedures used
- When reporting procedures and results, include a general description of the therapy program to include clinical methods, successful, and unsuccessful techniques
- Report results with level achieved (% accuracy)

Anthony will increase his phonetic inventory to include initial /s, □, f, v/ sounds as measured through a biweekly speech sample.

- *Baseline: Phonetic inventory did not include /s, □, f, v, l, r, □, /*
- *Procedure: Anthony will increase his phonetic inventory through drill with pictures, storybooks, activities, and visual, verbal, and tactile cues.*
- *Results: Phonetic inventory increased to include initial /s, □/ with minimal cueing*

Anthony will decrease /s/ cluster reduction to 60% occurrence in CCVC words.

- *Baseline: 100% occurrence*
- *Procedure: Visual and tactile cues will be used to facilitate production of /s/ clusters in storybook, crafts, activities, and drill.*
- *Results: 20% occurrence with tactile cueing only*

Anthony will produce final consonants in CVC words with 90% accuracy with minimal cueing.

- *Baseline: 0% accuracy*
- *Procedure: Visual and tactile cues will be used to facilitate production of final consonants in storybook, crafts, activities, and drill.*
- *Results: 80% accuracy with minimal cueing*

End of Semester Summary

- List and report any formal testing administered at the end of the semester
- Compared to start of therapy, how are their speech/language/behavioral characteristics different?
- State the current diagnosis and compare it with the original diagnosis
- State the current severity of the problem(s)
- State prognosis for further improvement, if indicated, and support for this prognosis
- Report anything not already mentioned in the results section per goal
- Overall, how has the patient improved?
- Include other related information such as results of a referral to audio or psych, or significant attendance issues, or observation of pt. in another environment (school), family involvement (observation/homework, etc.)
 - *Anthony's treatment was designed to help him increase his phonetic inventory and reduced phonological errors. Visual, tactile, and verbal cues helped Anthony produce the target sounds. He showed improvement in speech sound production by only requiring minimal cueing. Verbal cues seem to yield the most change (e.g., "use your good /s/ sound" or "use your arm"). Additionally, Anthony demonstrated the most change when applying the method of over exaggerating correct speech sound productions. He demonstrated acquisition of newly learned sounds by generalizing the newly learned sounds to other environments. Overall he enjoyed matching games and high-energy activities. Occasional redirections and schedule flexibility were required to keep Anthony on task.*

Recommendations

- Indicate whether therapy should be continued or terminated
- State recommended frequency of therapy
- State whether the patient should be re-evaluated
- State objectives for next semester, when applicable
- Be specific, rather than vague on recommended goals
- Use list format for recommendations
- Statement indicating that the recommendations were shared with pt/family and agreement secured
 - *It is recommended that Anthony continue to receive speech therapy at Lamar University Speech and Hearing Clinic, two times per week for 55-minute sessions in Fall 2010. Therapy should consist of:*
 - *Generalizing initial /s, □/ and s-cluster productions to spontaneous speech*
 - *Increasing initial /f, v/ production*
 - *Generalization of final consonant production in CVC words through the use of maximal opposition contrast words in facilitated play*

Disposition

- _____ Patient is recommended for additional therapy.
- _____ Patient is dismissed as sufficiently improved.
- _____ Patient is discharged from therapy due to ...

Clinician's name, degree
Graduate Clinician

Supervisor's name, degree, CCC-SLP
Speech-Language Pathologist

General Report Information for Semester Progress Report:

Rough Drafts

- Double-space all information to allow for editing
- Underline and bold all major headings,
- Addendum (therapy stimulus items, word lists, behavioral support, etc.)
- PROOFREAD ALL DRAFTS, use spell check and grammar check!
- Use 3rd person only
- Put patient name and page number in upper right hand corner of pages 2 thru end of report (Ex: John Doe, Page 2 or 6)

Final Drafts

- Double space before and after each heading
- Single space all text/narrative
- PROOFREAD! You are responsible for proofreading your final copy. Use spell check and grammar check.
- Fill in all phonemes using phonetic symbols and use black ink for signatures.
- Once approved, all final drafts are printed on LU letterhead in duplicate and submitted for signatures. Once signed, place one copy in patient file and have clinic secretary mail one to family.

Patient Conferences

A mid term and end of semester progress reporting conference is held with each adult patient, the patient's spouse or parent/guardian. During the conference with the patient it is recommended that summary comments be elicited from the patient to aid the clinician in determining the extent that the patient has meaningfully internalized clinical concepts and growth. Exemplary discussion questions to address with the patient include: "Has your speech/language pattern changed during the semester? If so, How? Give specifics. What can you do now that you were not able to do before? What has helped the most in therapy? The least? What did you enjoy most about therapy? The least? Where do we go from here?"

Parent Conference.

The clinician is responsible for keeping the parent informed throughout the semester. Therefore, parent conferencing is an important aspect of therapy programming. The various reasons to confer with parents are to: (1) acquaint parents with the nature and goals of therapy, (2) recommend referral to outside agencies, (3) share information regarding normal and disordered patterns of speech and language, (4) gather additional pertinent case history and background data, (5) report therapy progress, (6) discuss and evaluate parental involvement and home programming, and (7) discuss referral and/or dismissal consideration. A very important segment of the on-going clinician/parent interaction is the progress reporting conference at the end of the semester. The objective of this conference is to report patient progress in therapy. During the conference the clinician defines semester therapy goals, presents a comparison of past and present speech-language behavior, explains programs and techniques employed in therapy, discusses patient response and progress achieved, and outlines recommendations for future management. Discussion of interim home programs over semester breaks is also to be considered. Home programs aid with generalization and maintenance of therapy targets. A written summary of the conference is to be entered into the patient folder following the meeting.

The clinician should be well organized and present a relaxed composure during the conference. The session should never be rushed and the parent/guardian should be encouraged to ask questions and comment on the child's speech and language behavior changes. However, the time length of the conference may be specified to limit discussion of irrelevant topics. It is important also that the conference room be free from interruption.

Conference Summary Reports

Summaries of all conferences held during the semester that pertain to the patient are to be placed in the patient folder. The Conference Report form is to be utilized for any/all conferences, (e.g., parent, school personnel, physician, guardian, teacher, etc.). Reports should be completed immediately following formal interviews, telephone conversations, and informal discussions in which pertinent patient information is obtained or disseminated. The summary should include date, purpose, conference participants and a brief, concise statement of conference conclusions/resolutions. The report should be finalized as soon after the conference as possible, then signed by the clinician and supervisor. This information can also be reported in the SOAP note or Patient Chronology sheet.

Conference Report Speech-Language Pathology

Client Name: _____ Date: _____

Participants:
Reason for Conference (goal review, end of semester, other):
Conference Objectives: SAMPLE
Summary
Parent Comments/Outcomes:

Clinician: _____

Speech-Language Pathologist: _____

Evaluation of Speech-Language Services

Make sure you have the parents fill out the **Evaluation of Speech Therapy Services** form. This form is required by ASHA and it helps us make reflections and decisions regarding service deliver and overall clinic functioning. It is essential to the success of the clients and the LU clinic. Please turn these in to the clinic secretary.

LAMAR UNIVERSITY SPEECH & HEARING CLINIC
Evaluation of Speech-Language Therapy Services

Date: _____

Dear Patient or Family Member,

Your cooperation in completing this evaluation of Speech-Language Therapy received at Lamar University will help up improve the quality of our services.

Please check the following as they relate to the patient under consideration.

Patient Age Group: [] Child 2-6 [] Child 7-11
 [] Adolescent [] Adult

Therapy Received: [] Voice [] Fluency
 [] Language [] Articulation
 [] Other: _____

BASED ON YOUR PERCEPTION OF THE QUALITY OF SERVICE RENDERED, PLEASE CIRCLE YOUR EVALUATION BASED ON THE ROLLOWING RATINGS:

5 = Excellent 4 = Very Good 3 = Satisfactory 2 = Fair 1 = Poor NA = Not Applicable

Assistance, courtesy shown upon arrival for therapy sessions	5	4	3	2	1	NA
Punctuality beginning and ending therapy sessions	5	4	3	2	1	NA
Semester goals were explained early in the semester	5	4	3	2	1	NA
Semester goals were explained clearly, and understandably	5	4	3	2	1	NA
Permission for clinical observation was given and guidelines explained	5	4	3	2	1	NA
Homework was incorporated, was clearly explained and demonstrated	5	4	3	2	1	NA
Clinician and supervisor were available and responsive when needed	5	4	3	2	1	NA
Questions and concerns were addressed in an effective manner	5	4	3	2	1	NA
End of semester conference explained progress made during semester	5	4	3	2	1	NA
Recommendations were communicated clearly	5	4	3	2	1	NA
Overall quality of service received	5	4	3	2	1	NA

Comments: _____

Interim Therapy Home Program

Often there is an extended interim period between the close of one semester of therapy programming and the initiation of the succeeding term. The student clinician is responsible for planning and organizing material to be utilized in a home program during that period. The home program may emphasize goal reinforcement and extension and/or enrichment of the regular program. Initiation of home programming should prove relatively easy if the clinician has effectively achieved parent involvement over the course of the semester. Hopefully, the parent has already been made aware of the nature of the problem, goals of therapy, progress to date, as well as some of the techniques and procedures employed in the remediation process.

The home program must be approved by the clinical supervisor prior to introduction to the parent. Development of a notebook for home programming during regular therapy is easily extended to incorporate pages for home

programming during the break time. It is advisable to stress a limited number of specific objectives and activities in the home program rather than to suggest vague, general ideas and techniques to employ. Each activity listed should be pre-dated to ensure that the patient will not lag or move too rapidly through the program activities. Parent understanding of the nature, rationale, and activities of the home program is a must if it is to be effectively implemented.

Client Disposition Form

Immediately following the progress reporting conferences with the patient/parent, the clinician is to fill out a Client Disposition form indicating whether or not currently enrolled patients plan to return to the clinic next term. This information is to be obtained during the final patient/parent conference the last week of therapy. The form is to be filled out completely and returned to the clinical secretary on the appointed date for ALL patients.

CLIENT DISPOSITION FORM

DATE: _____

CLIENT'S NAME: _____ CLIENT'S DOB: _____

PARENT/GUARDIAN'S NAME: _____

DAYTIME PHONE: _____ CELL PHONE: _____

Recommended Tx:	Status:	Age:	Disorder:
<u>Individual</u>	<input type="checkbox"/> New	<input type="checkbox"/> Preschool	<input type="checkbox"/> Articulation
____ Sessions per week	<input type="checkbox"/> Continuing	<input type="checkbox"/> School-age	<input type="checkbox"/> Phonology
____ Minutes	<input type="checkbox"/> Dismissed	<input type="checkbox"/> Adult	<input type="checkbox"/> Language
			<input type="checkbox"/> Voice
<u>Group</u>			<input type="checkbox"/> Fluency
____ Sessions per week			<input type="checkbox"/> Hearing
____ Minutes			<input type="checkbox"/> Accent
			<input type="checkbox"/> Literacy
			<input type="checkbox"/> Birth to 3
			<input type="checkbox"/> Other: _____

For: Fall / Spring / Summer Semester, 20 _____

Please circle below any **PREFERRED** times that you may have. We will do our best to honor these times as long as scheduling permits:

		Days	Time (only in whole hours, no half/quarter hours please)
<input type="checkbox"/>	1 st preference	M/W T/T	_____ Any AM PM
<input type="checkbox"/>	2 nd preference	M/W T/T	_____ Any AM PM
<input type="checkbox"/>	3 rd preference	M/W T/T	_____ Any AM PM

Unsure of your preference? ... please have secretary call: daytime phone # () _____

Office Use Only

Previous schedule: _____

Previous clinician/supervisor: _____ / _____

Clinician

Supervisor

Confirmed: _____

Time: _____

Schedule

Starting Date

M T W R F

M T W R F

Supervisor Evaluation by Student

You are required by ASHA to complete a supervisor evaluation. Make sure you bring it to your final supervisor conference or submit the form anonymously into your supervisor's box. The evaluation guides the supervisor in reflection and adjustment of supervision approaches.

Evaluation of Supervisors

The Supervisor's Evaluation Form follows. A form may be filled out any time and may be given to the supervisor and/or the Department Chair.

**Lamar University Speech & Hearing Clinic
SPEECH-LANGUAGE PATHOLOGY PRACTICUM SUPERVISION EVALUATION**

Supervisor's Name	Practicum Site	Semester/Year
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_____ Total Number of Clients Supervised: A separate form for each client may be completed as long as the appropriate number of client(s) is marked on each form.

Please circle the number that corresponds to your evaluation.

SAMPLE

1. How clearly were expectations explained at the beginning of therapy, regarding grades, lesson plans, clinic policies, etc.?

very good 5	4	adequate 3	2	poor 1
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2. Availability of the clinical supervisor was _____ during the semester.

very good 5	4	adequate 3	2	poor 1
----------------	---	---------------	---	-----------
3. Openness of communication between the clinical supervisor and me as a clinician was

very good 5	4	adequate 3	2	poor 1
----------------	---	---------------	---	-----------
4. The clinical supervisor provided _____ direction in diagnostic testing of clients.

very good 5	4	adequate 3	2	poor 1
----------------	---	---------------	---	-----------
5. The clinical supervisor provided _____ direction in establishing therapy goals.

very good 5	4	adequate 3	2	poor 1
----------------	---	---------------	---	-----------
6. The clinical supervisor provided _____ direction in developing clinical methods.

very good 5	4	adequate 3	2	poor 1
----------------	---	---------------	---	-----------
7. The clinical supervisor provided _____ direction in writing the final report(s).

very good 5	4	adequate 3	2	poor 1
----------------	---	---------------	---	-----------
8. The quantity of feedback on therapy preparation (e.g., lesson plans, self-evaluations, data, etc.) was _____.

very good 5	4	adequate 3	2	poor 1
----------------	---	---------------	---	-----------
9. The quantity of feedback on therapy sessions was _____.

very good 5	4	adequate 3	2	poor 1
----------------	---	---------------	---	-----------
10. Supervisor feedback was generally _____ in nature.

constructive 5	4	3	2	non-constructive 1
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11. I would rate the overall quality of the supervision I received this term as:

excellent 5	very good 4	average 3	below average 2	poor 1
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Final Clinician-Supervisor Conference

In addition to possible weekly clinician-supervisor contact regarding therapy programming for each patient, a final conference may be held near the end of the semester. The major purpose of this conference is to facilitate effective clinic closure for the current semester. Factors to cover during the conference are (1) patient progress during the semester, (2) semester diagnostics administered (3) patient folder organization and completeness and (4) student clinician progress for the semester.

Return Materials & Clean/Clear Therapy Room

All borrowed and checked-out therapy/evaluation materials, CD and/or audio tapes, books, etc., must be returned by the clinician to appropriate persons and locations. In addition, the clinic materials room and diagnostic room are to be cleaned and efficiently organized for the coming semester. Clinic rooms must be straightened and organized and all materials, personal items must be removed by the end of the semester. If materials are left by a student, they are assumed to be donated to the clinic and will be placed in the clinic materials storage area.

Evaluation of Practicum

The KASA (see form on department website) for Certification & the Clinical Skills and Competency Form (see samples) were designed to collect information regarding a student's professional and interpersonal skills. Clinical supervisors and clinicians complete the appropriate sections of the form at mid-term and at the conclusion of the semester to determine a rating which reflects the independence and competence of the clinician during a practicum experience.

The student clinician evaluation process is multifaceted. It is comprised of information gathered through session critiques, weekly clinician-supervisor conferences, mid and end of semester practicum evaluations, final clinician-supervisor conferences, diagnostic/treatment preparation, targets, and delivery, and mid and end of semester group supervisor discussion and consensus.

The Individual Session Audit form serves as an individual therapy session evaluation/feedback tool. In addition, the clinician attends conferences, as needed, with each assigned supervisor that is designed to aid the student in designing efficacious treatment centered around best practice guidelines. You will receive a total of 10 surprise audits of your therapy sessions that aid in configuration of your Clinical Skill Grade on the CFCS form. The audit serves as one form of tangible data in grade configuration. Additionally, all sessions will be supervised based on the ASHA 25% criteria.

Individual Session Audit Form
Clinician: _____ **Date:** _____ **Timeframe:** ____ - ____

Client: _____ **Supervisor:** _____

		HIGHLIGHT CHOICE		
1.	Clinician uses procedures congruent with written objectives and modifies procedures when needed.	YES	NO	SOMETIMES
2.	Clinician uses appropriate language for mental and language abilities of client.	YES	NO	SOMETIMES
3.	Clinician provides instructions and explanations that enable client to understand what is expected.	YES	NO	SOMETIMES
4.	Clinician arranges environment to facilitate optimal behavior.	YES	NO	SOMETIMES
5.	Clinician conveys and maintains limits when dealing with inappropriate behavior.	YES	NO	SOMETIMES
6.	Clinician uses appropriate elicitation techniques.	YES	NO	SOMETIMES
7.	Clinician correctly models target behavior.	YES	NO	SOMETIMES
8.	Clinician discriminates client's errors from target behaviors.	YES	NO	SOMETIMES
9.	Clinician provides appropriate time for client to respond.	YES	NO	SOMETIMES
10.	Clinician effectively records client's response.	YES	NO	SOMETIMES
11.	Clinician uses appropriate correction techniques.	YES	NO	SOMETIMES
12.	Clinician provides consistent, concrete and concise feedback/reinforcement.	YES	NO	SOMETIMES
13.	Clinician maximizes quantity and quality of client's responses.	YES	NO	SOMETIMES
14.	Clinician encourages client to self-evaluate.	YES	NO	SOMETIMES
15.	Materials and activities are used effectively.	YES	NO	SOMETIMES
16.	Appropriate time is spent on each activity.	YES	NO	SOMETIMES
17.	Transition from activity to activity is smooth.	YES	NO	SOMETIMES
18.	Clinician provides appropriate closure of the session.	YES	NO	SOMETIMES
19.	Clinician implements appropriate carryover techniques at the end of the session.	YES	NO	SOMETIMES
20.	Clinician provides appropriate and timely information to parent/significant other.	YES	NO	SOMETIMES

Yes = 5 points each
 Sometimes = 2.5 points each
 No = 0 points each

Total of all YES _____ x 5 = _____
 Total of all Sometimes _____ x 2.5 = _____
 Total of all No..... _____ x 0 = 0

Combined Total Points = _____

Trouble meeting deadlines?

When a student is having trouble meeting timelines for assessment, planning, meetings, or any other clinic related duties; the supervisor will enter into a contractual agreement with the student in an effort to assist with time management. At this point, the clinician and supervisor will utilize the *Supervisor/Clinician Contract* (see sample below). Additionally, some supervisor's may be supervising 25 to 30 students and be responsible for 40 to 50 clients. Therefore, it can be helpful for the supervisor to have deadlines specific to their needs.

Lamar University Supervisor/Clinician Contract

Clinician: _____

Total ASHA Hours to Present: _____

Supervisor: _____

Conference Date: _____

Commitments that address the planning, analysis, or evaluation phases of the clinical process:

<u>Assignment</u>	<u>Due Date</u>	<u>Date Rcvd.</u>
Initial Supervisory Conference/Case Summary and Diagnostic Plan. Discuss supervisory/clinician contract. Comments: _____	_____	_____

Initial session with parent/client (if adult) interview. Comments: _____	_____	_____
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Submit identifying Information/Beginning Summary (if pertinent) of Semester Report. Comments: _____	_____	_____
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Lesson Plans Comments: _____	_____	_____
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Self-Evaluations Comments: _____	_____	_____
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<u>Assignment</u>	<u>Due Date</u>	<u>Date Rcvd.</u>
Interpretation of diagnostic results and formulations of LTGs and STGs. Comments: _____	_____	_____

Submit diagnostic/semester goals portion of report. Comments: _____	_____	_____
--	-------	-------

Submit outline for parent or client conference. Comments: _____	_____	_____
--	-------	-------

Conduct parent or client conference (videotape analysis). Comments: _____	_____	_____
--	-------	-------

Submit entire first half of report with revisions. Comments: _____	_____	_____
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Mid-term evaluation: Clinical Competency Form/Supervisory Evaluation Form. Comments: _____	_____	_____
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<u>Assignment</u>	<u>Due Date</u>	<u>Date Rcvd.</u>
Procedures Section of Report. Comments: _____	_____	_____

Videotape analysis of session. Comments: _____	_____	_____
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Submit cover letters, Clinical Impressions, and Consultation Section of report. Comments: _____	_____	_____
--	-------	-------

Submit copy of final diagnostics plan and discuss. Comments: _____	_____	_____
---	-------	-------

Complete final diagnostics: Comments: _____	_____	_____
--	-------	-------

Submit Progress and Recommendations sections of report. Comments: _____	_____	_____
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SAMPLE

Assignment

Submit Summary Report. (two to three pages)

Comments: _____

Due Date

Date Rcvd.

Conduct parent or client conference and last therapy session.

Comments: _____

Final Supervisory Conference; Clinical Competency form, Supervisor's evaluation form (oral, written, etc.), log cards, registration requests, client's completed file.

Comments: _____

Home Program.

Comments: _____

SUPERVISION

Observations:

Frequency _____ Type: Direct _____ Indirect _____ Direct/Indirect _____

Comments _____

Feedback:

Frequency _____ Type: Written _____ Verbal _____ Written/Verbal _____

Comments _____

Evaluations

Evaluations are usually done on a weekly basis and reflect the planning and execution of the past therapy session(s). The analysis should be based upon clinician's reflection of the session and information gathered from audio/video tapes. Evaluations are to include objective and subjective descriptions of the client's, parents' and clinician's, etc., behavior and their interaction. Both positive and negative aspects should be discussed. In addition, indicate concrete suggestions for improving future therapy sessions (see sample). You will be notified of diagnostic assignments via email. It is your responsibility to contact your supervisor to schedule a pre-diagnostic meeting in order to prepare for the evaluation.

A. DIAGNOSTIC CLINIC PROCEDURES

Clients at the LU Speech and Hearing Clinic typically are seen initially for a complete speech- language diagnostic evaluation. The evaluations are conducted at regularly scheduled times during the week and on Fridays. Each evaluation is supervised by an ASHA Certified and Texas State Licensed faculty or staff member and conducted by graduate students. In the first semester, diagnostics are sometimes conducted in teams of two (i.e. two clinicians are paired together).

Students assigned to the diagnostic evaluation should take the following preparatory steps:

Preparing for a Diagnostic Evaluation

1. Review the preliminary information contained in the client's file. Be sure that all requested pre- evaluation information has been obtained:
 - a. Obtain the client's file from a Clinic Secretary.
 - b. When finished with the client's file, place it in the tray or tub marked "Speech File."
 - c. A STUDENT MAY NOT REMOVE CLIENT FILES FROM THE CLINIC OFFICE. Instead, you must checkout the file by filling out a placeholder card. These cards are located at the clinic check-in window.
2. Schedule a meeting with the assigned faculty supervisor immediately following notification of the upcoming diagnostic evaluation. During this meeting, the student clinician(s) should plan to discuss with the supervisor the specific information contained in the case folder. Be prepared to discuss your thoughts and ideas relative to procedures, tests, and materials that might be useful in the diagnostic evaluation.
3. Approximately two (2) hours will be reserved for each diagnostic session. The student clinician(s) should arrive 20-30 minutes before the evaluation is to begin in order to:
 - a. Sign out test materials and forms from the Diagnostic Room 134.
 - b. Set up a video and/or tape recorder if needed and generally prepare the testing room.
 - c. Checkout an audiometer from the Audiology suites.
 - d. Attend to last-minute details.

Conducting the Diagnostic Session

Note: Be sure client has filled out all necessary billing paperwork with the clinic secretary.

When final preparations for a diagnostic session have been completed, those in charge of the session should:

1. Meet the client in the waiting room.
2. Introduce themselves to the client and/or his/her parents.
3. Describe the general procedures and approximate time schedule to be followed during the evaluation.
4. Review and have signed appropriate intake forms (i.e. legal release and request for admission, authorization for use and disclosure of PHI, release of information).

Specific procedures will be left to the discretion of the faculty supervisor. However, diagnostic sessions usually will include the following:

1. Interview of the client and/or parent.
2. Completion of appropriate speech and language tests.
3. Pure-tone hearing screening (obtain thresholds if appropriate). If you are assessing an infant/toddler or a low functioning client, you may need to schedule a hearing evaluation with the Audiology clinic.
4. Oral mechanism examination.
5. Staff conference concerning test results, interpretations, and recommendations.
6. Final counseling session for the purpose of communicating results, interpretations, and recommendations to the client and/or his/her parents. Most of the time this is done after data is analyzed and report is written. This can take place via phone, email, or the patient can schedule a separate time to come in for a face-to-face meeting.

If more than one diagnostic session is required to complete the evaluation, or if additional hearing testing is indicated, the client or his/her parents should be informed. The Clinic Instructor and the Clinic Secretary should also receive this information in order to schedule the additional evaluation.

After a Diagnostic Session

Upon completion of a diagnostic session, the following steps are to be taken by the student clinician(s):

1. Return clinic file to the front office.
2. All diagnostic materials need to be returned to the lab monitor or front office if the lab monitor is not available.
3. Audiometer needs to be returned to the closet in the Audiology suites.
4. **Immediately following the diagnostic you must fill out the client disposition form and turn it in to the Scheduling Coordinator.**
5. Fill out the **minute log** immediately following the diagnostic and be sure to include the **ICD-9 code** (see Fees Handbook 3) that can be found at the back of the minute log. The secretary will need this code for billing.

6. A first draft of the speech and language evaluation report and completed test forms, as required by the faculty supervisor, should be given to the supervisor no later than **4 DAYS** after the diagnostic session. Some supervisors may make additional requests regarding report deadlines. The supervisor will read and edit the first draft and return it to the student clinician(s). The student clinician(s) will then schedule a conference with the supervisor if deemed necessary to discuss suggested changes in the draft.
7. After the conference, the student clinician(s) will begin the process of constructing an acceptable report, with the final draft due in the supervisor's mailbox no more than 4 DAYS after the conference mentioned in section 3 above. Each supervisor will give you specific timelines. **However, the final draft should be on file no later than 2 weeks following the evaluation.**
8. Be sure that the test score sheets or protocol for each examination administered is properly completed and included in the client's file. The supervisor and clinician will insure that the report is typed properly and that the client's file is complete. In addition, the clinician will be sure that copies of the report are sent as requested to other professionals authorized by the client to receive them. This may require use of the fax machine located in the front office. Fax number: 409.880.2265.
9. Upon final approval of the draft, the report is then printed on LU letterhead. **PRINT TWO COPIES ON LETTERHEAD.** When the supervisor judges the final report complete and accurate, signatures of both the clinician and supervisor are affixed and the reports are given to the Clinic Secretary who mails one copy to client/parent and places the other copy in the client's file.

Instructions for Diagnostic Reports

Headings and Identifying Information:

These should be positioned and listed as shown on the "Report Heading Format" section.

REASON FOR REFERRAL: This section should include when the client was referred, by whom, and for what reason.

PERTINENT HISTORY: Include pertinent birth, medical, developmental, educational, speech-language, and social history. Identify with whom the client lives, occupation (if an adult), and the presence of family history of disability, if appropriate.

ASSESSMENT RESULTS:

Test Behavior: An objective description of the client's behavior including attention, distractibility, motivation, cooperativeness, and/or physical condition.

Test Data: List all tests administered and report the following information (as applicable) in table format: raw scores, standard scores, composite scores/quotients, and percentile ranks.

Skill Areas: This section provides an analysis of the client's performance, including interpretation of the test scores listed previously. The headings/organization of skill area discussion will vary according to disorder and salient client characteristics. As a general rule, this section should not be organized solely on a list of the subtests as presented in the previous table.

Other Pertinent Data: This section should include information about relevant areas of assessment such as oral-motor examination or hearing screening. Information should be as detailed as necessary based on client characteristics.

SUMMARY AND IMPRESSIONS: This section should pull together the assessment results discussed in the body of the report. Summary should include mention of both strengths and weaknesses in client profile. Provide clear statements of diagnosis, severity rating, and prognosis (as appropriate).

RECOMMENDATIONS: State whether or not intervention is recommended. If so, give an indication of the type and frequency of therapy needed. If appropriate, specific recommendations for goals and objectives to be addressed during intervention can be provided. Include recommendations for additional testing or referrals as appropriate.

The content of diagnostic reports may vary considerably based on disorder and client profile. See following pages for examples. Additional sample reports will be provided to students as needed.

Lamar University Letterhead
(obtain from front office)

Speech & Language Evaluation

Name: XXX YYY
Parents: Amy and Scott YYY
Address: 123 Speech Ave.
Anywhere, HI 90554
Phone: 555-000-0000
Date of Evaluation: 07/2/07
ICD-9: 389.7
Date of Birth: 12/x/99
Age: 7 years, 7 months
Gender: Male
Graduate Clinician: Rachel ZZZ, B.S.
Clinical Supervisor: Jane Smith,
M.S., CCC-SLP

Statement of Problem:

SAMPLE

XXX YYY, a 7 year, 7-month-old male, was evaluated at the Lamar University Speech and Hearing Clinic on July 2, 1905 because of his parent's concerns with his language expression and comprehension. Although XXX received services from his speech language pathologist at Blank Elementary in Cruz Independent School District (CISD), XXX's parents expressed the need for an additional comprehensive language evaluation. XXX's parents and teachers have noted that XXX often does not understand what is said to him in the classroom setting.

Pertinent History:

Information pertinent to XXX's development was obtained through a case history report and an interview with Mr. YYY, which took place at the time of the evaluation. Mr. YYY reported that although there were some problems experienced during birth, XXX's developmental milestones were met according to age appropriate norms.

According to Mr. YYY, XXX began to babble at 10 months of age, but did not produce his first words until 2 years of age. At four years of age, XXX began to produce short phrases and sentences. Mr. YYY reported that XXX will often become silent when his communication attempts fail. Another strategy XXX utilizes is to allow his three-year-old sister to speak for him because her speech is better understood by others. Mr. YYY also reported that XXX has a substantial fear of being unsuccessful and will often not attempt to complete challenging assignments. Mr. YYY explained that when given verbal and emotional support, this becomes less of an issue for XXX.

Mr. YYY reported that XXX's language difficulties were brought to their attention by XXX's kindergarten teacher. Mr. YYY explained that XXX has problems with all subjects that are mediated by complex language such as reading, writing, and complicated math word problems. In addition, XXX has difficulty with understanding directions given orally in the classroom setting. Mr. YYY reported that XXX can become easily distracted at home and in the school setting, but once he is focused he is able to complete what is asked of him.

During the 2006-1905 school year, XXX received the following services at Blank Elementary: assistance from parent educators, weekly sessions with a speech language pathologist, and reading assistance provided by a reading specialist. Mr. YYY reported that although the services have been helpful, he believes that the frequent transition periods from one service/teacher to the next has been difficult for XXX. Mr. YYY expressed concerns with XXX's somewhat erratic routine in school and felt that a smaller classroom with one primary teacher and a consistent daily schedule would be more beneficial for him. They are currently considering enrollment in St. Christopher Catholic School in Honolulu, HI that provides small class sizes, more individualized instruction, and a more diverse student body.

With regards to social skills, Mr. YYY reported that XXX does not have any trouble interacting with peers in the neighborhood and seems to prefer spending time with older children.

ASSESSMENT RESULTS

SAMPLE

Test Behavior

XXX presented as a pleasant but reserved child during the evaluation. He particularly enjoyed manipulating items throughout the session and the sports-themed breaks. He tolerated the standardized testing well. When XXX experienced some difficulty with a task, he tended to decline to respond or even guess. With some encouragement and verbal prompting from the examiner, XXX was able to complete a core language test battery. Results from formal and informal evaluations, are felt to be a fairly accurate representation of XXX's speech and language abilities.

Test Data

Clinical Evaluation of Language Fundamentals- Fourth edition (CELF-4):

CELF Core Language: □ (Mean= 100, Standard Deviation= 15)

CELF Subtests: □ (Mean= 10, Standard Deviation= 3)

CELF Subtest	Raw Score	Standard Score	Percentile
Formulated □ sentences	2	1	0.1
Word Structure	9	1	0.1
Concepts and □ Following Directions	7	1	0.1
Recalling sentences	19	3	1
Number Repetition			
Forward	6	7	29
Backward	4	11	63
Core Language □ Score	6	44	0.1

Test of Pragmatic Language (TOPL):

Raw Score	Percent Correct
14/24	58

Expressive Vocabulary Test- Second Edition (EVT-2):

(Mean= 100, Standard Deviation= 15)

Raw score	Standard score	Percentile
70	83	13

Peabody Picture Vocabulary Test-Fourth Edition (PPVT-4):

(Mean= 100, Standard Deviation= 15)

Raw score	Standard Score	Percentile
89	81	10

Spontaneous Language Sample:

Measure	Total
Mean Length of Utterance	$334/75 = 4.45$
Type Token Ratio	$112/301 = .37$

Skill Areas

SAMPLE

Semantics: XXX's understanding of single word meanings was measured through administration of the PPVT-4. This task required XXX to listen to a single word spoken by the clinician and then point to the correct picture from a field of 4. His standard score of 81 corresponds to a percentile rank of 10 and falls slightly more than one standard deviation below the mean score for his chronological age. On the Concepts and Following Directions subtest of the CELF-4, XXX demonstrated marked difficulty understanding spoken directions of increasing length and syntactic complexity (e.g., "Point to the shoe before you point to the houses") as indicated by his standard score of 1 and corresponding 0.1 percentile rank. Multiple repetition of the stimulus sentence resulted in a slightly improved performance. Despite these difficulties, XXX demonstrated the ability to understand important spatial concepts (e.g. next to, first, etc.) when the oral directions were presented in shorter and less syntactically complex forms.

XXX's expressive semantic abilities were assessed at the single-word level via administration of the EVT and at the connected speech level via analysis of a spontaneous language sample. The EVT required XXX to name or provide synonyms for pictured objects. His standard score of 83 and percentile rank of 13 fall one standard deviation below the mean and represent the lower end of the average range of performance for his chronological age. Semantic skills in connected speech were measured using a Type-Token ratio (TTR) analysis on Roahnn's 75-utterance language sample. XXX used a subset of generic words multiple times throughout the sample (e.g., "I don't know"). The degree of variability in vocabulary usage for typically developing children between the ages of three and eight generally results in a TTR score of .45-.50. XXX's TTR score was calculated to be .37, which is slightly below average and is congruent with his single-word EVT score.

Test results and observations are indicative of low average to mildly impaired ability to process and encode word meaning at the level of single words as well connected speech.

Syntax and morphology

The stimulus items on the *Concepts and Following Directions* subtest of the CELF assessed XXX's ability to interpret morphological information (e.g., plurals, superlatives) embedded in increasingly longer and more complex sentence structures. XXX's standard score of 7 and percentile rank of 0.1 are

indicative of significant difficulty in processing morpho-syntactic information presented verbally. While XXX was able to successfully complete two step directions involving spatial concepts when they were presented simply and slowly as separate entities (e.g., "Point to the fish and then point to the blue house"), he demonstrated consistent difficulties when the directions contained spatial concepts that were presented together in longer and more complex utterances such as "Point to the ball between the houses and to the last car in the row." He generally responded by pointing to the last item in the sequence (e.g., last car in row).

The *Word Structure* subtest of the CELF-4 measured XXX's ability to use grammatical rules while labeling pictures. An item analysis of his errors on this task indicated that he had trouble with the following structures: regular plural (e.g., books, horses), irregular plural (e.g., mice), third person singular (e.g., reads, flies), noun derivations (e.g., singer), possessive pronouns (e.g., yours), future tense (e.g., will slide), comparative and superlative (e.g., faster, fastest), adjective derivation (e.g., lucky), subjective pronouns (e.g., she, they), and irregular past tense (e.g., drew). XXX demonstrated success on items featuring the following morphosyntactic structures: possessive nouns (e.g., Paula's), contractible copulas (e.g., she's), auxiliary + ing (e.g., the boy is eating), regular past tense (e.g., climbed), and uncontractible copula (e.g., she is). He often produced answers that made sense relative to the item, but did not contain the desired syntactic form. This performance pattern may have been influenced by task format characteristics. For example, when the stimulus item was intended to elicit the superlative form of fast (i.e. fastest), XXX responded with "winner" which was semantically correct, but did not follow the format of previous practice items.

The CELF-4 *Recalling Sentences* subtest also assessed XXX's ability to produce syntactically and morphologically correct sentences. He was generally able to repeat simple sentences spoken by the examiner (e.g., "The tractor was followed by the bus"), but his performance deteriorated significantly as the sentences became longer and more syntactically complex (e.g., "The girl stopped to buy some milk, even though she was late for class"). Performance on the *Formulated Sentences* subtest of the CELF-4, which measured XXX's ability to produce grammatically correct sentences using given words based on specific pictures, yielded a percentile rank of 0.1 based on a standard score of 1. This is indicative of significant difficulty in the encoding of morpho-syntactic structures (e.g., when presented with a picture and the word "gave," XXX produced the sentence "I want some oatmeal"). Once again, he showed a pattern of answering in ways that were semantically appropriate, but not relevant to the instructions or practice items administered at the beginning of the task. XXX struggled with this task format even when the examiner presented the target word in writing and gave verbal prompts such as "What are they doing in this picture?" and "Remember to include the word."

Additionally, XXX's spontaneous speech sample was analyzed for the presence of grammatical morphemes and sentence structures. The following forms were present in the sample: present progressive —ing (e.g., is walking), -s plurals (e.g., toys), contractible copula (e.g., that's, it's), 3rd person regular present tense (e.g., it walks), and the preposition "on." It should be noted that three forms which were problematic during standardized testing were observed during XXX's spontaneous productions (e.g., regular plurals, third person singular, and future tense verbs). This pattern supports other observations of XXX's difficulty in identifying/maintaining task format parameters.

Pragmatics

Pragmatics describes how language is used to interact effectively and be socially appropriate with others. XXX seemed to understand social routines, as he appropriately responded to greetings, observed conversational turn taking rules, maintained eye contact, and responded to requests for clarification during the evaluation. Formally, the Test of Pragmatic Language (TOPL) was

administered as a measure of XXX's ability to use language in a socially appropriate way. Due to time constraints, the entire test could not be administered which resulted in the inability to use the norm-referenced scores. Based on an informal analysis, XXX was able to respond correctly to approximately 58% of the items on this measure. This assessment tool includes a lengthy, syntactically complex set of directions that the examiner presents verbally. The redundancy of information contained in these directions did not seem to aid XXX's understanding of the task. He did seem to benefit from having the directions summarized and presented multiple times. Based on his performance with this measure and an informal analysis of his expressive language sample, XXX's overall pragmatic language abilities were deemed to be within normal limits and appropriate for his chronological age.

Auditory/ verbal working memory

XXX completed the *Numbers Forward* and *Numbers Backward* subtests of the CELF-4, which evaluated auditory/verbal working memory by assessing the individual's ability to repeat increasingly longer sequences of random numbers. XXX's standard score of 7 and percentile rank of 29 for forward repetition and standard score of 11 and percentile rank of 63 on backward repetition indicated that his performance is well within the normal range for his age group. This indicated that XXX has a sufficient ability to hold non-meaningful verbal information in his working memory. However, during today's evaluation, he consistently demonstrated difficulty with both processing and encoding tasks when meaningful linguistic stimuli are presented in longer/more complex utterances.

OTHER PERTINENT DATA

SAMPLE

Hearing Screening

XXX passed a complete audiological evaluation completed a year prior to the current evaluation. Parents and teachers report no concerns about his hearing status.

Articulation

XXX's ability to produce speech sounds was analyzed via his spontaneous language sample. No errors were noted and intelligibility was judged to be approximately 100%.

SUMMARY AND IMPRESSIONS

A number of standardized and non-standardized measures were used during today's session to assess XXX's speech and language skills. His articulation/speech sound production skills are judged to be age appropriate. However, XXX's overall language skills were consistently characterized by performance in the low average to below average range for his chronological age as evidenced by his CELF-4 Core Language standard score of 44 and corresponding 0.1 percentile rank. His ability to process and produce word meaning is considered a relative strength in his profile while sentence grammar and word structure abilities were judged to represent areas of weaknesses in XXX's linguistic repertoire. In the classroom, this overall profile may result in XXX demonstrating difficulty in understanding verbally presented directions of increasing length and syntactic complexity and also when he is required to produce well-formed sentences during academic tasks.

Overall, XXX's understanding of verbal input was facilitated by provision of directions and test items in written modality, as well as auditory. Additionally, he seemed to benefit when verbal instructions were summarized and presented multiple times. It is possible that some of the standardized test scores obtained during today's session may have slightly underestimated XXX's true abilities due to his apparent difficulty in identifying/maintaining task formats.

RECOMMENDATIONS

It is recommended that XXX receive speech and language services to improve his language comprehension and expressive skills. Twice-weekly therapy is recommended especially with his transition into grades where sufficient reading comprehension is critical to academic success.

Speech and language services are available at the Lamar University Speech and Hearing clinic, but services can also be received by XXX's home, school district or from a private speech-language pathologist. The American Speech Language Hearing Association (ASHA) will be able to provide contact information for private services, number is 1-800-638-8255, web address is www.asha.org .

Throughout today's assessment, XXX benefited from accommodations and alternative presentation of verbal information. The following are a list of accommodations that could be provided in the classroom environment to facilitate his academic success:

SAMPLE

Classroom Strategies

1. Clearly stated verbal directions (simple and concrete)
2. Written directions if verbal directions are still being misinterpreted
3. Use multiple modalities (written, gestures, demonstration) when delivering information
4. Provide many model examples of target productions or behaviors
5. Provide verbal prompts to aid in correct response

Claire Smith, B.S.
Graduate Clinician

Monica Sullivan, M.S., CCC-SLP
Speech-Language Pathologist
Clinical Supervisor

Conflict Resolution

There are always cases of disagreement between individuals, but if a dispute arises between a faculty member, academic or clinical, and student, the student may feel uncertain about how to resolve the problem without prejudice. The following policies have been adopted to give students a forum within which issues can be aired and, hopefully, resolved satisfactorily. The best hope is that the disagreement can be resolved by a discussion between the two parties. If the dispute cannot be resolved between the principle parties for any reason, the student should bring the complaint to the Clinical Director. The Clinical Director will act as mediator between all individuals involved in the complaint and will attempt to arrive at a fair solution. If the dispute still cannot be resolved between the principle parties and the Clinical Director, the complaint will be taken to the Department Chair. The Department Chair will establish a group, including the complainant, to discuss the issue and reach a resolution.

Questions pertaining to classroom assignments, performance, or grading should be raised with the course instructor. Students that are uncertain or confused as to policies or procedures with regard to course selection, requirements, or any of a number of other such issues, should see their advisors.

Questions regarding assignments in particular practicum/internship sites should be directed to the appropriate Clinical Advisor. Canards cannot be relied upon. Contact the appropriate individual by telephone, email, or personal visit to obtain accurate information. If a satisfactory solution is not reached, it is then appropriate to discuss the matter with the Clinical Director, who can advise further actions or avenues of appeal.

Complaints regarding clinic caseload, supervision, internships/externships, or any other clinically related issues/concerns should attempt to be resolved with the individual supervisor/instructor, professor, or clinical advisor directly involved. If a satisfactory solution is not reached, it is then appropriate to discuss the matter with the Clinical Director.

All complaints must be signed and submitted in writing prior to meeting with the Clinical Director. The document must clearly describe the specific nature of the complaint, the names of all parties involved in the complaint, steps taken to alleviate the problem, the outcomes thus far, and any other significant information.

A student may request to meet with the Clinical Director in private. However, all parties involved in the episode may request to attend the meeting. Most of the time, the parties to a dispute settle the issues during these discussions. However, if a student remains dissatisfied with the outcome of these conversations, the student may submit a written request to meet with the Department Chair to discuss conflict resolution. The letter must state the specific nature of the complaint and the redress, or remedy, the student seeks as an outcome of the meeting.

It is important to recall that the complaint process requires a student in conflict with an instructor, supervisor, or clinical advisor to attempt to resolve the dispute before meeting with either the Clinical Director or the Department Chair.

The student should start the process by meeting with the instructor/supervisor and then with the Clinical Director, and finally the Department Chair.

Students are encouraged to resolve complaints (or grievances) at the appropriate level of dispute; however, should this approach fail or be inappropriate, students may submit written complaints to the Office of Student Affairs in the Wimberly Building, Suite 115 or via fax (409) 880-1726.