MATRIX HOME CARE **SPEECH LANGUAGE PATHOLOGY VISIT NOTE/PROGRESS REPORT**

PATIENT/CLIENT NAME:_______________________ **DATE:**__________

Reevaluation: ______________________________

Voice Disorder Treatments: ______________________________

Speech Articulation Disorder Treatment: ______________________________

Dysphagia Treatments: ______________________________

Language Disorder Treatments: ______________________________

Aural Rehabilitation ______________________________

(Reserved): ______________________________

Establish and/or design non-oral communication system: ______________________________

Other: ______________________________

Treatment Done: ______________________________

Instructions/Teaching: ______________________________

Narrative: ______________________________

Plan/Goal: ______________________________

Time In: __________ **Time Out:** __________

Patient/Designee: I certify that the Matrix Home Care Employee listed on this time slip worked the times indicated and the work was performed in a satisfactory manner. I agree to the times regarding this time slip.

Team Conference:______________________ **Physician Contact:** ❑ **Yes** ❑**No**

Patient/Client Signature: ______________________

SLP Name (Print): ______________________ **SLP Signature:** ______________________