ARKANSAS STATE UNIVERSITY
SPEECH AND HEARING CENTER
P.O. Box 910, State University, AR 72467-0910
Phone: 870-972-3301 Fax: 870-972-3788

Speech-Language-Hearing Evaluation Report

Name: File Number:
Birthdate: Date of Evaluation:
Parents: Telephone:
Address: Referred by:

Background Information:

Evaluations and Observations:

Hearing Screening

Oral Peripheral Examination

Language: (List formal and informal assessment instruments and results)

Articulation: (List formal and informal assessment instruments and results)

Voice: (List formal and informal assessment instruments and results)

Fluency: (List formal and informal assessment instruments and results)

Clinical Impressions:

(State exactly the diagnosis, level of severity, and salient characteristics of the disorder/delay. Include a prognostic statement regarding the potential for therapeutic improvement in the condition.)

Recommendations:

(Include specific therapy targets to be addressed along with the most appropriate therapy strategies to achieve the targeted objectives. Specify the number of sessions per week that are recommended.)

_____ _____
(Include student's name and credentials) (Include Supervisor's name and credentials)
Student Clinician Clinical Supervisor