Best Practice Guidelines In Speech-Language Therapy For Early Intervention Programmes
Preface

The practice of therapy has evolved, developed and matured over the years. The last decade saw significant growth and expansion of therapy services in social service sectors. With the growth and expansion in clinical therapy practice, it is of paramount importance that sound practice principles and protocols are in place.

Professionalism has taken a deeper root in the way we practice as we mature as a profession and the clients we serve become more knowledgeable. A basic tenet of professionalism of therapy practice is dependent on the standards of the service provided. It is therefore important for all practitioners to strive for excellence in the standards of service delivery.

Best Practice Guidelines for Speech therapy services requires that the therapists not only act in accordance with the knowledge, principles, and philosophies of their own profession, but also with a larger set of beliefs in mind. These beliefs and philosophies have grown out of collective experiences across disciplines. These collective experiences have evolved through much endeavour to manage and support the client with special needs. The aim is to enable them to overcome the various challenges to their capabilities and well being.

This Best Practice Guideline for Speech-Language therapy services will provide the therapists not only with the practice protocols but also serve as an evaluation tool.

Strategy and Specialisation
Service Development Division
National Council of Social Service
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Strategy and Specialisation Department
Service Development Division
National Council of Social Service, Singapore
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Definition

Speech-Language Therapists are professionally trained to prevent, screen, identify, assess, diagnose, refer, and provide intervention for, and counsel persons with, or who are at risk for, articulation, fluency, voice, language, communication, swallowing, and related disabilities. In addition to engaging in activities to reduce or prevent communication, swallowing, and related disabilities, Speech-Language Pathologists also counsel and educate families or professionals about these disorders and their management. (ASHA, 1996c)

The Individuals with Disabilities Education Act (IDEA) includes Speech-Language Pathology as both a related service and as a special education. As related services, speech-language pathology is recognised as “developmental, corrective, and other supportive services… as may be required to assist a child with a disability to benefit from special education… and includes the early identification and assessment of disabling conditions in children” [Section 602(22)]. Speech-Language Pathology is considered special education rather than a related service if the service consists of “specially designed instruction, at no cost to the parents, to meet the unique needs of the child with a disability, including instruction conducted in the classroom, in the home… and other settings.”

School-based speech-language pathologists prevent, identify, assess, evaluate and provide intervention for students with speech, language and related impairments, disabilities and handicaps. (WHO, 1980)

The school-based speech-language pathologist’s purpose in addressing communication and related disorders is to effect
functional and measurable change(s) in a student’s communication status so that the student may participate as fully as possible in all aspects of life – educational, social and vocational. (ASHA, 1997e)
Best Practice

Best Practice is the process of seeking out and studying the best internal practices that produce quality performance. In therapy practice it is a professional decision and action based on knowledge and evidence that reflects the most current and innovative ideas available for therapy service.

Objectives of Best Practice guidelines

- Improved client care.
- Define roles of Speech-language Therapist
- To be used as a model for development or modification of the policies and procedures
- Tool for advocacy
- Enhance growth of individual speech-language therapists
- Delineate the responsibilities of Speech-language Therapist
- Provide a scientific and systematic procedure for delivery of therapy services.
- A resource for therapy practitioners, administrators, social service and health care policy makers and other professionals.
- Describe the practice and delivery of therapy services using the disablement model within the context of the school’s objective.
• Establish the preferred practice pattern of therapy service within the rehabilitation setting.

• Delineate preferred practice patterns and help therapists/therapy services to:
  - Improve quality of care.
  - Enhance positive therapy outcomes.
  - Ensure efficient service provision.
  - Develop specialisation and specialist service provision.

• Establish benchmarks/quality indicators in therapy practice in the social service sector.

• Document the provision and outcome of therapy service in the social service/community sector.

• Serve as a basis for evaluation and accreditation of therapy services in the social service sector.
Disability Model

The model of disablement refers to the impact of acute and chronic conditions on the functioning of the body system, human performance, and of the usual, expected and personal desired roles in society. This model is used to delineate the consequences of disease and injury at the level of the person and the society.

A number of models have emerged and all the models attempt to explain the inter-relationship of diseases, impairments, functional limitation, disability, handicap and the effect of the interaction of the individual with the environment.

The definition of an individual with a disability under which NIDRR operates is Rehabilitation Act of 1973, (Public Law 93-112, U.S.A.) as amended. The law describes a person with a disability as follows:

...any person who (i) has a physical or mental impairment which substantially limits one or more of such person’s major life activities, (ii) has a record of such an impairment, or (iii) is regarded as having such an impairment [29 U.S.C. 706(8)(B)(U.S.A.)].

This definition is similar to those contained in the ADA, the Assistive Technology Act of 1998, and the Technology-Related Assistance for Individuals with Disabilities Act (Tech Act)(U.S.A.).

The impairments that cause limitations in activities may relate to genetic conditions or to acquired diseases or traumas. The extent of a disability and the conditions
associated with a disability are significant to individuals, to families, and to the nation.

Prevailing definitions clearly do not reflect new paradigm concepts of disability. Nearly all definitions identify an individual as disabled based on a physical or mental impairment that limits the person’s ability to perform an important activity. Note that the other possibility—that a barrier in society or the environment limits the individual—is never considered.

This plan suggests that it is useful to regard an individual with a disability as a person who has an impairment that requires an accommodation or intervention rather than as a person who is limited solely by a condition. This new approach derives from the interaction between personal variables and environmental conditions. Because accommodations can address person-centred factors as well as socio-environmental factors, a need for accommodation is a more adaptable concept for the new paradigm.

**Nagi Model**

<table>
<thead>
<tr>
<th>Active Pathology</th>
<th>Impairment</th>
<th>Functional Limitation</th>
<th>Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interruption of normal process, and effort of organism to regain normal state</td>
<td>Anatomical, physiological, mental, or emotional abnormalities and loss</td>
<td>Limitation of performance at the level of the organism or person</td>
<td>Limitation of performance of socially defined roles and tasks within a sociocultural and physical environment</td>
</tr>
</tbody>
</table>
### Pathophysiology

Interruption or interference with normal physiological and developmental processes or structure.

### Impairment

Losses or abnormalities of cognitive, emotional, physiological, or anatomical structure or function, including losses or abnormalities that are not those attributable to the initial pathophysiology.

### Functional Limitation

A restriction or lack of ability to perform an action in the manner or within the range consistent with the parts of an organ or organ system.

### Disability

An inability or limitation in performing tasks, activities, and roles to levels expected within the physical and social context.

### Societal Limitation

Restrictions attributable to social policy and barriers (structural or attitudinal) which limits fulfilment of roles and denies access opportunities that are associated with full participation in society.

<table>
<thead>
<tr>
<th>Impairment</th>
<th>Disability</th>
<th>Handicap</th>
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</thead>
<tbody>
<tr>
<td>Definitions</td>
<td>Abnormality of structure or function at the organ level</td>
<td>Functional consequences of an impairment</td>
</tr>
<tr>
<td>Examples</td>
<td>Speech, language, cognitive, or hearing impairments</td>
<td>Communication problems in context of daily life activities</td>
</tr>
<tr>
<td>Outcome measures</td>
<td>Traditional instrumental and behavioural diagnostic measures</td>
<td>Functional status measures</td>
</tr>
</tbody>
</table>

World Health Organisation – International Classification of Functioning, Disability and Health (ICIDH-2)

ICIDH – 2 as a classification does not model the “process” of functioning and disability. However it is used to describe the process by providing the means to map the different constructs and domains.
<table>
<thead>
<tr>
<th>Construct</th>
<th>Part 1: Functioning and Disability</th>
<th>Part 2: Contextual factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body functions &amp; Body Structures</td>
<td>Activities &amp; Participation</td>
<td>Environmental Factors</td>
</tr>
<tr>
<td>Body functions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Body parts</td>
<td></td>
<td>Personal Factors</td>
</tr>
<tr>
<td>Life areas (task, actions)</td>
<td>External influences on functioning</td>
<td></td>
</tr>
<tr>
<td>Capacity Executing tasks in a standard environment</td>
<td>Facilitating or hindering impact of features of the physical, social, and attitudinal world</td>
<td></td>
</tr>
<tr>
<td>Performance Executing tasks in the current environment</td>
<td>The impact of attributes of the person</td>
<td></td>
</tr>
<tr>
<td>Change in Body function (physiological)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in Body structure (anatomical)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive aspect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Functional and structural integrity</td>
<td>Activity Participation</td>
<td>Facilitators</td>
</tr>
<tr>
<td>Activity Participation</td>
<td></td>
<td>Not applicable</td>
</tr>
<tr>
<td>Negative aspect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impairment</td>
<td>Activity limitation</td>
<td>Barriers / hindrances</td>
</tr>
<tr>
<td>Disability</td>
<td>Participation restriction</td>
<td></td>
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</tbody>
</table>
ICIDH-2 classification provides a unified and standard language and framework for the description of health and health-related states. It defines components of health and some health-related components of well being (such as education, labour, etc.). The ICIDH-2 domains can be seen as health domains and health-related domains.

These domains are described from body, individual and societal perspectives by two basic lists: (1) body functions and structure; (2) activities and participation.

ICIDH-2 systematically groups different domains for a person in a given health condition (e.g. what a person with a disease or disorder does do or can do). Functioning refers to all body functions, activities and participation as an umbrella term; similarly, Disability serves as an umbrella term for impairments, activity limitations or participation restrictions. ICIDH-2 also lists environmental factors that interact with all these constructs. In this way, ICIDH-2 provides a useful profile of individuals' functioning, disability and health in various domains.

ICIDH-2 provides the language to code a wide range of information about health (e.g. diagnosis, functioning and disability, reasons for contact with health services) and uses a standardized common language permitting communication about health and health care across the world in various disciplines and sciences. It provides a multi – perspective approach to the classification of functioning and disability as an interactive and evolutionary process.
An individual functioning in a specific domain is an interaction or complex relationship between health condition and the contextual factor (i.e. environment and personal factor). There is a dynamic interaction among these entities and intervention is one of the entities, which have the potential to modify one or more of the entities.

The scope of practice in speech-language therapy encompasses all components and factors identified in the WHO framework. That is, speech-language therapists work to improve quality of life by reducing impairments of body functions and structures, activity limitations, participation restrictions, and environmental barriers of the individuals.
they serve. They serve individuals with known disease processes (e.g., aphasia, cleft palate) as well as those with activity limitations or participation restrictions (e.g., individuals needing classroom support services or special educational placement), including when such limitations or restrictions occur in the absence of known disease processes or impairments (e.g., individuals with differences in dialect). The role of speech-language therapists includes prevention of communication, swallowing, or other upper aero-digestive disorders as well as diagnosis, habilitation, rehabilitation, and enhancement of these functions.
Future Development of Best Practice Guidelines

Best Practice Guidelines (BPG) are evolving guidelines and will be constantly updated and modified to be relevant with the development of scientific literature, outcome research, new intervention strategies and practice settings.

Therapy best practice guidelines will be integrated with the Programme Evaluation System (PES). It will form the basis for evaluating individual therapists and departmental performance through structured reporting systems.

Schematic diagram to depict how BPG can form the basis of programme evaluation, manpower planning and appraisal.
BPG will also assist in future manpower planning of the sector by delineating appropriate programme-specific manpower requirements and practice patterns.

Schematic diagram to depict role of BPG in manpower forecast
Programme Standards
**Programme Standard**

- To provide an effective and high quality intervention programme incorporating the best paediatric speech-language therapy practices for children with special needs to help them to develop to their potential.

- Therapists are expected to attain a high level of professional practices including the professional code of ethics in their professional work as a staff member of agency as well as a professional in their field of work. The same applies to their representation on behalf of agency in any other official/professional capacities.

- To maximise limited resources for optimal benefits of their clients and their parents/caregivers.

- To provide an effective collaboration/partnership with parents, other professionals (internal and external) and external agencies.

- Therapists are expected to adhere to their professional code of ethics as well as to be responsible for their professional growth and development through the support of agency, where relevant.
1 Agency – Early Intervention

- Objectives

The Early Intervention Programme’s (EIPIC) primary objective is to equip young children with the necessary skills to communicate effectively with their parents and caregivers.

Objectives in brief are

- To provide parents and caregivers with the satisfaction of early two-way communication
- To provide the child with appropriate early amplification and training
- To establish early emotional bond between the child and family
- To provide a foundation for speech and language development
- To provide an understanding of the social world
- To provide parents and caregivers with materials, resources and books about impairment

2 Objectives for Speech-Language Therapy Department

- To provide therapy intervention to facilitate, develop, improve and maintain communication & self help (eating and drinking) skills of clients.
• To optimise functional communicative ability through the use of appropriate assistive and adaptive technology.

• To provide comprehensive caregiver programme.

• To work collaboratively with teachers and other professionals to maximise clients development and potential.

• To provide paediatric speech-language therapy services for the children in centre to address the diversified needs of students, including – Speech, Language, Hearing, Cognitive, functional Communication, Educational, Reading and Writing skills.

3 Objectives for agency based therapy programmes

Individual sessions

• Individual Therapy Session is allocated as per the individualized need of a student. Individual sessions are offered in the form of consultation and home visits as well as in therapy department.

• Frequency of therapy depends on the need of the student as well as on the availability of slots. Individual sessions are allocated on a weekly/fortnightly/monthly basis.

• Short Individual Consultations are done to oversee other client waiting to be seen by the therapists at the
centre. Blocks of 5-6\(^1\) sessions are given to an individual student to identify the problems, workout the therapy plan; provide hands on training to parents and caregivers. At times, the therapy sessions are extended at the discretion of the therapist’s professional & clinical judgment. Following which, the client is placed on a subsequent follow-up by the therapist.

**Group Session**

- The Speech-Language therapy department offers different group therapy program\(^2\) incorporating objectives in the following areas – a) Speech: Articulation/Phonology, Fluency b) Language, c) Voice/Resonance, d) Cognitive-perceptual, e) Hearing, f) Drooling, g) and other forms of functional communication.

**Classroom session/consultation**

- Are carried out within classroom environment to address Group-communication/ Speech: Articulation/Phonology, Fluency, Voice / Resonance, Reading, Hearing etc.

**Parent education and Consultation**

- Educate parents/caregivers on students communication, hearing and cognitive functions.

- Engage the parents/caregivers in overall management of the student.

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\(^1\) Certain cases may need more number of sessions  
\(^2\) Group consists of 2+clients in a small and 4+ clients in a big group
• To provide demonstration therapy for home programs to reinforce therapy goals.

4 Objectives of home based therapy programmes
(Home visits)
• Provides Therapy intervention for students.

• Facilitates continuity of therapy program between school and home.

• Assess home environments and any need for home modification.

• Addresses parent’s specific needs or concerns of student.

• Facilitate better management by parental counselling

5 Objectives for holiday therapy programme
• Home visits - are done by the therapist as and when there is a need either with teachers or independently.

• Home Management - Therapists provide written home program for the student to facilitate functional objectives set during the individual sessions or in classroom session.

• Students who needs continuity of therapy intervention during the school holiday.
• Parent consultation / Training
• Make up sessions
• Demonstration therapy

6 Objectives for individual therapy consultation
• Provide direct / indirect intervention in school setting.
• To facilitate a smooth transition of the student into class.
• To allow therapists to offer 80% of their time providing direct services to students.
• To develop, facilitate / improve / maintain communication, hearing, reading, cognitive, issues among students with special need
• More direct and individual attention can be paid

7 Intake criteria for School based Speech-Language therapy programmes

Referral Criteria for SLT
• Alternative or Augmentative communication
• Language Development
• Speech: Articulation/Phonology, Fluency
• Voice / Resonance
• Hearing
• Oro-motor skills
• Reading and writing skills
• Cognitive communication
• Training caregivers and parents
• Perceptual Motor Dysfunction
• Perceptual Cognitive functions
• Feeding and Swallowing functions

8 Distribution of work in relation to department’s objectives

• Direct Therapy Intervention is 80% of working hours.
  - Individual Therapy
  - Group therapy
  - Home based therapy programme
  - Consultation (teachers, professionals, parents / caregivers)
  - Training for teachers, parents / caregivers, professionals

• Continuing Education and Training 5% of total working hours.

• Departmental and/or organisational meeting 5% of total working hours.

• Planning and Departmental Administrative work 10 % of total working hours.

1 Allocated percentile hours include intervention, caregiver training and documentation.
2 80% of Therapists working hour should be spent in “Direct intervention”
9 Indicators for Speech-Language Therapy Department

- Department will spend at least 80% of working hours in direct intervention.

- SLT Department delivers at least 90% of scheduled therapy sessions.

- SLT Department achieves at least 75% of targeted therapy outcome for every six-monthly review of individual care plans/IEPs.

- Department will complete 100% of projects\(^1\) undertaken.

- Department achieves 80% of satisfied service recipients (client/ caregiver)

- Department has 100% compliance to safety guidelines at any given time.

- Department staff will spend at least 5% of man-hours in continuing therapy education and in-service training per year.

\(^{1}\) 85% Identified projects should be speech therapy practice (Care Path / Research / Technique or Programme Development) or department-related.
Therapy Service Delivery and Intervention
Speech-Language Therapists determine their care plan based on competent reasoning and decision making on ideas consistent to the philosophy of Speech-Language Therapy practice.

Speech-Language therapists work with different members in the school system, and it is important that other professional colleagues and family members of the child understand what is being planned for the child.

The various frames of reference in Speech-Language therapy are useful in relating the care plans from different team member’s perspective. These frames of references provide a systematic way to consider performance problems, and identify the priorities for intervention to address the problem. It is important to look into several options when determining the care plan.

The following MEANS, REASONS AND OPPORTUNITIES MODEL\(^1\) explains the service delivery issues in Speech-Language therapy practice.

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\(^1\) Broxtowe and Hucknall Primary care trust
• Without MEANS of communication, nobody can express themselves

• Without REASONS for communication, there is no point in or need to communicate

• Without OPPORTUNITIES, there cannot be communication

1 Assessment

Assessment refers to data collection and gathering of evidence. Evaluation refers implies bringing meaning to that data through interpretation, analysis and reflection. (Routman, 1994)
A core role of the Speech-Language therapist at the center is to conduct a thorough and balanced speech, language, or communication assessment.

The Speech-Language Therapy department selects assessment measures that
- minimise cultural and linguistic bias
- are appropriate for the student’s age
- match the stated purpose of the assessment tool to the reported needs of the student
- describe the student’s specific communication abilities and difficulties
- elicit optimal evidence of the student’s communication competence
- describe real communication tasks

1.1 Assessment plan

A comprehensive assessment plan is developed within mandated time lines. It documents the areas of speech & language and swallowing to be assessed, the reason for the assessment, and the personnel conducting the assessment.

The result from the screening is used to identify the specific areas of speech and language and Swallowing to be addressed. The client’s dominant language and level of language proficiency are specified in the assessment plan. Parents may participate in the development of the assessment plan. Parents are provided the written assessment plan (if needed).
The foundation of quality individualised assessment is to establish a complete history. Since no single assessment measure can provide sufficient data to create an accurate and comprehensive communication profile, conducting both standardized and non-standardised assessments is recommended. (Haney 1992)

During assessment data collection Speech-language therapist is responsible to gather information, select appropriate assessment methods and conduct a balanced assessment.

The balanced assessment may include:

- gathering information from parent(s), family, student, teachers, other service providers
- compiling a student history from interviews and thorough record review
- collecting client-centered, contextualised, performance-based, descriptive, and functional information
- selecting and administering reliable and valid standardized assessment instruments that meet psychometric standards for test specificity and sensitivity

2 Evaluation

Once the comprehensive assessment has been completed, the results are interpreted. It’s the Interpretation that gives value to the assessment data hence the term evaluation. (Routman, 1994)
It is the responsibility of the speech-language therapist, as a part of a team, to assist in interpreting data that will:

- identify strengths, needs and emerging abilities

- establish presence of a disorder, delay, deficient or difference – including determining the clients abilities within the context of home and/or community

- determine a severity rating (preferably standardised)

- define the relationship between the students level of speech, language and communication and hearing abilities and any adverse effect on educational, social and vocational performance

- determine if the communication disability is affected by additional factors influencing the results of the communication assessment

- summarise evaluation results and make recommendations

The evaluation report serves as the basis for the team’s discussion of alternatives and recommendations. It includes the following information:

- Student history information from record review and parent, teacher, and/or student interview

- Date(s) of assessment(s)

- Relevant behaviors noted during observation

- Assessment information from all disciplines
• Observation/impressions in a variety of communication settings

• Results of previous interventions

• Descriptive assessment results

• Standardized assessment results and documentation of any variations from standard administration

• Discussion of students strengths, needs and emerging abilities

• Disorder / delay / difference determination, including the students communication abilities within the context of home and community

• Severity rating (when applicable)

• Educational relevance, including academic, social-emotional and vocational areas

• Interpretation/integration of all assessment data

• Evaluation results and recommendations for strategies, accommodations and modifications

3 Eligibility determination

Comprehensive assessment (data collection) and evaluation (interpretation of that data) enable the speech-language therapist to identify students with significant educationally relevant communication disorders.
4 IEP Development

An individualized education program (IEP) is developed for all students who qualify for speech and/or language services. The IEP team, including the speech-language therapist, develops the IEP document. The team may include:

- the parents of a child with a disability
- at least one regular education teacher of such student (if the student is, or may be, participating in regular education environment)
- at least one special education teacher or, where appropriate, at least special education provider of such student
- a representative of management committee (if possible)
- other individuals…. Who have the knowledge or expertise regarding the student, including related services personnel as appropriate
- at least one member from other disciplines like Audiologist, Occupational Therapy, Social work, Psychology, nurse (where applicable) etc.
- If possible, the student with disability

Special factors in developing the IEP content include:

- in case of a Student whose behavior impedes his or her learning, or that of others, consider, when
appropriate, strategies including positive behavioral interventions and supports to address that behavior

- consider the language needs of the students as such needs relate to the students IEP

- consider the communication needs of the students who is deaf or hard of hearing, consider the students language and communication needs, opportunities for direct communications with peers and professional personnel in the students language and communication mode, academic level, and full range of needs, including opportunities for direct instruction in the students and his/her communication mode.

- consider whether the student requires assistive technology devices and services

4.1 Required components of IEP

<table>
<thead>
<tr>
<th>Strengths</th>
<th>The strengths of the student and the concerns of the parents for enhancing the education of their student</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation results</td>
<td>The results of the initial evaluation or the most recent evaluation</td>
</tr>
<tr>
<td>Present level of educational</td>
<td>The effect of the student’s disability on the involvement and progress in the general education</td>
</tr>
<tr>
<td>performance</td>
<td>curriculum (or participation in appropriate preschool activities if appropriate). General areas</td>
</tr>
<tr>
<td>Table</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>-------------</td>
</tr>
<tr>
<td>should include</td>
<td>Language, Cognition, Motor skills, Social competency, self help skills and other areas.</td>
</tr>
<tr>
<td>Annual goals and short-term objectives</td>
<td>Measurable goals, benchmarks, or objectives related to meeting general educational curriculum or other educational needs that result from disability</td>
</tr>
<tr>
<td>Amount of special education or related services</td>
<td>Projected beginning date, frequency and duration of service</td>
</tr>
<tr>
<td>Supplementary aids and services</td>
<td>Programme modifications or support services necessary for the student to advance toward attaining annual goals, be involved and progress in general education curriculum, participation in non-academic activities, and be educated and participate in activities with other students.</td>
</tr>
<tr>
<td>Test modifications</td>
<td>Modifications in the administration of assessments of student achievement that are needed in order for the student to participate in the assessment (If exempt, the reason why test is not appropriate must be stated)</td>
</tr>
<tr>
<td>Transition Plan or service</td>
<td>At appropriate age, transition services specify interagency responsibilities or needed community links</td>
</tr>
<tr>
<td>Evaluation procedures and</td>
<td>Measures of student’s progress, how often the evaluation would</td>
</tr>
<tr>
<td>method of measurement</td>
<td>take place. Progress must be reported as often as possible.</td>
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<tr>
<td>-----------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>IEP team members</td>
<td>Signatures of all members of the IEP team that developed the IEP</td>
</tr>
</tbody>
</table>

The quality of Speech-Language therapy care involves a problem solving process where the therapist makes an effective decision on intervention based on symptoms, signs, and limitation of function when assessing / evaluating and re-assessing the student with special needs.

- All students receiving services at the therapy department must be screened/ assessed before commencement of service.

- All students referred to the therapy department will be screened/ assessed within three to six weeks depending on the availability of resources.

- All assessment and screening will follow a standardised format.

- Departments / therapists are encouraged to use therapy documentation software for standardisation of assessments/reassessments and daily reports.

- All documentation (assessment / reassessment/ daily reports) preferably should be completed within the same day of the event/ intervention.

- It is mandatory that assessment / reassessment/ daily report be dated and signed by the therapist.
• Therapists should make every effort to include parents / caregivers while evaluating the student.

• All assessments/ reassessments and daily reports should be accompanied by recommendations, goals and intermediate and long-term outcomes/goals for therapy interventions.

• All students should be reassessed every six months.

• Therapists should effectively communicate their assessment/evaluation findings, goals and anticipated outcomes with parents and referral agencies.

Assessment forms are attached in Appendix*

5 Care Plan

• Therapists are encouraged to use the therapy care-plan as a guide.

• Individualised care-plans should be developed after full student assessment and in consultation with other professionals, the client, family / caregiver.

• Care-plan outcomes should be documented.

• All care-plans should be reviewed every two years.

• Therapists are encouraged to expand the care-plan whenever required.
• All individualised care-plans must incorporate caregiver training.

• Therapist must communicate the findings of his/her examination, evaluation, diagnosis and prognosis with other professionals and caregiver.

• Therapists shall inform and collaborate with the student/caregiver to establish treatment goals and care-plan.

Specific Care Plans are attached in Appendix*

6 Intervention

Speech-Language therapy services may be provided for students with speech, language, hearing or communication disorders as defined by the evaluation and eligibility criteria established policies and procedures for special education and related services.

Students receive intervention when their ability to communicate effectively or swallow safely is impaired (or their diagnosis indicates risk for impairment) and there is a reason to believe that intervention will reduce the degree of impairment, disability or handicap and lead to improved communication behaviours and swallowing functions.

6.1 Direct Service Model

• Services are provided to a student by the SLT or by a speech/communication assistant, a paraprofessional under the supervision of the SLT.
• Services may take place in a separate room in the school, in the classroom, in the community, or in a combination of settings.

• Services may be one-on-one, in a group setting, or both.

• Services might include assessment (testing), and the instruction, practice and generalization of communication skills training. Examples of the many services include:
  
  o Observing in various environments in order to obtain functional assessment information about interaction skills;

  o Observing in the classroom to check for generalization of skills;

  o Assessing vocabulary comprehension and use through formal and informal means;

  o Teaching someone to lower volume control, that is, to speak with average or increased volume;

  o Teaching someone acceptable ways of requesting peer or adult attention;

  o Teaching someone to understand when a question format requires a time-related response;

  o Teaching someone to signal when he or she wants to change topics during a conversation;

  o Teaching someone how to use a communication device; and

  o Teaching a student who is having difficulty learning to read about phonological or sound awareness.
Observing the feeding sessions to look for any signs of aspiration.

Training the teachers, assistants or aides, on safe and correct ways of feeding the student

• Generalization of skills is always a concern when using this model, especially for services that only take place in a therapy room. That does not mean, however, that pull out services (i.e., services in a therapy room) should never be provided on a short- or long-term basis. Instead, it means selecting the best option for a specific situation

6.2 Consultation Model

• Consultation can include a variety of activities. Before an Individualized Education Program (IEP) is completed, a team discussion with clarification of roles and expectations regarding the consultant's services is necessary

• Sometimes consultation services have a major collaborative or partnership component

• In some situations, a consultant uses an expert service delivery model. In this role, the service is as needed or on a one-time basis, and is usually not ongoing on a scheduled basis. Activities could include the following:

  • Someone has a problem and the SLT is requested to observe, evaluate the student, and provide suggestions to the teacher. Sometimes a consultation is requested in response to a challenging situation.
Consultation also can be used in a proactive manner. For example, an SLT may observe the effectiveness of a teacher's discourse or oral communication with a class during group instruction. The SLT might make suggestions that could improve the attending behaviour or verbal comprehension of the student with autism spectrum disorder as well as other students in classroom.

- Consultation services also may represent a means of monitoring a student's generalization of skills into everyday situations through intermittent checks with a teacher.

- SLT consultation services may be combined on the IEP with other service delivery options or roles, or instructional goals.

### 6.3 Collaboration Model

- Collaboration, like consultation, can vary and will need definition as it pertains to a particular student and his/her IEP.

- Collaboration can involve team planning and team implementation of a communication plan. The SLT, classroom teachers, and teaching assistants meet to plan specific activities. The SLT may or may not be in the classroom or community when activities occur.

- Collaboration could also include teaching a class or team teaching. Careful monitoring may be needed to insure that a given student is given the designated
amount of contact time or instruction specific to his/her goals when this option is used.

- Collaborative planning allows communication goals to be practiced throughout the school day. Potentially, more practice will occur each day than would occur if only a pull out model (services in a therapy room) were used to teach a given skill. Data keeping is needed to insure that sufficient communication teaching or practice occurs during activities each day.

- A collaborative model has the potential to insure that communication is learned in functional or daily situations. Collaborative planning also must include adequate training and support of all persons who implement daily or weekly instruction.

Examples of collaboration include the following:

- Supporting the student and others during a classroom writing activity
- Attending a weekly problem-solving meeting that focuses on behavioural issues. (Communication and behaviour are often intimately linked.)
- Designing topic communication boards that support a minimally verbal student during a classroom discussion and providing on-site support during the activity as a means of training the child's professional staff
- Meeting with classroom teachers to discuss upcoming units in subject areas, the background knowledge students may need, as well as the visual supports and strategies that may be needed to aid comprehension.
## 6.4 Methods of Effective Intervention

<table>
<thead>
<tr>
<th>Responsibilities</th>
<th>Methods</th>
</tr>
</thead>
</table>
| Planning intervention  | • Determine priority areas for intervention  
                        • Determine content to meet goals and objective  
                        • Select appropriate materials  
                        • Determine intervention methods based on student learning styles                                                                 |
| Managing interventions | • Establish classroom management system  
                        • Establish positive environment  
                        • Use time productively  
                        • Communicate realistic expectations  
                        • Coordinate curriculum and goals with other educational staff, parents/families  
                        • Motivate students                                                                 |
| Delivering intervention| • Present instruction  
                        • Promote problem-solving and thinking skills  
                        • Provide relevant practice of skills  
                        • Provide opportunity for communication in the natural environment  
                        • Keep students actively involved  
                        • Provide feedback  
                        • Prompt/cue as appropriate during guided learning                                                                 |
| Evaluating intervention| • Monitor intervention time  
                        • Track students performance  
                        • Maintain record of students progress  
                        • Inform IEP team members of the                                           |
progress
- Use treatment outcome date to make decisions
- Modify instructions if necessary

6.5 Scope of Intervention

Speech-Language therapy area is a dynamic and continuously evolving practice area. The scope of practice includes treatment and intervention and follow-up services for disorders of:
- Language (involving the phonology, morphology, syntax, semantics and pragmatics. Disorders of expressive and receptive communication in oral, written, graphic and manual modalities)
- Cognitive aspects of communication (including communication disability and other functional disabilities associated with cognitive impairment)
- Social aspects of communication
- Speech (articulation, fluency)
- Voice (respiration, phonation and resonance)
- Oral, pharyngeal, esophageal and related functions (feeding, dysphagia, oro-motor functions, oro-facial functions, etc)
- Reading and Writing
Therapist provides, or directs and supervises, the therapy intervention in a manner consistent with examination data, evaluation and the care-plan.

- Intervention is based on examination, diagnosis, prognosis and care plan.

- Provided under direction and supervision of the therapist.

- Intervention is altered in accordance to the change in status and response of the client.

- Intervention may be multidisciplinary on occasions to meet the needs of the client.

- Intervention can be individualised or in a group setting.

- Each individual session is of minimum 30 minute duration.

- Group therapy session should have a minimum number of 2+ clients in a small group and 4+ in a big group. Duration of group session is approximately 45 minutes to 60 minutes.

- Group should be as homogeneous as possible with regards to their rehabilitation outcome and activities.

- Frequency of intervention will depend on the client’s need identified by the therapist following assessment and client’s / caregiver’s ability to attend therapy sessions.
7 Documentation

All interventions must be documented. This could be in the form of initial assessment, assessment, special tests, progress notes, therapy notes, daily reports, re-assessments and therapy outcomes. It should also include the IEP and checklists for care plans if applicable.

- All handwritten documents should be duly entered and signed with ink; electronic entries should have appropriate security and confidentiality features.

- Documentation of all the episodes of care must be done on the same day

- All documents related to student are confidential.

- All documentation related to therapy should be filed within the same day in designated folder of students file

- All correspondence related to the student should be filed promptly in students file.

- All reports either internal or external should be copied and filed within the same day in designated folder of students file.

- Requests for external reports should be filed in designated folder of students file.
8 Referral

- Referral may be either internal or external.

- All referrals need to be documented and explained to students/parents/caregivers (where applicable).

- External referral should include formal letter and a short status report.

9 Discharge

Discharges are the process of ending an episode of therapy services when anticipated goals and expected outcomes have been achieved. The discussion of discharge is done during the eligibility meeting when prognostic indicators and guidelines for discharge are discussed with parents and teachers. Consideration may be given to
- Potential to benefit from intervention
- Medical factors
- Psychosocial factors
- Attendance
- Parent involvement
- Teacher involvement
- Other disabling conditions
- Student motivation
- Progress with different services

Other considerations
- Discharge is based on therapist’s assessment and findings and clinical judgements, when anticipated goals and outcomes have been achieved.
• Reasons for discharge and interdisciplinary teams recommendation for dismissal are documented

• Discharge plan should include possible referral and follow ups if applicable.
• All discharge reports should be duly signed by Head of the Department/supervisor and documented.

• The discharged students report should go to the central file and department file.

• The student’s file should be kept in the designated filing cabinet and shouldn’t be discarded immediately.
Personnel
1 Code of Conduct

- Therapists recognise the individuality of each student and respect their differences.

- Therapist’s conduct must not be abusive, harassing or discriminatory against students and associates.

- Therapists should obtain informed consent from student/caregiver before treatment and related activities.

- Therapists should disclose nature of proposed intervention and expected outcomes to student/parent/caregivers/teachers etc (where applicable).

- Therapists should accept responsibility for therapy management within the scope of practice and should exercise sound judgment.

- Speech-language Therapist’s should not delegate responsibility to a less qualified person for an activity that requires the skill, knowledge and judgement of a qualified Speech-language therapist.

2 Recognised qualification

- Speech- Language Therapists employed at VWOs/ (programme type) should be from institutions accredited by relevant authorities.
All the therapists are encouraged to apply for membership with the Speech-Language Hearing Association (Singapore).

3 Outline for Job description of a Speech-Language Therapist

Inter-relationship

- Clients: children with disability in School
- Medical Professionals and other support service personnel
- Administration personnel

Reporting Structure

- The therapist must abide by the standard reporting structure as stipulated by the organisation

Duties and Responsibilities

- Speech-Language Therapy Treatment
- Assess and identify individual needs of clients and formulate / develop and implement appropriate individualised Speech-Language therapy programmes. These would aim to facilitate, restore, improve or maintain movement and functional abilities.
• Work with clients on a one-to-one basis, group or special setting based on their levels of function and severity of disability.

• Liase with various disciplines involved in the rehabilitative treatment process.

• Evaluate and document client’s speech-language therapy needs and progress at regular intervals, monitor training programmes and review their effectiveness.

• Provide consultation, support and update about the clients’ progress and status to caregiver and all those involved in the rehabilitation team.

• Refer clients to respective specialists for consultation and appropriate intervention.

• Evaluate, prescribe and fabricate/purchase assistive devices to improve function as required by the client.

• Train and supervise caregivers in maintenance of therapy programmes.

• Involve in discussions of client – related issues with caregivers and members of the caregiver team.

Administration

• Efficient documentation
• Engage in administrative duties relevant to departmental work

**Professional / Staff Development**

• Continuing education/ in service training/ research

**Other Activities**

• Undertake responsibilities and duties assigned by the HOD/ Principal/ Director/ Management

**Maintenance**

• Ensure proper maintenance/ inventory of equipment

**Immediate Subordinate**

• Speech-Language therapy support staff

**School**

• Involve in individual and group activity programmes conducted for children in school setting

• Train and teach school teachers/assistants in relevant basic techniques of Speech-Language therapy to facilitate implementation in the classroom setting.
• Liase with and teach parents basic client handling skills to ensure and encourage continuity of Speech-language therapy programmes at home and at school.

• Provide support and counselling to family members/carers of client if required.

4 Dress code

The desired dress code policy combines the professionalism of the business look with the comfort of an informal but smart look.

Professional Image

• Therapist should project an image of professionalism, reliability, conscientiousness and competence.

Consideration for Dressing

• The golden rule of dressing is to apply audience analysis and to consider what one’s image objective is. Staff should determine whom they would be dealing with so that what they wear matches the people and situation. Dressing should be in accordance with people in contact and prevailing situations.
Working Days (Smart Professional)

- Mondays to Friday, staff should dress more formally and project a professional Image. The recommended clothing for staff is:

**Recommended for Men**

- Plain or striped shirts
- Long Pants
- Polo ‘T’ shirt

**Recommended for Women**

- Skirts with Collared blouses
- Skirt Suits, Pant Suits
- Pants with Shirts/Blouses/ Polo ‘T’ shirt
- Punjabi suits
- Baju Kurung

5 Client’s confidentiality

- Therapist should act in the client’s best interest.
• Information relating to clients status/ condition may not be communicated to a third party not involved in client’s care without prior consent of the client.

• Information from professional reviews/ case conference shall be kept confidential unless the members of the review committee and client/ caregiver consent to the release of the information.

• Therapists can disclose information to appropriate authority at official request and it is necessary to protect the welfare of the client.

6 Continuing education

• Therapists should be actively participating in Continuing Education Programme (CEP) within their organisation, NCSS and professional bodies.

• Therapists should organise monthly/quarterly in-service sessions within their dept/ organisation.

• Therapists should attend at least 1-2 other type of courses (I.T., Interpersonal skills, communication, writing, and first-aid skills etc.

• Smaller agencies should collaborate with other agencies and organise in-service training.

• Therapists should attend at least two-therapy related workshops within a calendar year.
• Therapists are strongly encouraged to attend therapists’ Networking meetings on a regular basis.

• Therapist should spend 80 to 100 hours in CEP per year or 5% to 6% of total annual work hours.

7 Resources

The department should have adequate resources to enhance and expand the therapy practice as needed.

It is recommended that the department take the following measures to develop the resources

• At least one professional journal

• Purchase of at least two therapy related books every year.

• Each department to have internet access for further research and development

• Equipment / software’s (Speech & Language)

• Standardised tests / assessment lists
Organisation and Management
1 **Administration of Therapy Services**

- Therapy service should have mission, purposes and goals

- Therapy service should define the scope and limitation of therapy service provision.

- Therapy service should have a written and endorsed organisational plan that:
  - Describes relationships between therapy service and other components of the organisation.
  - Ensures that service is directed by a therapist
  - Defines supervisory structures within the service
  - Ensures compliance with NCSS requirements for therapy service.
  - Ensures compliance with NCSS Standards of practice and Best Practice Guidelines for VWOs/Community Therapy Services.

2 **Speech-Language therapist’s monthly report**

- All therapists should submit completed monthly reports to the respective department head by 5th day of the following month

- Compiled departmental monthly report to be submitted to the Principal within 10 days of the following month.
• Individual and departmental monthly report should indicate if the monthly targets are achieved.

• All monthly individual and departmental reports should be collated at the end of each quarter and annually for annual reports.

• All reports should be in Excel document.

A copy of the standardized monthly report is attached in the Appendix

3 Meetings

• Therapists should have at least one departmental meeting per month.

• Departmental head/ appropriate staff should report departmental progress at monthly organisational meeting.

• All departmental meetings should be recorded and filed.

• Therapist without administrative responsibility should not attend more than four meetings a month.

• Department head/in charge should report the outcome achieved by the department to the head of the organisation within the first ten working days of the month.
4 Inventory for equipment / resources

Equipment refers to all the items in the therapy department used for therapy delivery, administration, continuing education and caregiver training.

- Department should maintain an inventory for therapy equipment/resource/office equipment.
- All equipment should be listed using organisational coding.
- Stocks of consumable items should be monitored to ensure proper supply.
- Review of equipment for wear/tear and potential safety hazard.
- Assess need to increase/stock/order of new equipment

5 Environment and safety guidelines

- The safety of the client is of paramount importance during therapy sessions and when participating in any activity involving a department’s staff.
- Department should ensure strict infection control.
- Clients should not be left unattended at any time.
- Client safety should be ensured at all times; injury and falls should be avoided through proper department layout and written safety guidelines.
• Therapy areas should be free from obstructions as children may have physical or cognitive perception limitations.

• Department should ensure that equipment, training devices and the environment is clean and safe for use.

• Department should have a written preventive maintenance plan for all therapy equipment.

• In case of injury or accident to the client a report should be made to school nurse (if applicable) or any relevant person, and recorded in the school accident book. All accidents during therapy sessions must be reported to appropriate authorities as soon as possible.

• It is recommended that all staff should be certified First aid provider.

• Department should maintain a First Aid box.

• In case of fire the organisational fire evacuation plan should be followed.
Appendices
## Appendix 1
### Oral and Written Receptive and Expressive Factors

<table>
<thead>
<tr>
<th></th>
<th>Listening Speaking</th>
<th>Reading Writing</th>
<th>Receptive Expressive</th>
<th>Receptive Expressive</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Form</strong></td>
<td>Applies phonological, morphological and syntactic rules for comprehension or oral language</td>
<td>Uses words and sentences correctly in discourse according to phonological, morphological and syntactic rules</td>
<td>Applies grapho-phonemic, morphological, and syntactic rules for comprehension of text</td>
<td>Uses words and sentences correctly in writing according to spelling, morphological and syntactic rules</td>
</tr>
<tr>
<td><strong>Content</strong></td>
<td>Comprehends the meaning of words</td>
<td>Selects words and uses oral language to convey meaning. Formulates thoughts into oral language. Uses precise and descriptive vocabulary</td>
<td>Comprehends the meaning of words and text</td>
<td>Selects words and uses written language to convey meaning. Formulates thoughts into written language. Uses precise and descriptive vocabulary</td>
</tr>
<tr>
<td><strong>Function</strong></td>
<td>Follows directions understands social meanings</td>
<td>Uses appropriate language for the social context. Takes turns in listener/speaker role</td>
<td>Understand tone, style mood, and context of the text</td>
<td>Follows rules of discourse. Uses various styles and genres of writing</td>
</tr>
<tr>
<td><strong>Cognitive communication components</strong></td>
<td>Attention, long- and short-term memory, problem solving and related components</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Appendix 2

### Articulation/phonology components

<table>
<thead>
<tr>
<th>Phonemic</th>
<th>Phonological</th>
<th>Oral-Motor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speech sounds,</td>
<td>The rules for the sound system of the language including the set of phonemes</td>
<td>Oral motor range, strength, and mobility. Planning, sequencing, and</td>
</tr>
<tr>
<td>Characterised by vowels and by</td>
<td>with allowable combination and pattern modifications</td>
<td>co-articulation of speech movements</td>
</tr>
<tr>
<td>consonant manner, place and voicing</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Appendix 3
### Fluency factors

<table>
<thead>
<tr>
<th>Affective</th>
<th>Behavioural</th>
<th>Cognitive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feelings about speaking</td>
<td>Respiration</td>
<td>Language/linguistic competencies</td>
</tr>
<tr>
<td>Self-esteem</td>
<td>Articulation</td>
<td>Accuracy of perceptions</td>
</tr>
<tr>
<td>Feelings in response to environmental and situational influences</td>
<td>Phonation</td>
<td>Attitude about speaking</td>
</tr>
<tr>
<td>Feeling of fluency control</td>
<td>Rate of speaking</td>
<td>Attitudes regarding fluency</td>
</tr>
<tr>
<td>Concomitant factors</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Appendix 4

## Voice and resonance factors

<table>
<thead>
<tr>
<th>Physical</th>
<th>Functional</th>
<th>Emotional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiration – Lungs, diaphragm</td>
<td>Loudness/intensity, sustained phonation</td>
<td>Confidence</td>
</tr>
<tr>
<td>Phonation – larynx, vocal folds</td>
<td>Pitch, onset of phonation</td>
<td>Self-esteem</td>
</tr>
<tr>
<td>Resonance – velopharyngeal, oral and nasal resonance structures</td>
<td>Resonance and airflow</td>
<td>Stress</td>
</tr>
</tbody>
</table>
## Appendix 5
### Swallowing factors

<table>
<thead>
<tr>
<th>Physical</th>
<th>Functional</th>
<th>Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral, pharyngeal, esophageal function</td>
<td>Safe and efficient eating</td>
<td>Pulmonary complications</td>
</tr>
<tr>
<td>Respiratory function</td>
<td>Developmental skills for eating</td>
<td>Nutritional implications</td>
</tr>
<tr>
<td>Gastrointestinal consideration</td>
<td>Pleasure of eating, social interaction</td>
<td>Modified diet</td>
</tr>
</tbody>
</table>
# Appendix 6

## Language Development Chart

<table>
<thead>
<tr>
<th>Age of Child</th>
<th>Typical Language Development</th>
</tr>
</thead>
</table>
| **6 Months** | • Vocalization with intonation  
               • Responds to his name  
               • Responds to human voices without visual cues by turning his head and eyes  
               • Responds appropriately to friendly and angry tones |
| **12 Months** | • Uses one or more words with meaning (this may be a fragment of a word)  
               • Understands simple instructions, especially if vocal or physical cues are given  
               • Practices inflection  
               • Is aware of the social value of speech |
| **18 Months** | • Has vocabulary of approximately 5-20 words  
               • Vocabulary made up chiefly of nouns  
               • Some echolalia (repeating a word or phrase over and over)  
               • Much jargon with emotional content  
               • Is able to follow simple commands |
| **24 Months** | • Can name a number of objects common to his surroundings  
               • Is able to use at least two prepositions, usually chosen from the following: in, on, under  
               • Combines words into a short sentence-largely noun-verb combinations (mean) length of sentences is given as 1.2 words  
               • Approximately 2/3 of what child says should be intelligible  
               • Vocabulary of approximately 150-300 words  
               • Rhythm and fluency often poor  
               • Volume and pitch of voice not yet well-controlled  
               • Can use two pronouns correctly: I, me, you, although me and I are often confused  
               • My and mine are beginning to emerge  
               • Responds to such commands as "show me your eyes (nose, mouth, hair)" |
|              | • Use pronouns I, you, me correctly |
| 36 Months | • Is using some plurals and past tenses  
• Knows at least three prepositions, usually in, on, under  
• Knows chief parts of body and should be able to indicate these if not name  
• Handles three word sentences easily  
• Has in the neighbourhood of 900-1000 words  
• About 90% of what child says should be intelligible  
• Verbs begin to predominate  
• Understands most simple questions dealing with his environment and activities  
• Relates his experiences so that they can be followed with reason  
• Able to reason out such questions as "what must you do when you are sleepy, hungry, cool, or thirsty?"  
• Should be able to give his sex, name, age  
• Should not be expected to answer all questions even though he understands what is expected |
| 48 Months | • Knows names of familiar animals  
• Can use at least four prepositions or can demonstrate his understanding of their meaning when given commands  
• Names common objects in picture books or magazines  
• Knows one or more colours  
• Can repeat 4 digits when they are given slowly  
• Can usually repeat words of four syllables  
• Demonstrates understanding of over and under  
• Has most vowels and diphthongs and the consonants p, b, m, w, n well established  
• Often indulges in make-believe  
• Extensive verbalization as he carries out activities  
• Understands such concepts as longer, larger, when a contrast is presented  
• Readily follows simple commands even thought the stimulus objects are not in sight  
• Much repetition of words, phrases, syllables, and even sounds |
|  | • Can use many descriptive words spontaneously—both adjectives and adverbs |
| 60 Months       | • Knows common opposites: big-little, hard-soft, heave-light, etc  
|                 | • Has number concepts of 4 or more  
|                 | • Can count to ten  
|                 | • Speech should be completely intelligible, in spite of articulation problems  
|                 | • Should have all vowels and the consonants, m,p,b,h,w,k,g,t,d,n,ng,y (yellow)  
|                 | • Should be able to repeat sentences as long as nine words  
|                 | • Should be able to define common objects in terms of use (hat, shoe, chair)  
|                 | • Should be able to follow three commands given without interruptions  
|                 | • Should know his age  
|                 | • Should have simple time concepts: morning, afternoon, night, day, later, after, while  
|                 | • Tomorrow, yesterday, today  
|                 | • Should be using fairly long sentences and should use some compound and some complex sentences  
|                 | • Speech on the whole should be grammatically correct  

| 6 Years         | • In addition to the above consonants these should be mastered: f, v, sh, zh, th,l  
|                 | • He should have concepts of 7  
|                 | • Speech should be completely intelligible and socially useful  
|                 | • Should be able to tell one a rather connected story about a picture, seeing relationships  
|                 | • Between objects and happenings  

| 7 Years         | • Should have mastered the consonants s-z, r, voiceless th, ch, wh, and the soft g as in George  
|                 | • Should handle opposite analogies easily: girl-boy, man-woman, flies-swims, blunt-sharp short-long, sweet-sour, etc  
|                 | • Understands such terms as: alike, different, beginning, end, etc  
|                 | • Should be able to tell time to quarter hour  
|                 | • Should be able to do simple reading and to write or print many words  

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<table>
<thead>
<tr>
<th>8 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Can relate rather involved accounts of events, many of which occurred at some time in the past</td>
</tr>
<tr>
<td>• Complex and compound sentences should be used easily</td>
</tr>
<tr>
<td>• Should be few lapses in grammatical constrictions—tense, pronouns, plurals</td>
</tr>
<tr>
<td>• All speech sounds, including consonant blends should be established</td>
</tr>
<tr>
<td>• Should be reading with considerable ease and now writing simple compositions</td>
</tr>
<tr>
<td>• Social amenities should be present in his speech in appropriate situations</td>
</tr>
<tr>
<td>• Control of rate, pitch, and volume are generally well and appropriately established</td>
</tr>
<tr>
<td>• Can carry on conversation at rather adult level</td>
</tr>
<tr>
<td>• Follows fairly complex directions with little repetition</td>
</tr>
<tr>
<td>• Has well developed time and number concepts</td>
</tr>
</tbody>
</table>
Appendix 7
ASSESSMENT FORM
(Speech Therapy)

A. Brief History of Speech and Language Development:
1. At what age was the problem first noticed?

2. Onset: Gradual / Sudden.

3. How is the problem now? Same/Better/Worse.

4. Is the child aware of his / her problem? Yes / No

5. Did the child receive speech therapy? Yes / No
   (Give details:)

B. Communication:
1. Primary mode of communication:

<table>
<thead>
<tr>
<th>Forms</th>
<th>Verbal Communication</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Comprehension</td>
</tr>
<tr>
<td>Vocalizations</td>
<td></td>
</tr>
<tr>
<td>Single words</td>
<td></td>
</tr>
<tr>
<td>Two-word phrases</td>
<td></td>
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<tr>
<td>Three-word phrases</td>
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<td>Simple sentences</td>
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<td>Complex sentences</td>
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<td>Questions</td>
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## Non-verbal Communication

<table>
<thead>
<tr>
<th>Comprehension</th>
<th>Expression</th>
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<tbody>
<tr>
<td>Gestures</td>
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<td>Facial Expressions</td>
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<td>Finger Spelling</td>
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<tr>
<td>Picture Communication</td>
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<td>Any other</td>
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</tbody>
</table>

2. Purpose of communication:
   - □ Requesting
   - □ Greeting
   - □ Commenting
   - □ Informing
   - □ Asking question
   - □ Any other __________

3. Communicative partner:
   - □ Mother
   - □ Father
   - □ Siblings
   - □ Outsiders
   - □ Any Others __________

4. Does the child initiate communication? Yes / No

5. Does the child use any mode of communication other than speech? Yes / No
   *If yes, Please give details.*
C. **Pre-Language Skills:**

1. How is the child’s eye contact? □0-3 secs □3-5 secs □5-10 secs □>10secs

2. Does the child attempt to imitate?
   - Gross actions  Yes / No
   - Fine actions  Yes / No
   - Facial Expressions  Yes / No
   - Speech  Yes / No

3. Does the child understand cause and effect relationships?  Yes / No

4. Does the child indicate choices?  Yes / No

5. How does the child show likes and dislikes?
   - Likes:
   - Dislikes:

6. Does the child track visually?  Yes / No

7. Does the child demonstrate some matching skills with objects and pictures?  Yes / No

8. How is the child’s attention span?  Good / Fair / Poor

9. Does the child take turns?  Yes / No
D. **Hearing Status:**

1. Was child’s hearing tested?  Yes / No

   *If yes, please write down the findings:*

   - Normal
   - Mild
   - Moderate
   - Mod-Severe
   - Severe
   - Profound

2. How does the child respond to sound / voice?

   - Turning head
   - Startle response
   - Eyeblink
   - Moving eyeball
   - Crying
   - Ceases activity
   - Any other__________

3. Does the child respond to sound / voice consistently?  Yes / No

4. Does the child ask for repetition frequently?  Yes / No

5. Does the child use Hearing Aids?  Yes / No  *If yes, please write down the type:*

E. **Receptive Language:**

1. Does the child recognize parents, siblings and other family members?  Yes / No  *(Example:)*

2. Does the child identify common objects around him?  Yes / No  *(Example:)*

3. Does the child identify pictures / line drawings of common objects?  Yes / No  *(Example:)*
4. Does the child identify face and body parts?  
   Yes / No (Example:)

5. Does the child follow 1-step instructions?  
   Yes / No (Example:)

6. Does the child follow 2-step instructions?  
   Yes / No (Example:)

7. Does the child understand questions?  
   Yes / No (Example:)

8. Does the child understand ‘yes’ and ‘no’?  
   Yes / No

F. Expressive Language:

History:

1. At what age did the child utter the first sound?

2. At what age did the child utter the first word?

3. How is the child’s speech at present?  
   □Improving       □Worsening       □No change

Language:

1. Does the child name people?  
   Yes / No  (Example:)

2. Does the child name common objects / pictures?  
   Yes / No  (Example:)
3. Does the child name face and body parts?
   Yes / No  (Example:)

4. How does the child speak to communicate with others?
   □ Single words  □ Two-word phrases  □ Three-word phrases  □ Sentences

5. Does the child have echolalia?
   □ Immediate  □ Delayed  □ No echolalia

6. Does the child use jargons?
   □ Never  □ Always  □ Sometimes  □ Rare

7. Does the child indicate ‘yes’ and ‘no’?
   Yes / No  If yes, how does the child indicate?

8. Any other significant information:
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

Articulation:

1. Does the child have any misarticulations?
   Yes / No / NA
   If yes,  □ Vowel  □ Consonants
   □ Blends  (Examples:)

2. Is the child’s speech intelligible in most of the situations?
   Yes / No / NA

3. Is the child stimulable for speech sounds?
   Yes / No
**Respiration and Voice:**

1. Child’s breathing during speech?
   - □ Clavicular
   - □ Diaphragmatic-thoracic
   - □ Thoracic

2. Parameters of voice:
   - Pitch: □ Normal □ High □ Low
   - □ Monopitch □ Other
   - Loudness: □ Normal □ Soft □ Loud
   - □ Monotone □ Other
   - Quality: □ Normal □ Hoarse □ Breathy
   - □ Strained □ Other
   - Resonance: □ Normal □ Hypernasal □ Hyponasal
   - □ Other

   **Phonation duration:** /a/ _____ sec.  /i/ _____ sec.
   /u/ _____ sec.

**Fluency:**

1. Rate of speech: □ Appropriate □ Excessively fast
   - □ Excessively slow

2. Prosody: □ Normal
   - □ Excessive stressing
   - □ Prolongation □ Other

3. Intonation pattern: □ Appropriate
   - □ Monotonous
F. Conversational Skills:

1. Does the child maintain eye contact when spoken to?  
   Yes / No / NA
2. Does the child take turns during conversation?  
   Yes / No / NA
3. Does the child stay on the topic for sometime?  
   Yes / No / NA
4. Does the child maintain proper sequences while speaking on a topic?  
   Yes / No / NA

G. Oral Peripheral Mechanisms:

1. Structure and Functions of Oral Peripheral mechanisms:

<table>
<thead>
<tr>
<th>Structure</th>
<th>Normal</th>
<th>Impaired</th>
<th>Function</th>
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<td>Jaw</td>
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<td>Uvula</td>
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2. Does the child have any cleft?
   □ Cleft of Lip  □ Cleft of Palate
   □ Cleft of Lip & Palate  □ Submucous cleft
   □ No cleft

   □ Repaired  □ Not repaired  □ Fistula
   □ NA

3. Does the child drool?
   □ Always  □ Sometimes  □ Rarely  □ Never

H. Reading:

1. Does the child identify alphabets?
   Yes / No  *If yes, please give details*

2. Does the child read simple words?
   Yes / No  *If yes, please give details*

3. Does the child read phrases and short sentences?
   Yes / No  *If yes, give details*

4. Does the child answer simple questions after reading a short passage? Yes / No  *If yes, give details*

5. Does the child write on dictation?
   *If yes, give details*  Yes / No

I. Swallowing:

(Please fill up this part, if the child shows any swallowing difficulties)

1. Does the child drool without food?  Yes / No
2. Does food or drink dribble from the mouth?  
   Yes / No

3. Does food get left in the mouth after the meal?  
   Yes / No

4. Does the child regularly cough or choke during swallowing?  
   Yes / No

5. What utensils are used to feed the child?  
   □ Spoon    □ Cup     □ Special utensils  
   □ Any other

6. What types of foods are hardest for your child?  
   □ Pureed    □ Blended    □ Chopped    □ Soft  
   □ Regular    □ Any other_____  

7. What types of liquids are hardest for your child?  
   □ Mild thickened    □ Medium thickened  
   □ Thickened

8. Does the child prefer any particular food tastes?  
   Yes  No  
   □ Sweet    □ Sour    □ Salty    □ Spicy  
   □ Any other

9. Does the child prefer any particular food textures?  
   Yes / No

10. Does the child prefer food at any certain temperature?  
    Yes / No  
    □ Hot    □ Cold    □ Warm    □ Room temperature
11. Where do you feed the child most of the time?
   □ Lap □ Chair □ Car seat □ Mat □ Any other

12. How long does it take to feed a proper meal to the child?

13. What is the average amount of food the child takes?

14. Does the child show any signs of aspiration?
   Yes / No
   □ Coughing □ Choking □ Lung infection
   □ Weight loss □ Any other

15. What feeding process is affected for the child?
   □ Sucking □ Biting □ Chewing
   □ Drinking □ Swallowing

16. Can the child drink through straw?
   Yes / No

17. Any other significant information:

   __________________________________________________
   __________________________________________________
   __________________________________________________
   __________________________________________________
   __________________________________________________

J. Any Other Significant Information:
Formal Test(s) used:

1. Have you used any formal test(s) / checklist(s)?
   Yes / No
Please list down the name(s) of the test(s) / checklist(s):
1.
2.
3.
4.

Provisional Diagnosis:

Recommendations:

Date of Review / IEP / Case Conference:

Name of the Speech Therapist:

Signature of the Speech Therapist:

Date of Assessment:
Intervention Plan
(Speech Therapy)

Long Term Goal(s):
1. 
2. 
3. 

Short Term Goal(s):

<table>
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<tr>
<th>Areas</th>
<th>Goals</th>
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<tr>
<td>Pre-Language</td>
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<tr>
<td>Receptive Language</td>
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<td>3.</td>
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</table>
General Information
Speech Therapy

Name:
D.O.B.:
Age:
Sex:
Diagnosis:
Race:
I/C No:
Address:
Telephone:
Referred by:

State whether the child has any of the following medical problems.

☐ Convulsions  ☐ Hearing  ☐ Vision
☐ Physical problem  ☐ Lung disease  ☐ Heart
☐ Skin disease  ☐ Cleft Lip & Palate
☐ Any other

Is the child currently receiving Speech Therapy?
Yes / No
CHILD REASSESSMENT FORM  
(Speech Therapy)

A. General Information:

1. How is the problem now? Same / Better /Worse.

2. Is the child aware of his / her problem? Yes / No

3. Did the child receive speech therapy? Yes / No  
   (Give details: )

B. Communication:

1. Primary mode of communication:

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<thead>
<tr>
<th>Forms</th>
<th>Verbal Communication</th>
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<tr>
<td></td>
<td>Comprehension</td>
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<td></td>
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Non verbal Communication

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<tr>
<td>Any other</td>
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</tbody>
</table>

2. Purpose of communication:
   □ Requesting □ Greeting □ Commenting
   □ Informing □ Asking question
   □ Any other ____________

3. Communicative partner:
   □ Mother □ Father □ Siblings
   □ Outsiders □ Any Other ____________

4. Does the child initiate communication?
   Yes / No

5. Does the child use any mode of communication other than speech?
   Yes / No  If yes, Please give details.
C. Pre-Language Skills:

1. How is the child’s eye contact?  
   □ 0-3 secs  
   □ 3-5 secs  
   □ 5-10 secs  
   □ >10 secs

2. Does the child attempt to imitate?  
   Gross actions: Yes / No  
   Fine actions: Yes / No  
   Facial Expressions: Yes / No  
   Speech: Yes / No

3. Does the child understand cause and effect relationships? Yes / No

4. Does the child indicate choices? Yes / No

5. How does the child show likes and dislikes?  
   Likes:  
   Dislikes:

6. Does the child track visually? Yes / No

7. Does the child demonstrate some matching skills with objects and pictures? Yes / No

8. How is the child’s attention span? Good / Fair / Poor

9. Does the child take turns? Yes / No
D. **Hearing Status:**

1. Was child’s hearing tested?  
   Yes / No
   
   *If yes, please write down the findings:*
   - □ Normal
   - □ Mild
   - □ Moderate
   - □ Mod-Severe
   - □ Severe
   - □ Profound

2. How does the child respond to sound / voice?  
   - □ Turning head
   - □ Startle response
   - □ Eye blink
   - □ Moving eyeball
   - □ Crying
   - □ Ceases activity
   - □ Any other____________

3. Does the child respond to sound / voice consistently?  
   Yes / No

4. Does the child ask for repetition frequently?  
   Yes / No

5. Does the child use Hearing Aids?  
   Yes / No  *If yes, please write down the type:*

E. **Receptive Language:**

1. Does the child recognize parents, siblings and other family members?  
   Yes / No  *(Example:)*

2. Does the child identify common objects around him?  
   Yes / No  *(Example:)*

3. Does the child identify pictures / line drawings of common objects?  
   Yes / No  *(Example:)*
4. Does the child identify face and body parts?
   Yes / No  *(Example:)*

5. Does the child follow 1-step instructions?
   Yes / No  *(Example:)*

6. Does the child follow 2-step instructions?
   Yes / No  *(Example:)*

7. Does the child understand questions?
   Yes / No  *(Example:)*

8. Does the child understand ‘yes’ and ‘no’?
   Yes / No

**F. Expressive Language:**

*Language:*

1. Does the child name people?
   Yes / No  *(Example:)*

2. Does the child name common objects / pictures?
   Yes / No  *(Example:)*

3. Does the child name face and body parts?
   Yes / No  *(Example:)*

4. How does the child speak to communicate with others?
   □ Single words  □ Two-word phrases
   □ Three-word phrases  □ Sentences
5. Does the child have echolalia?
   □ Immediate  □ Delayed  □ No echolalia

6. Does the child use jargons?
   □ Never  □ Always  □ Sometimes  □ Rare

7. Does the child indicate ‘yes’ and ‘no’?
   Yes / No  If yes, how does the child indicate?

8. Any other significant information:

   __________________________________________________
   __________________________________________________
   __________________________________________________

Articulation:

1. Does the child have any misarticulations?
   Yes / No / NA
   If yes, □ Vowel  □ Consonants  □ Blends
   (Example:)

2. Is the child’s speech intelligible in most of the situations?
   Yes / No / NA

3. Speech Intelligibility:
   □ Improved  □ No change  □ Worse

4. Is the child stimulable for speech sounds?
   Yes / No
**Respiration and Voice:**

1. Is the child’s breathing normal during speech?
   □ Clavicular □ Diaphragmatic-thoracic □ Thoracic

2. Parameters of voice:
   - Pitch: □ Normal □ High □ Low □ Monopitch □ Other
   - Loudness: □ Normal □ Soft □ Loud □ Monotone □ Other
   - Quality: □ Normal □ Hoarse □ Breathy □ Strained □ Other
   - Resonance: □ Normal □ Hypernasal □ Hyponasal □ Other

   Phonation duration: /a/ ____ sec. /i/ ____ sec. /u/ ____ sec.

**Fluency:**

1. Rate of speech: □ Appropriate □ Excessively fast □ Excessively slow

2. Prosody: □ Normal □ Excessive stressing □ Prolongation □ Other

3. Intonation pattern: □ Appropriate □ Monotonous
F. Conversational Skills:

1. Does the child maintain eye contact when spoken to?  
   Yes / No / NA

2. Does the child take turns during conversation?  
   Yes / No / NA

3. Does the child stay on the topic for sometime?  
   Yes / No / NA

4. Does the child maintain proper sequences while speaking on a topic?  
   Yes / No / NA

G. Oral Peripheral Mechanisms:

1. Structure and Functions of Oral Peripheral mechanisms:

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<thead>
<tr>
<th></th>
<th>Structure</th>
<th>Function</th>
</tr>
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<tbody>
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2. Does the child have any cleft?
   □ Cleft of Lip  □ Cleft of Palate
   □ Cleft of Lip & Palate  □ Submucous cleft
   □ No cleft  □ Repaired
   □ Not repaired  □ Fistula  □ NA

3. Does the child drool?
   □ Always  □ Sometimes  □ Rarely  □ Never

H. Reading:

1. Does the child identify alphabets?
   Yes / No  If yes, please give details

2. Does the child read simple words?
   Yes / No  If yes, please give details

3. Does the child read phrases and short sentences?
   Yes / No  If yes, give details

4. Does the child answer simple question after reading a short passage?  Yes / No  If yes, give details

5. Does the child write on dictation?
   Yes / No  If yes, give details

I. Swallowing:
(Please fill up this part, if the child shows any swallowing difficulties)

1. Does the child drool without food?
   Yes / No
2. Does food or drink dribble from the mouth?
   Yes / No

3. Does food get left in the mouth after the meal?
   Yes / No

4. Does the child regularly cough or choke during swallowing?
   Yes / No

5. What utensils are used to feed the child?
   □ Spoon □ Cup □ Special utensils □ Any other

6. What types of foods are hardest for your child to swallow?
   □ Pureed □ Blended □ Chopped □ Soft □ Regular □ Any other

7. What types of liquids are hardest for your child?
   □ Mild thickened □ Medium thickened □ Thickened

8. Does the child prefer any particular food tastes?
   Yes / No
   □ Sweet □ Sour □ Salty □ Spicy □ Any other

9. Does the child prefer any particular food textures?
   Yes / No

10. Does the child prefer food at any certain temperature?
    Yes / No
       □ Hot □ Cold □ Warm □ Room temperature
11. Where do you feed the child most of the time?
   □ Lap  □ Chair  □ Car seat  □ Mat
   □ Any other

12. How long does it take to feed a proper meal to the child?

13. What is the average amount of food the child takes?

14. Does the child show any signs of aspiration?
   Yes / No
   □ Coughing  □ Choking  □ Lung infection
   □ Weight loss  □ Any other____________

15. What feeding process is affected for the child?
   □ Sucking  □ Biting  □ Chewing  □ Drinking
   □ Swallowing

16. Can the child drink through straw?
   Yes / No

17. How is the problem with swallowing now?
   □ Improved  □ No change  □ Worse

18. Any other significant information:

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
J. Any Other Significant Information:

Formal Test(s) used:

1. Have you used any formal test(s) / checklist(s)? Yes / No
   Please list down the name(s) of the test(s) / checklist(s):
   1. 
   2. 
   3. 
   4. 

Current Status:

Recommendations:

Date of next Review / IEP / Case Conference:

Name of the Speech Therapist:

Signature of the Speech Therapist:

Date of Assessment:

Name of the Clinician        Signature
## Progress Report

<table>
<thead>
<tr>
<th>Areas</th>
<th>Progress</th>
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<td>3.</td>
</tr>
</tbody>
</table>
## Therapy Goals

<table>
<thead>
<tr>
<th>Areas</th>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Language</td>
<td>1.</td>
</tr>
<tr>
<td></td>
<td>2.</td>
</tr>
<tr>
<td></td>
<td>3.</td>
</tr>
<tr>
<td>Receptive Language</td>
<td>1.</td>
</tr>
<tr>
<td></td>
<td>2.</td>
</tr>
<tr>
<td></td>
<td>3.</td>
</tr>
<tr>
<td>Expressive Language</td>
<td>1.</td>
</tr>
<tr>
<td></td>
<td>2.</td>
</tr>
<tr>
<td></td>
<td>3.</td>
</tr>
<tr>
<td>Swallowing/Oral Motor</td>
<td>1.</td>
</tr>
<tr>
<td></td>
<td>2.</td>
</tr>
<tr>
<td></td>
<td>3.</td>
</tr>
<tr>
<td>Any Other</td>
<td>1.</td>
</tr>
<tr>
<td></td>
<td>2.</td>
</tr>
<tr>
<td></td>
<td>3.</td>
</tr>
</tbody>
</table>
CHILD INITIAL SCREENING FORM  
(Speech Therapy)

1. Does the child understand simple instructions?  
   Yes / No

2. Does the child understand complex instructions?  
   Yes / No

3. Does the child understand questions?  
   Yes / No

4. How does the child communicate?  
   Speech / Gestures / Signs / Pointing / Pictures / any other mode.

5. Does the child have any speech?  
   Yes / No  
   If yes, give examples:
   - Phoneme level - Yes / No
   - One word level - Yes / No
   - Two word level - Yes / No
   - Phrase / Sentence level - Yes / No

6. Does the child imitate?  
   Yes / No  
   (e.g. speech, gestures, facial expressions)

7. Does the child ask questions?  
   Yes / No  
   (if yes, e.g.)

8. Does the child indicate ‘Yes’ / ‘No’?  
   Yes / No

9. Does the child respond to sounds?  
   Yes / No  
   (e.g. loud sound only, all sounds, inconsistent responses etc.)
10. How does the child respond to sound?  
   *(e.g. head turn, eye blink, startle etc.)*

11. What languages are spoken at home?

12. Child’s oral peripheral mechanisms.

13. Does the child present any other associated problems?  
   *(e.g. hearing, vision, epilepsy etc.)*

14. Does the child have any feeding problems?  
   Yes / No  
   *(e.g. sucking, chewing, biting, drinking, swallowing etc)*

15. Does the child drool?  
   Yes / No

16. Any other significant information:

Speech Therapy *Recommended / Not Recommended*

Name of the Speech Therapist:

Signature of the Speech Therapist:

Date of the Initial Screening:
## Appendix 8

### Signs and effects of Communication Disorders

<table>
<thead>
<tr>
<th>Type of disorder</th>
<th>Signs</th>
<th>Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Language</strong></td>
<td>Student may show impaired comprehension and poor verbal expression.</td>
<td>Student may be excluded from play and group activities. Student may withdraw from group situations.</td>
</tr>
<tr>
<td><strong>Articulation/ Sound Sequencing</strong></td>
<td>Abnormal production of speech sounds; “speech impairment not typical for student’s chronological age.”</td>
<td>Student may be ridiculed or given “cartoon character” nickname; may be ignored or excluded from group activities.</td>
</tr>
<tr>
<td><strong>Fluency</strong></td>
<td>Abnormal flow of verbal expression, characterized by impaired</td>
<td>Student may be ridiculed by others. Student may begin to avoid</td>
</tr>
</tbody>
</table>

**Social**

**Learning**

Student may fail to understand instruction. This may have the same result as missing school altogether. “Learning problems” may result.

Student may have decoding or comprehension problems with respect to specific words.

Student may do poorly on reports, oral assignments.
| Voice       | Abnormal vocal quality, pitch, loudness, resonance and duration may be evidenced. Child's voice does not sound “right” | Student may be ridiculed, ignored or excluded from play or group activities | Student’s self-confidence may suffer. This may lead to withdraw from participation in class, and grades may fall. |
| Hearing    | Student may give evidence of not hearing speech. | Student may appear to be isolated. Student may not participate in group activities as a matter of course. | Student may fail to follow directions or fail to get information from instruction |
Appendix 9
THERAPY SERVICES
Speech-Language Therapy Monthly Report Document

Agency/Programme: ____________________________

Name: ____________________________ Designation: ____________________________ Month: ____________________________

<table>
<thead>
<tr>
<th>Part-1 Monthly Profile</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No. Working Days (A)</td>
<td>Annual Leave (B)</td>
</tr>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Details of Extra Hours Worked</th>
<th>Extra Hours Worked (I)</th>
<th>Time Off (Hours) (II)</th>
<th>Total Hours Worked J=(G-H-I)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Event(s)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hours</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Part – 2 Direct Intervention</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Individual Intervention Session</td>
<td>Weekly</td>
</tr>
<tr>
<td>Number</td>
<td></td>
</tr>
<tr>
<td>Group Intervention Session</td>
<td>Weekly</td>
</tr>
<tr>
<td>Number</td>
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</tbody>
</table>

| Intervention Session (Total) | Total No of clients receiving therapy service | Total No. of scheduled intervention sessions | Total number of delivered intervention session | % of total Delivered Therapy Session | Hrs spent on individual therapy intervention | Hrs spent on group therapy intervention | Total Hrs spent on therapy intervention (Individual & Group) (K) | % of total Delivered Therapy Hours |
| Number/Hours                 |                                            |                                          |                                           |                               |                             |                                         |                               |                              |

<table>
<thead>
<tr>
<th>Assessment/ Review/ Caregiver Training</th>
<th>Initial Assessment</th>
<th>Assessment</th>
<th>Case Review / IEP</th>
<th>Case conference</th>
<th>Caregiver Training</th>
<th>Others</th>
<th>Total Hours on Assessment/ Review/ Caregiver Training (L)</th>
<th>Total Hours Of Direct Intervention (K +L)</th>
<th>% of delivered hours in Direct Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number/Hours</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Caregiver Training conducted</th>
<th>Date</th>
<th>Title / Name of the course / seminar / talk / workshop</th>
<th>Hours</th>
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</thead>
<tbody>
<tr>
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</table>

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### Part – 3 Administrative Work

<table>
<thead>
<tr>
<th>Admin. Work</th>
<th>Documentation and filing of Assessment / Review / ISP</th>
<th>Monthly reports / Status report etc.</th>
<th>Phone calls to parents, clients</th>
<th>Letter to school / hospital / others</th>
<th>Writing Minutes / Vetting Minutes etc.</th>
<th>Supervision Of staff Therapist Therapy aide (Specify the no of staff)</th>
<th>Others</th>
<th>Total Hours spent on Admin. Work</th>
<th>% of time spent in Admin Work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>108</td>
<td>108</td>
</tr>
<tr>
<td>Hours</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>108</td>
<td>108</td>
</tr>
<tr>
<td>Meeting</td>
<td>Department</td>
<td>Organisation</td>
<td>Initial Assessment</td>
<td>IEP/ ISP</td>
<td>Projects</td>
<td>Other</td>
<td>Total No. of Meeting</td>
<td>Total Hours Spent on Meeting(s)</td>
<td>% of time spent on Meeting(s)</td>
</tr>
<tr>
<td>Number</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<td>108</td>
<td>108</td>
</tr>
<tr>
<td>Hours</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>108</td>
<td>108</td>
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</tbody>
</table>

### Part 4 Training and Continuing education

<table>
<thead>
<tr>
<th>Training Conducted</th>
<th>Talks/ workshops, In-service Training Conducted</th>
<th>Preparation Time</th>
<th>Total No. of Training Conducted</th>
<th>Total Hrs. of Training Conducted (Inc. preparation time)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hours</td>
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</tr>
</tbody>
</table>

Details of Training Conducted

<table>
<thead>
<tr>
<th>Date</th>
<th>Title/ name of the course/ seminar/ talk/ workshop</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Training Attended</th>
<th>Talks/ workshops, In-service Training/ Network Attended</th>
<th>Hours</th>
<th>Total No. of Training Attended</th>
<th>Total Hrs. of Training Attended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td></td>
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</tbody>
</table>

### Part – 5 Projects undertaken (Please include Research, Publication, Assessment tool, care path and therapy protocol development)

<table>
<thead>
<tr>
<th>Date</th>
<th>Description of Project</th>
<th>% of Completion</th>
<th>Hours</th>
<th>Total Hours Spent</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

### Monthly Report Summary

<table>
<thead>
<tr>
<th>Indicators for therapist/ therapy department</th>
<th>Number/Hours</th>
<th>% of scheduled tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work -hours spent on Direct Intervention</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delivered Scheduled Therapy Session</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time spent on Administrative work and Meetings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Man – hours spent on training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapy outcome achieved following 6 monthly review</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Projects completed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfied Service Recipients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compliance to Safety Checks (please report any accidents in the department)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of clients served during the month</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Appendix 10

### THERAPY SERVICE

#### CLIENT/CAREGIVER QUESTIONNAIRE

Satisfaction with Speech Therapy Service

For each of the following questions, please tick the rating that best expresses your opinion.

1. I am satisfied with the treatment provided/recommended by therapist.

<table>
<thead>
<tr>
<th>1 Strongly Disagree</th>
<th>2 Disagree</th>
<th>3 Neutral</th>
<th>4 Agree</th>
<th>5 Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>非常不同意</td>
<td>不同意</td>
<td>没意见</td>
<td>同意</td>
<td>非常同意</td>
</tr>
</tbody>
</table>

2. Regular therapy as per clients need is provided at scheduled appointment.

<table>
<thead>
<tr>
<th>1 Strongly Disagree</th>
<th>2 Disagree</th>
<th>3 Neutral</th>
<th>4 Agree</th>
<th>5 Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>非常不同意</td>
<td>不同意</td>
<td>没意见</td>
<td>同意</td>
<td>非常同意</td>
</tr>
</tbody>
</table>

3. The instructions/home programme given by the therapist was helpful.

<table>
<thead>
<tr>
<th>1 Strongly Disagree</th>
<th>2 Disagree</th>
<th>3 Neutral</th>
<th>4 Agree</th>
<th>5 Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>非常不同意</td>
<td>不同意</td>
<td>没意见</td>
<td>同意</td>
<td>非常同意</td>
</tr>
</tbody>
</table>

4. This service has helped the child to function better at school and home.

<table>
<thead>
<tr>
<th>1 Strongly Disagree</th>
<th>2 Disagree</th>
<th>3 Neutral</th>
<th>4 Agree</th>
<th>5 Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>非常不同意</td>
<td>不同意</td>
<td>没意见</td>
<td>同意</td>
<td>非常同意</td>
</tr>
</tbody>
</table>

5. The overall quality of therapy service is satisfactory.

<table>
<thead>
<tr>
<th>1 Strongly Disagree</th>
<th>2 Disagree</th>
<th>3 Neutral</th>
<th>4 Agree</th>
<th>5 Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>非常不同意</td>
<td>不同意</td>
<td>没意见</td>
<td>同意</td>
<td>非常同意</td>
</tr>
</tbody>
</table>

6. Suggestions (if any):

Total Score = \[
\frac{\text{_______}}{5}
\]
References


National Centre for Medical Rehabilitation and Research (NCMRR) US Dept of Health Services, NIH Publications No. 93-3509, March 1993.


Regie Routman, *Conversations: Strategies for Teaching, Learning, and Evaluating* (*Heinemann, 2000*)

Royal College of Speech Language Therapists, *Nottingham Community Health SLT service*


Winnie Dunn (2000) Best Practice Occupational Therapy, In Community Service with Children and Families: SLACK