

# **CLINIC PRACTICUM PROCEDURAL MANUAL**

**2017-2018**

## **CLINICAL INSTRUCTORS**

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## WELCOME!

We are glad you are joining our graduate program, and that soon you will be joining us in the ranks of CCC-SLPs (by the way, the Cs stand for *certificate of clinical competence*, and are often referred to as “Cs”. Your Cs will be granted by the American Speech-Language-Hearing Association (ASHA), the only accrediting body for SLPs. The Cs are also often referred to as your “ASHA certification”. So you know what to expect, here is a brief overview of the ASHA requirements for certification, which will also give you an overview of the program. There is Successful completion of an accredited graduate program (we are accredited ☺). This generally includes **2 major aspects**:

- 1) Graduate Courses
- 2) Clinical Experiences (including those at our on-site clinic, and those experiences off-site that we coordinate for you)

ASHA has certain stipulations about these experiences.

- The student must have obtained a sufficient variety of supervised clinical experiences in different work settings and with different populations so that he or she can demonstrate skills across the ASHA Scope of Practice in Speech-Language Pathology. *Clinical experience* (i.e., assessment/diagnosis/evaluation, screening, treatment, report writing, family/client consultation, and/or counseling) should allow students to:
  - interpret, integrate, and synthesize core concepts and knowledge;
  - demonstrate appropriate professional and clinical skills; and
  - incorporate critical thinking and decision-making skills while engaged in identification, evaluation, diagnosis, planning, implementation, and/or intervention
- Successful completion of clinical experiences sufficient in breadth and depth must cover the following aspects:
  - Evaluation
  - Intervention
  - Interaction and Personal Qualities (e.g., effective communication, recognizing the needs, values, preferred mode of communication, and cultural/linguistic background of the client/patient, and relevant others, effective collaboration with other professionals in case management).

During your graduate program, your Clinical Practicum will include:

- **On-Site SPPA 5030 at University of Wyoming Speech and Hearing Clinic (UWSHC)**
  - **2 semesters**
- **Off-Site SPPA 5030: Community Placements**
  - **1 semester**
- **Offsite SPPA 5270 & Off-site SPPA 5290**
  - The externships are viewed as an *extension* of academic and clinical experiences. Clinical instruction continues in these experiences. A student’s academic and clinical performance may be shared with external supervisors to enable them to best support the student’s learning.
  - Graduate students complete **two** full-time, **twelve-week externships** following completion of coursework and SPPA 5030 requirements.
  - Students register for one externship in the Spring and one in the Summer semester, but the beginning and ending dates do not align with semesters.
    - One externship is to occur in an **educational setting** (a school or early childhood program), and one is to occur in a **medical or clinical setting**. Most students will complete the educational internship first.

# CLINIC PRACTICUM PROCEDURAL MANUAL

The Clinic Coordinator will determine all clinical assignments, including evaluations and observations. Client assignments are generally given at the start of each semester; diagnostic assignments are given throughout the semester. ).

**\*Refer to the SPPA 5030 syllabus for information concerning the specific time lines for written assignments, conferences and grading.**

## 1. CLINICAL DOCUMENTATION

### 1a. Permanent File Folders

The permanent files contain the most current paperwork that we have received from or about our clients. They also include the documentation from our clinic (e.g., Evaluation, Case History, STP, Progress Report, Permission forms). Documents that you complete throughout the semester will also be placed into the file when completed (i.e., signed by supervisors) by you.

Permanent folders should be signed in and out from the Clinic front office on the Permanent File Folder Sign-Out Sheet (**Appendix 1a-3**) in the Service Log Book and an “out” card should be placed in the spot from which the file has been removed. If unable to return a folder, the folder should be secured in a locked location until it can be returned to the front office. Students, not the clinic manager, are responsible for returning the files to the correct location and removing the ‘out’ card. Students MUST notify a supervisor in advance to obtain permission to keep a permanent folder over-night.

*Archived folders* are kept behind the middle section of the file cabinets for those clients no longer receiving services.

The Clinic manager will label the outside of the permanent folder, after receiving information from the clinician. The inside of the permanent folder will be labeled by the clinician. Sheets of labels are kept in the sample permanent file folders located in the Clinic Lab. If more labels are needed, inform the Clinic manager. Additional information such as client work samples, homework, notes to parents, etc., is also kept in the permanent folder as long as it is properly dated (i.e., day/month/year).

There are three sample permanent folders (2 green and 1 red) in Room 170. Instructions for how to set-up the permanent files are in **Appendix 1a-1.**

Permanent folders *never* leave the Clinic premises **unless** the folders are being transported to your supervisor’s office for a meeting. Do not shred anything from permanent folders unless advised by your supervisor. These are confidential documents and should be treated with great care. Do not photocopy any of the information but take notes using the Permanent File Summary forms. This form is used to review the permanent files. It is a *guide* for clinicians to gain important information about a client as photo-copying information from the permanent file is not allowed. Other information gathering forms are acceptable to use (**See Appendix 1a-2.**)

Do not remove items from the permanent folder but keep the folder together as a whole unit.

When removing a permanent file from the clinic office you must check it out. Please use the Permanent File Folder Sign-Out Sheet (**APPENDIX 1a-3.**)

Violation of these procedures is a violation of confidentiality as stated in the Graduate Handbook and may result in a failure of SPPA 5030 for the semester.

## 1b. Working Client Folders

You will have a working folder (manila colored) for each of your assigned clients. You will be given this folder by the Clinic Coordinator or your supervisor when you are assigned your client. Working folders are kept in room 170 in a file drawer. Each clinician has her/his own file folder labeled with his/her last name. This is where you will keep all of your clients' working folders (labeled with client initials). During your session, the client's working folder should be in the observation room so that your supervisor and observers can view it. When not in session, working folders should be in room 170 in your file drawer. Working folders are turned in to your supervisor at the end of each semester. (See Appendix 1b-1.)

## 1c. Clinic Forms

All UW clinic forms are available in WYOCOURSES under the module called Forms for the Permanent Folder. They also appear in the appendices of this procedural manual. The forms are:

- **Treatment Agreement (Appendix 1c-1)**
  - This form is completed every semester and signed by the client/parent and supervisor for all Clinic clients.
  - It is the financial agreement between the UW Clinic and the client/parent to pay for the services provided.
  - Use the current SLP fee schedule to complete the 'charge' and fee schedule level on the form. There are examples of how to do this in **Appendix 1c-2**.
  - Discuss any questions you have about billing with your supervisor before you present the form to clients.
  - Once signed by the supervisor and a copy is made for the client, return this completed form to the Clinic office associate who will copy it to update her computer file.
  - File the original in the client's permanent folder.
  - This form is reviewed every semester. Documentation for sliding fee levels 2 or 3 must be collected and presented to either the supervisor or Clinic Coordinator for approval and signature. Obtain this financial information within the first month of clinic services.
- **Permission to Treat (Appendix 1c-3)**
  - This form is reviewed/initialed every semester and signed annually.
  - Offer a copy to clients.
- **Notice of Privacy Practice (Appendix 1c-4)**
  - This form should be reviewed each semester and a copy offered for clients to keep/read.
  - The complete Notice of Privacy Practices can be found in two black binders in the Clinic waiting room and on the Com Dis website under the UW Clinic tab. Clients are to receive a copy and informed where they may obtain one electronically.
- **Permission to Audio/video (Appendix 1c-5)**
  - This form is reviewed/initialed every semester and signed annually. For a diagnostic, this form is typically the first to be signed allowing a full recording to be made of the evaluation.
- **Permission for Activities (Appendix 1c-6)**
  - This form is reviewed/initialed every semester and signed annually.
  - There is a section that says: *Exceptions to above* on this form. This is the place to note food allergies and any other restrictions the client may have.
- **Use/disclosure forms (Appendix 1c-7)**
  - This form is reviewed/initialed every semester and signed annually. This allows the UW Clinic to USE a client's PHI within our covered entity and to receive information from or disclose information to another entity.

- **Client Attendance Policy (Appendix 1c-8)**
  - *Every* semester this form is completed and signed by the client/parent. The information outlines the expectations/procedures for participation in services provided by the UW Clinic. Write on the form the known closure dates for the Clinic. The client/parent is given a copy (i.e., yellow) of the form and the original (i.e., white) is retained in the permanent file.
  - IF needed, this form should be reviewed/initialed every semester and signed annually. A copy of this signed form should accompany all faxes sent and copies mailed to those designated on the form. Students should follow-up with a facility that they are obtaining information from, in 5-7 days to verify permission form was received and information will be mailed (or faxed) as requested. Note correspondence in Contact Log.
- **Speech-language pathology Service Codes (CPT and ICD-10) (Appendix 1c-9)**
  - This sheet is filled out once a week and is our billing sheet. It is often referred to as the “green sheet” and should be printed off on GREEN paper. You fill it out and then turn it in to your supervisor. Your supervisor signs it and gives it to the Clinic Office Associate. You will likely need help filling it out the first time!
- **UW Speech and hearing Client Questionnaire (Appendix 1c-10)**
  - At the end of each semester and/or when the final evaluation report is mailed to the client, the questionnaire should be given or mailed to the client/parent to complete. Attach a self-addressed stamped UW envelope and ask that the client/parent supply the Division with constructive feedback about the clinical services they received. The form is intended to be confidential and anonymous but client/parent has the option of submitting their name.
  - This should also be sent after every diagnostic.
- **Client Intention letter (Appendix 1c-11)**
  - All clients are presented with this form about 2 weeks prior to the end of the semester. Clinicians complete the top portion and client/parents complete the bottom portion, including scheduling and contact preferences. Only the bottom portion is returned to the Clinic Coordinator.

*Clinicians should complete known information on the forms prior to the clients signing, to make it faster and easier for the client. Do not leave ‘blanks’ on the forms. (Either put a dash or “N/A”). After completing the forms, place them into your supervisor's mailbox. She/he must sign the Treatment Agreement form. Then put all of them in the client’s permanent folder. Don’t forget to use the appropriate hole punch (it’s not a three-hole punch).*

**1d. MOEC Clients** have slightly different paperwork because the UWSHC is named as the speech/language service provider on their Individualized Education Plans (IEPs). *All of the above forms* still need to be completed for these clients within one week after initiating treatment, but the reports and timelines are different. If you have a MOEC client, your supervisor will advise you on following the appropriate report formats and timelines.

### **1e. SOAP Notes**

\*The most important thing to remember in writing a SOAP note is to write the note immediately following your session when things are freshest in your mind.

\*The most important thing to remember in taking data is that you get something on paper first; have it make sense to you; and analyze it immediately following your session. Ask yourself the question: “What

does the data tell me about my client? What does the data mean? How can it help me plan for my next session?”

- Keep legibility in mind when writing your notes. If needed, use an alternate method for documenting your session with approval of your supervisor.
- Sign SOAP note using a complete signature. This includes name, degree and title (i.e., Graduate Student Clinician).
- Use the “codes” on the top of the form. For example, G = group. Always put in the actual time that was spent with the client in the left-hand margin.
- It is always helpful to include a few examples in the body of the treatment note. Left hand margin is a good place to record target words, types of prompts, etc.
- Adding a key or legend is helpful to define exactly what system you are using. Examples: A = approximated; P = prompted; D = demonstrated; S = spontaneous, etc. It also helps to provide an example of a prompt or cue so another person (e.g., parent, colleague) can replicate it.
- Avoid the use of “I, we” and other personal pronouns and avoid contractions. Refer to yourself as the clinician and the client by name/initial or a generic term such as the client, but not both. Be consistent in the format you select.
- It is always better to describe a behavior rather than to label it. Example: “She was so stubborn today.” Try: Maggie refused to attempt any tasks presented by the clinician by declaring, “I don’t have to do what you say if I don’t want to!” The right word choices can get the same meaning across to the reader without being judgmental.
- Do not use “white out” in your treatment notes. These documents become part of the permanent record, which is a legal, confidential document. The proper way to correct a mistake is to make a single line through the error, initial it, and then write the correct word. This pertains to all clinical documents including treatment notes, contact logs, and clock hours.
- Add client name/initials and complete date on all data collection sheets. Refer to the data collection sheets in your treatment notes by stating, “See attached data sheet.”
  - Data must still be analyzed even though you are stating, “See attached data sheet.” This should be done in the body of the treatment note by answering the question, “What does the data mean?” The analysis you provide should direct your plan.
- An addendum can be added to a SOAP note if information was inadvertently left out of a preceding note. Write Addendum and then proceed with note as usual.
- Remember that good clinical writing skills take time to develop. It is an on-going learning process. Be open to suggestions and modifications.

Remember that the S & O sections are a record of what *actually occurred* in the session. It should be completed immediately after the session. The note should include actual time (in minutes) spent with the client not what the client was *scheduled* to receive. Clinicians should sign each entry with a complete signature/title. If an error is made, cross out the error with a single line, initial it and make the correction. If a supervisor makes a correction, she will follow the same procedure and will co-sign the note next to your signature.

Two SOAP note pages *may* be kept in the client’s *working* folder but then it should be transferred to the permanent folder.

Please refer to the Appendices: Professional Writing Tips (**Appendix 1e-1.**) and Acceptable Notations for SOAPS (**Appendix 1e-2.**) and the SOAP Explanatory Template (**Appendix 1e-3.**) A blank SOAP template is available on WYOCOURSES as well.

## 1f. Clinic Reports

### Overview Of Written Communication:

- Refer to the recommended textbooks for SPPA 5030, a college handbook for proper English writing e.g., A Writer's Reference by Hacker, a dictionary, spell and grammar-check, etc. for tips on editing/proofreading all written work.
- A recommended textbook is Professional Writing in Speech-Language Pathology and Audiology by Robert Goldfarb and Yula C. Serpanos (Plural Publishing, 2009) to read about professional clinical writing in this field.
- Single-space all drafts (unless your individual supervisor instructs differently). When re-submitting any draft, be sure to ask your supervisor if he/she would like you to resubmit the Written Product Feedback form and include all previous drafts to facilitate review by the supervisor. Do not shred corrected drafts until you have turned in your final version to your supervisor to be signed.
- Always keep your intended audience in mind. Write clearly and logically avoiding assumptions on the part of your audience. Be concise. Avoid extra words (e.g., in order to, did behave, as well as, was able to).
- Practice good proofreading! Print a double-sided draft version of your report and read the report backwards as a way to check for spelling and punctuation errors, allow time between the writing of the report and proof-reading the report, and read the report aloud. Computer 'spell-checks' do not catch agrammatical sentences.
- Read report aloud to yourself or a fellow clinician. Listen for particular qualities (clarity, long or confusing sentences) that detract from your message.
- Use direct quotes when it is appropriate to clarify contents of the report. Give examples to help clarify unfamiliar terms or procedures.
- Make an editing checklist for problems you frequently encounter in your writing.
- Allow sufficient time to properly proofread before the report is due. Sometimes a little distance from your work can add a fresh perspective.

### ASHA Information On Report Wording:

- ASHA guidelines state that "tests" should no longer be underlined. Assessment names are capitalized only. Spell out the name of the assessment before using the acronym.
- Assessment instruments in speech-language pathology are often called "tests" (e.g., Test of Word Finding). The word "test" has very specific requirements and very few of our instruments meet such requirements. Use the words: instrument, assessment, evaluation, or measurement, rather than the word "test".
- ASHA no longer recommends using the word "therapy" in professional writing. It is suggested to use: intervention, remediation, programming, management, or treatment.
- Chronological ages are to be written using a semi-colon (e.g., 3;6) not a colon or a hyphen. In narrative form, ages are written as, Mary is a 13-year-old student or Mary is a 13 years, 7 months old student.
- When referencing stuttering, it is appropriate to use the term, stuttering, as disfluency can be confused with other disorders

**Semester Treatment Plans (STPs)** are *typically* due within 24 hours after the third session with your client. Please see your syllabus for specific dates. There is an explanatory template for the STP in **Appendix 1f-1** and

a blank template in WYO Courses. Use this template to create each client's STP. You must follow the policies for saving this document to ensure confidentiality. The original STP is signed and placed into the permanent folder and a copy is given to the client/parent. An STP conference is held with the client/parent after it has been approved and signed by your supervisor. This STP conference is noted on the Face Sheet in the permanent folder.

**Midterm Progress Reports** (see **Appendix 1f-2** for an explanatory template and WYOCOURSES for a blank template) are done halfway through the semester (approximately), and Final **Progress Notes** (see explanatory template in **Appendix 1f-3**, and WYOCOURSES for a blank one) are done at the end of the semester. Please see the SPPA 5030 syllabus for dues dates. Please be aware that your due dates will be different for different supervisors. It is *your* responsibility to get clarity from each supervisor as to his/her specific deadlines.

Please see the Written Product Feedback (**Appendix 1f-4**) form for how you will be graded.

*(See the Diagnostic Procedure section for information about Diagnostic reports)*

## **APPENDIX 1a-1.**

### **Set-Up for Permanent File Folders**

#### **GREY/LIGHT GREEN:**

Follow these steps when initiating a new patient/client permanent folder OR *revising* an existing folder. **All documents should follow a chronological progression with the most current information on top.** There are sample folders in the front office and in the Clinic Lab for reference. \***Exception:** consult with supervisor to determine which type of folder should be used *before* initiating a folder. **Red** single divider folders should be used for DX or SCREENING only client.

#### **Left front**

- Consent to Use PHI forms
- Permission forms
- Release of Information forms
- Client Attendance Policy Forms
- **Right** inside- labeled as **CONTACT LOG (APPENDIX 3a-1)**
- Contact Logs (including e-mail and other written correspondence)
- Insurance information (including **sliding fee scale documentation**)
- Treatment Agreement forms
- Diagnostic Agreement forms
- Face Sheet (s)
- DX Intake Sheet

#### **Left middle (labeled as SOAP NOTES)**

- SOAP Notes

#### **Right middle (labeled at CLINIC REPORTS)**

- Progress reports
- Progress notes
- Semester Treatment Plans
- Clinic Evaluation Reports (including DX plan form, case history, assessment protocols, etc.)

#### **Second left (labeled as WORK SAMPLES)**

- Work Samples (only those with a complete date i.e., month/day/year)

#### **Right back**

- Information received from *outside* agencies (**not** to be copied for clients)
- MOEC evaluations, IEPs, school-based progress notes (**not** to be copied for client)

#### **RED/BRICK RED:**

**Red** single divider folders are used for DX or SCREENING only clients (i.e., no treatment). **All documents should follow a chronological progression with the most current information on top.** There is a sample folder in the Clinic Lab for reference. \*Consult with supervisor to determine which type of folder (red or green) should be used *before* initiating a permanent folder.

#### **Left (inside front)**

- Consent to Use PHI forms
- Permission forms
- Release of Information forms

**Right** (inside labeled as **CONTACT LOG**)

- Contact Logs (including e-mail and other written correspondence)
- Insurance information (including **sliding fee scale documentation**)
- Diagnostic Agreement form
- Face Sheet (s)
- DX Intake Sheet

**Left** (inside labeled as **EVALUATON REPORT**)

- Clinic Evaluation Reports (including DX plan form, case history, and assessment protocols)

**Right** (inside back)

- Information received from *outside* agencies (**not** to be copied for clients)
- **MOEC** evaluations, IEPs and school-based forms (**not** to be copied for clients)

*There are example folders in a drawer in room 170, if you need more guidance*

**APPENDIX 1a-2.**

**Permanent File Summary Form**

*The permanent folder contains confidential client information. **Nothing** should be photocopied from this folder without supervisor permission. **Read and take notes** from the permanent folder using the following outline. If the information does not apply to your client, write N/A.*

Client Initials:

Age:

Is the Face Sheet information (address, phone, etc.) current? \_\_\_\_\_ YES \_\_\_\_\_ NO

Date Last Permission Forms **Signed**:

**Current** Treatment Time: (e.g., total (direct and/or consult) time; minutes per session and sessions per week)

Expiration Date of Current IEP:

Next Triennial Evaluation Date: (occurs every **three** years):

Disorder Classification (s):

Family History: (e.g., who the client lives with, siblings; etc.)

Medical History: (e.g., prenatal/birth; illnesses/hospitalizations; medications; hearing status, etc.)

Educational History: (e.g., school name, grade, any special services, last grade achieved, etc.)

Social/Emotional/Behavioral History: (e.g., interventions, outside agencies involved, medications taken, etc.)

Communication, Cognitive, or Swallowing Evaluations: (e.g., dates, scores, diagnosis, recommendations, etc.)

Other Evaluations: (e.g., OT, PT, Psychology, Vocational, etc., include dates, scores, diagnosis and recommendations)

Treatment History: (e.g., duration, general goals and outcomes; recommendations, etc.)



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## **APPENDIX 1b-1.**

### **Procedures for Working Folders**

**Working** folders should be signed-out AND returned daily to the Clinic Lab using the ‘out’ card indicating the location of the folder during regular Clinic hours. **Only two** SOAP note pages and **current** work samples should be in the file. Clients’ **working** folders should not have **any** identifying information inside them. This means that the folder itself should only have the client’s initials on the outside. Everything else should be retained in the permanent file. **Clients’ complete names will not be used on written documentation until it is ready to be placed in the permanent file folder.** That means that the top portion of a SOAP note will only have the client’s initials until such time the clinician has completed a full page and it is ready to be placed in the permanent folder. At that time, the clinician should complete the client’s full name. For example:

Clinical treatment note format for the working folder

Name **H**\_\_\_\_\_ **P**\_\_\_\_\_

When the note is placed into the permanent folder

Name **H**arry **P**otter

If you need to obtain new **working/permanent** folders, they are located in the file cabinet of room 170. Working folders (in good condition) may be recycled but the permanent folder should be new.

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**APPENDIX 1c-1.  
TREATMENT AGREEMENT**

Client: \_\_\_\_\_ DOB: \_\_\_\_\_

Age Code: \_\_\_\_\_

Type of treatment: \_\_\_\_\_

Treatment begins: \_\_\_\_\_ Ends: \_\_\_\_\_

Session (day/time): \_\_\_\_\_

Length of Session: \_\_\_\_\_ Individual \_\_\_\_\_ Group

Charge per semester: \_\_\_\_\_ Sliding fee level: \_\_\_\_\_  
**(documentation required for level II & III)**

Graduate student clinician: \_\_\_\_\_

Supervisor signature: \_\_\_\_\_

Comments: \_\_\_\_\_

**\*Billing statements are sent at the end of each month so that clients may submit charges to their insurance company. Services for each semester should be paid in full before initiating services for the next semester.**

**Insurance coverage:** \_\_\_ Cigna \_\_\_ Medicare \_\_\_ Medicaid \_\_\_ Other (name: \_\_\_\_\_)

\_\_\_\_\_  
Client/Parent/Guardian Signature (*circle one*)

\_\_\_\_\_  
Date

Are there any changes to your home address and telephone number? If yes, please update the information here: \_\_\_\_\_

Age Codes: 1= 0.1 -5.0; 2= 5.1-13.0; 3= 13.1-19.0; 4= 19/1-50.0; 5= 50.1 +

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APPENDIX 1c-2.  
**Treatment Agreement Form Samples**

**SAMPLE 1 (MEDICAID)**

Charge per semester/half semester: **\$220**      Sliding fee level: **N/A**  
*Circle one*      (documentation required)

Graduate student clinician: \_\_\_\_\_

Supervisor signature: \_\_\_\_\_

Comments: **Bill to Medicaid**

**\*Billing statements are sent at the end of each month so that clients may submit charges to their insurance company. Services for each semester should be paid in full before initiating services for the next semester.**

Insurance coverage: \_\_\_Cigna/GWL \_\_\_Medicare **X** Medicaid \_\_\_Other (name: \_\_\_\_\_)

**SAMPLE 2 (VOCATIONAL REHAB)**

Charge per semester/half semester: **\$220**      Sliding fee level: **N/A**  
*Circle one*      (documentation required)

Graduate student clinician: \_\_\_\_\_

Supervisor signature: \_\_\_\_\_

Comments: **Bill to Vocational Rehab**

**\*Billing statements are sent at the end of each month so that clients may submit charges to their insurance company. Services for each semester should be paid in full before initiating services for the next semester.**

Insurance coverage: \_\_\_Cigna/GWL \_\_\_Medicare \_\_\_ Medicaid **X** Other (name: **Voc Rehab**)

**SAMPLE 3 (CONTRACTED SERVICES)**

Charge per semester/half semester: **See comments**      Sliding fee level: **N/A**  
*Circle one*      (documentation required)

Graduate student clinician: \_\_\_\_\_

Supervisor signature: \_\_\_\_\_

Comments: **MOEC under contract with UW Speech and Hearing Clinic OR  
PH & H under contract with UW Speech and Hearing Clinic**

**\*Billing statements are sent at the end of each month so that clients may submit charges to their insurance company. Services for each semester should be paid in full before initiating services for the next semester.**

Insurance coverage: \_\_\_Cigna/GWL \_\_\_Medicare \_\_\_ Medicaid **X** Other (name: **MOEC or PH&H**)

## APPENDIX 1c-3.

University of Wyoming  
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Division of Communication Disorders  
Department 3311  
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### Permission for Evaluation/Treatment

My signature upon this form indicates that I fully understand and agree that:

I have had the opportunity to read the Notice of Privacy Practices document, the rights guaranteed under Public Law 105-17, the University of Wyoming affirmative action/equal opportunity statement.

Services rendered in audiology and speech-language pathology may be performed by students of the Division of Communication Disorders who are under appropriate supervision by the faculty of the Division.

Services rendered in audiology and speech-language pathology may be observed by students in the Division of Communication Disorders and other educational disciplines who are under appropriate supervision by faculty of the Division.

Protected Health Information (PHI) gathered during the evaluation and/or treatment process may be used for habilitation, rehabilitation, and educational purposes. This information will **not** be used or disclosed by the UW Speech and Hearing Clinic or the Division of Communication Disorders without written permission as described in the Notice of Privacy Practices document.

Are you covered by  Medicaid  Blue Cross Kid Care CHIP  CIGNA  Other

#### A copy of your insurance card must be provided to the UW Clinic

*As stated in the Notice of Privacy Practices document, we may use and disclose health information about you to obtain payment for health care services that you received. We may use health information about you to arrange for payment (such as preparing bills and managing accounts). We may also disclose health information about you to others (such as insurers, collection agencies, and consumer reporting agencies). In some instances, we may disclose health information about you to an insurance plan before services are rendered because we may want to know whether the insurance plan will pay for a particular service.*

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
DOB

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Printed name of Patient or Personal Representative

\_\_\_\_\_  
Address

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Date

Access the **Division's website** at: <http://uwadmnweb.uwo.edu/comdis/clinic/privacynotice.htm>

Revised 12/2011

## Appendix 1c-4

### UW SPEECH AND HEARING CLINIC (UWSHC) NOTICE OF PRIVACY PRACTICES

#### **THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

The University of Wyoming by and through the UW Speech and Hearing Clinic (“UWSHC” or “we”) is required by law to maintain the privacy of your protected health information (“PHI”), give you this notice that describes our legal duties and privacy practices concerning your PHI and to notify you following a breach of security of your PHI. In general, when we release your PHI, we must release only that information necessary to achieve the purpose of the use or disclosure. However, all of your PHI, with limited exceptions, will be available for release if you sign an authorization form, if you request the information for yourself, to a provider regarding your treatment, or due to a legal requirement. *Health information and other records of University of Wyoming students generally are not subject to this notice and are protected by other federal and state laws.*

**How we may use and disclose information about you with or without your consent:** The following categories describe some different ways that the UWSHC may use and disclose your PHI.

1. **Treatment:** For example, we may use or disclose PHI to determine which treatment option best addresses your health needs or so other health care professionals can make decisions about your care. However, in non-emergency situations, authorization is required to disclose certain mental health care information to outside providers or facilities.
2. **Payment:** In order for an insurance company to pay for your treatment, we must disclose PHI that identifies you, your diagnosis, and the treatment provided to you, to the insurance company. We also may release information to someone who helps pay for your care.
3. **Health Care Operations:** We may use or disclose your PHI in order to improve the quality or cost of care we deliver. These activities may include evaluating the performance of your health care providers, or examining the effectiveness of the treatment provided to you. They may also include providing training programs for students, trainees, healthcare providers or non-healthcare professionals to help them practice or improve their skills. In addition, we may use or disclose your PHI to send you a reminder about your next appointment.
4. **Business Associates:** We may use or disclose your PHI to a Business Associate, who is specifically contracted to provide us with services utilizing that health information, pursuant to an approved business associate agreement which assures that the business associate will handle the PHI in compliance with privacy regulations.
5. **Individuals Involved in Your Care:** We may release your PHI to a family member, other relative, or close personal friend who is involved in your medical care if the PHI released is directly relevant to the person’s involvement with your care.

#### **Special situations in which the UWSHC will or may disclose your PHI.**

1. **Required by Law:** As required by law, we may use and disclose your PHI. For example, we may disclose medical information to government officials to demonstrate compliance with HIPAA.
2. **Public Health:** As required by law, we may use or disclose your PHI to public health authorities for purposes related to preventing or controlling disease, injury, or disability; reporting births and deaths; reporting child or elder abuse or neglect; reporting reactions to medications or problems with products and notifying patients of recalls or products they may be using; notifying a person who may have been exposed to or be at risk for contracting or spreading a disease or condition; or notifying an authorized government authority if we reasonably believe you to be a victim of abuse, neglect, or domestic violence. We will only make this disclosure if authorized by law.
3. **Health Oversight Activities:** We may use or disclose your PHI to health agencies during the course of audits, investigations, licensure and other proceedings related to oversight of the health care system.
4. **Judicial and Administrative Proceedings:** We may disclose your PHI in response to a court or administrative order, or in response to a subpoena, discovery request or other lawful process.
5. **Law Enforcement:** We may use or disclose your PHI to a law enforcement official for purposes such as reporting a crime at our facility or for other law enforcement purposes as authorized or required by statute.
6. **Coroners, Medical Examiners and Funeral Directors:** We may release PHI to a coroner or medical examiner to identify a deceased person or to determine the cause of death. We may also release PHI to funeral directors as necessary to help them carry out their duties.
7. **Organ and Tissue Donation:** If you are an organ donor, we may use or disclose your PHI to organizations involved in procuring, banking or transplanting organs and tissues.

8. **Public Safety:** We may use or disclose your PHI to appropriate persons in order to prevent or lessen a serious and imminent threat to the health and safety of any individual.
9. **National Security:** We may disclose PHI to authorized federal officials for the conduct of lawful intelligence, counter-intelligence, and other national security activities authorized by law.
10. **Protective Services:** We may disclose your PHI to authorized federal officials in order to provide protection to the President of the United States, other authorized persons or foreign heads of state, or to conduct special investigations.
11. **Worker's Compensation:** We may disclose your PHI as necessary to comply with worker's compensation laws that provide benefits for work-related injuries or illness without regard to fault.
12. **Disclosures to Plan Sponsors:** We may disclose your PHI to the sponsor of your health plan (if applicable), for the purposes of administering benefits under the plan.
13. **Research:** We may disclose your PHI for research, regardless of the source of funding of the research, provided that we obtain documentation that an alteration to or waiver of authorization for use or disclosure of PHI has been approved either by an Institutional Review Board or a privacy board, or if such disclosure is otherwise permitted by law.
14. **Military and Veterans:** If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.
15. **Inmates:** If you are an inmate at a correctional facility or in the custody of a law enforcement official, we may use or disclose your PHI to the facility or the official as may be necessary to provide information about immunization and/or a brief confirmation of general health status, or required by law.
16. **Emergency Services:** We may use or disclose your PHI to provide to emergency services, health care or relief agencies a brief confirmation of your health status for purposes of notifying your family or household members.
17. **Limited Data Set:** We may use or disclose your PHI as part of a limited data set if we enter into a data use agreement with the limited data set recipient. A limited data set is PHI that excludes most direct identifiers.

**When the UWSHC May Not Use or Disclose Your PHI:**

Except as described in this Notice of Privacy Practices, we will not use or disclose your PHI without written authorization from you. A written authorization is required, with limited exceptions, for the use or disclosure of psychotherapy notes, for the sale of your PHI and for the use or disclosure of your PHI for marketing purposes. If we ask for an authorization, we will give you a copy. If we disclose partial or incomplete information as compared to the authorization to disclose, we will expressly indicate that the information is partial or incomplete. If you do authorize us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. If you revoke your authorization, we will no longer be able to use or disclose health information about you for the reasons covered by your written authorization, though we will be unable to take back any disclosure we have already made with your permission. If we use your PHI for underwriting purposes for your health plan, we are prohibited from using your genetic information for such purposes.

**Statement of Your Health Information Rights:**

1. **Right to Request Restrictions:** You have the right to request restrictions on certain uses and disclosures of your health information. The UWSHC is not required to agree to every restriction that you request. If you would like to make a request for restrictions, you must contact the Contact Person listed at the end of this Notice and submit the required form with your request in writing.
2. **Right to Request Confidential Communications:** You have the right to request that you receive your health information through a reasonable alternative means or at an alternative location. A University health care provider is required to accommodate reasonable requests. To request confidential communications, contact the Contact Person listed at the end of this Notice and submit the required form with your request in writing.
3. **Right to Inspect and Copy:** With very limited exceptions, you have the right to inspect and copy your health information. To inspect and copy such information, submit your request in writing to the Contact Person listed at the end of this Notice. If you request a copy of the information, we may charge you a reasonable fee to cover the expenses associated with your request. In the event that the UWSHC uses or maintains an Electronic Health Record of information about you, then upon your request, we will provide an electronic copy of the PHI to you or to a third party designated by you.
4. **Right to Request Amendment:** You have the right to request the UWSHC correct, clarify and amend your health information. To request a correction, clarification or amendment, contact the Contact Person listed at the end of this Notice and submit your request on the required form in writing. We may add a response to your submitted correction, clarification or amendment and will provide you with a copy. We may also deny your request. If we do deny your request, we will provide you with a written notification detailing our reasons for the denial.

5. **Right to Accounting of Disclosures:** You have the right to receive a list or “accounting of disclosures” of your health information made by the UWSHC, except that we generally do not have to account for non-electronic disclosures made for the purposes of treatment, payment, or health care operations; for disclosures made to you; for disclosures made pursuant to an authorization; for those made to our facility’s directory or to those persons involved in your care; incidental disclosures; for lawful inquiries made pursuant to national security or intelligence purposes; for lawful inquiries made by correctional institutions or other law enforcement officials in custodial situations; or, for disclosures when your information may become part of a limited data set. To request an accounting of disclosures, submit your request in writing to the Contact Person listed at the end of this Notice. Your request should specify a time period of up to six years. The UWSHC will provide one list per 12 month period free of charge; we may charge you for additional lists.
6. **Right to Paper Copy:** You have a right to receive a paper copy of this Notice of Privacy Practices at any time. To obtain a paper copy of this Notice, send your written request to the Contact Person listed at the end of this Notice. You may also obtain a copy of this notice at our website: [www.uwyo.edu/comdis](http://www.uwyo.edu/comdis) under the UW Speech and Hearing Clinic menu.

If you would like to have a more detailed explanation of these rights, or if you would like to exercise one or more of these rights, contact the Contact Person listed at the end of this Notice.

### **Special Protections**

Special privacy protections apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information. Similarly, some Wyoming law may be more stringent than the federal laws and regulations protecting the privacy of your medical information. This means that parts of this Notice may not apply to these types of information because stricter privacy requirements may apply. The UWSHC will only disclose this information as permitted by applicable state and federal laws. If your treatment involves this information, you may contact our Privacy Officer to ask about the special protections.

### **Changes to this Notice of Privacy Practices**

The UWSHC reserves the right to amend this Notice of Privacy Practices at any time in the future and to make the new Notice provisions effective for all health information that we maintain. We will promptly revise our Notice and distribute it to you at your next visit whenever we make material changes to the Notice and will make the new notice available at our office and on our website. The UWSHC is required by law to abide by the terms of the Notice currently in effect. The end of the Notice will contain the Notice’s effective date.

### **Complaints**

Complaints about this Notice of Privacy Practices or requests for further information should be directed to the Contact Person listed below. The UWSHC will not retaliate against you in any way for filing a complaint, participating in an investigation, or exercising any other rights under the Health Insurance Portability and Accountability Act (HIPAA). All complaints to the UWSHC must be submitted in writing. If you believe your privacy rights have been violated, you also may file a complaint with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, SW, Washington D.C. 20201 or call 1-877-696-6775.

### **CONTACT PERSONS:**

**Erin Page, Privacy Officer**

**Teresa Garcia, Security Officer**

University of Wyoming Speech and Hearing Clinic

Dept. 3311, 1000 E. University Avenue

307/766-6426

[emorris9@uwyo.edu](mailto:emorris9@uwyo.edu)

[tgarcia@uwyo.edu](mailto:tgarcia@uwyo.edu)

**Effective Date of this Notice: 04/14/2003; latest revision: 08/17/2017**

### **University of Wyoming Equal Education and Employment Opportunity Statement**

The University is committed to equal opportunity for all persons in all facets of the University’s operations and is an Equal Opportunity/Affirmative Action employer. The University will provide all applicants for admissions, employment and all University employees with equal opportunity without regard to race, gender, religion, color, national origin, disability, age, protected veteran status, sexual orientation, genetic information, gender identity, creed, ancestry, political belief, any other applicable protected category, or participation in any protected activity. The University ensures non-discriminatory practices in all matters relating to its education programs and activities and extends the same non-discriminatory practices to recruiting, hiring, training, compensation, benefits, promotions, demotions, transfers, and all other terms and conditions of employment.

The Division of Communication Disorders applies the University’s Equal Education and Employment Opportunity Statement and Policy to persons served in the program’s clinic, and also provides equal opportunity regardless of an individual’s status as a parent.



**APPENDIX 1c-6.**

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**PERMISSION FOR ACTIVITIES**

(clients/family should *check boxes and initial* **only those that apply**)

I, \_\_\_\_\_, hereby give permission for  
(Name of client, parent or guardian)

\_\_\_\_\_ to do the following:  
(Name of client)

- \_\_\_\_\_ Participate in outside activities (e.g., walking around campus, to the Student Union, or various buildings on campus) during his/her diagnostic or treatment sessions at the UW Speech-Language and Hearing Clinic.
- \_\_\_\_\_ Participate in off-campus activities (e.g., trip to a store, office, etc.) during his/her diagnostic or treatment sessions at the UW Speech-Language and Hearing Clinic.
- \_\_\_\_\_ Walk independently to/from the UW Speech-Language and Hearing Clinic to a designated location (specify location \_\_\_\_\_).
- \_\_\_\_\_ Consume edible items during diagnostic or treatment sessions at the UW Speech-Language and Hearing Clinic.
- \_\_\_\_\_ Authorize supervisor-approved visitors to observe diagnostic or treatment sessions at the UW Speech-Language and Hearing Clinic.

\_\_\_\_\_  
Client or Parent/Guardian's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

Revised 07/2011

APPENDIX 1c-7.

**Patient Authorization for Use or Disclosure  
of Protected Health Information (PHI)**

---

I, \_\_\_\_\_, hereby authorize \_\_\_\_\_ to:  
*(patient or representative)* *(name of facility)*

\_\_\_\_\_ **Use** the following Protected Health Information, and/or

\_\_\_\_\_ **Disclose** the following Protected Health Information to:

\_\_\_\_\_  
*(name and complete address of facility)*

-----  
-----

Describe in detail the information to be used or disclosed.

This PHI is being used or disclosed for the following purpose(s):

-----  
-----

List Specific Purposes

I direct and hereby authorize \_\_\_\_\_ to deliver the PHI  
*(name of facility)*

specified in this Authorization to the party or parties specified in the following medium, if available:

- Hardcopy Format, such as paper or facsimile (fax).
- Electronic Format, such as CD-ROM or flash drive (memory stick).
- Email.
- No Format Preference.

I understand that electronic media, and delivery methods such as email, pose certain risks to the privacy and security of my PHI that may be beyond the control of the **UWSHC**. I agree to assume such risks personally, and to hold the **UWSHC** \_\_\_\_\_ harmless in the event my PHI is breached or compromised as a result of my

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directing and authorizing \_\_\_\_\_ to transmit or deliver such information electronically.  
(name of facility)

This Authorization shall be in force and effect until \_\_\_\_\_ at which time this Authorization to use or disclose this PHI shall expire.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending such written notification to the **UWSHC** at the address listed above.

I understand that a revocation is not effective to the extent that the **UWSHC** \_\_\_\_\_ has relied on this authorization for the use or disclosure of the PHI.

I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

The **UWSHC** will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide Authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy the PHI to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Have an electronic copy of my health records, or a portion thereof, transmitted to any third party or person I designate.
- Refuse to sign this Authorization.

The use or disclosure requested under this Authorization will result in direct or indirect remuneration to the **UWSHC** from a third party (*If applicable*).

\_\_\_\_\_  
Signature of Patient **or** Personal Representative (circle one)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Personal Representative

\_\_\_\_\_  
Description of Personal Representative's Authority (if applicable)

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Division of Communication Disorders  
Department 3311  
1000 E. University Avenue  
Laramie, WY 82071  
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▼▼▼ FOR OFFICE USE ONLY ▼▼▼

<b>Received by:</b>			
<b>Date Received:</b>		<b>Time Received:</b>	
<b>Action(s) Taken:</b>			
<b>PHI Disclosed To:</b>			
<b>Disclosure Media:</b>	<input type="checkbox"/> Hardcopy <input type="checkbox"/> Memory Stick <input type="checkbox"/> CD-ROM <input type="checkbox"/> Email <input type="checkbox"/> Other (describe)		
<b>Discloser Signature:</b>			

**APPENDIX 1c-8.**

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Speech and Hearing Clinic  
Division of Communication Disorders  
Department 3311  
1000 E. University Avenue  
Laramie, WY 82071  
307/766-6426**

**CLIENT ATTENDANCE POLICY**

Dear Client, Parent or Guardian:

Please read this policy statement, sign it, and return it to the clinician. The yellow copy is yours to keep and the white copy will be retained in the permanent folder.

**Clinic Attendance**

The University of Wyoming Speech-Language and Hearing Clinic is pleased to offer speech, language and hearing services. Regular attendance of scheduled treatment is required because:

- It promotes the best results from treatment.
- There may be a waiting list of other clients who could use the reserved time.
- Clinicians must obtain a certain number of clinical experiences for graduation and certification.

If you must miss a scheduled appointment due to illness or an emergency, notify the clinic secretary as soon as possible. Because of our responsibility to all clients, unnotified absences will be subjected to a fee for a “no-show” to a scheduled appointment. Lack of regular attendance may result in postponement of services to a semester more convenient for you. You will be notified about clinic closings or cancellations by your clinician.\* Typically, any time the University of Wyoming is closed, the clinic will be closed. This includes emergency closings or closures due to inclement weather. This also includes periods between semesters, vacation breaks and holidays such as July 4<sup>th</sup>, Thanksgiving, and Easter. The clinic expects clients to maintain a 90% attendance rate. This permits us to provide the best treatment and meets our clinic needs and responsibilities. If you have any questions, contact the clinical supervisor.

\_\_\_\_\_  
Signature of Client, Parent or Guardian

\_\_\_\_\_  
Date

\*Closure dates for semester: \_\_\_\_\_

Revised 5/2014

# APPENDIX 1c-9.

## Speech-Language Pathology Service Codes (CPT and ICD-10)

Client: \_\_\_\_\_ Dates of Service: \_\_\_\_\_  
(Full Name)

### Current Procedure Terminology (CPT) Codes

- \_\_\_\_ 92521 Evaluation of speech fluency (stuttering, cluttering).
- \_\_\_\_ 92522 Evaluation of speech sound production (articulation, phonological process, apraxia, dysarthria).
- \_\_\_\_ 92523 Evaluation of speech sound production with evaluation of language comprehension and expression.
- \_\_\_\_ 92524 Behavioral and qualitative analysis of voice and resonance.
- \_\_\_\_ 92610 Evaluation of oral and pharyngeal swallowing function.
- \_\_\_\_ 92611 Motion Fluoroscopic evaluation of swallowing function by cine or video
- \_\_\_\_ 92507 Treatment of speech, language, voice, communication, and/or auditory processing disorders (includes aural rehabilitation) **for an individual**
- \_\_\_\_ 92508 Treatment of speech, language, voice, communication and/or auditory processing disorders (includes aural rehabilitation) **in a group setting**
- \_\_\_\_ 97532 Development of cognitive skills to improve attention, memory, problem solving, (includes compensatory training), direct (one-on-one) patient contact by the provider
- \_\_\_\_ 96125 Standardized cognitive performance testing per hour (includes face-to-face time with patient and time interpreting test results and preparing report)

### International Classification of Diseases (ICD-10-CM) Codes

- |  |  |
|--|--|
| ____ F70 Mild intellectual disabilities  | ____ F80.0 Phonological disorder (articulation)                  |
| ____ F80.1 Expressive language disorder  | ____ F80.2 Mixed receptive-expressive language disorder          |
| ____ F80.4 Speech/language developmental delay due to hearing loss H90. ____ H91. ____ | ____ F80.81 Childhood onset fluency disorder                     |
| ____ F81.0 Specific reading disorder   | ____ F81.81 Disorder of written expression                       |
| ____ F84.0 Autistic disorder   | ____ F84.5 Asperger's syndrome                                   |
| ____ I69.320 Aphasia following cerebral infarction                                     | ____ I69.322 Dysarthria following cerebral infarction            |
| ____ J38.2 Nodules of the vocal cords  | ____ J38.3 Other diseases of the vocal cords                     |
| ____ R41.841 Cognitive communication deficit   | ____ R47.89 Other speech disturbance (social pragmatic disorder) |
| ____ R49.9 Unspecified voice and resonance disorder                                    | ____ R62.0 Delayed milestone in childhood (late talker)          |
| ____ S06.2 Diffuse traumatic brain injury  | ____ S06.3 Focal traumatic brain injury                          |
| ____ Other (specify: _____)  | ____ Other (specify: _____)                                      |

Graduate Clinician Signature: \_\_\_\_\_

Supervisor Signature: \_\_\_\_\_

**APPENDIX 1c-10.**

**UW SPEECH AND HEARING CLINIC**  
**CLIENT QUESTIONNAIRE**

Name (optional): \_\_\_\_\_ City: \_\_\_\_\_ Date \_\_\_\_\_

1. How did you learn about the University of Wyoming Speech and Hearing Clinic?

Physician  Newspaper  Dentist  Radio  School  
 Phone Book  Friend  Website  Other (explain) \_\_\_\_\_

2. What type of service did you or your family member receive?

Speech-Language Evaluation  Hearing Aid Evaluation  
 Speech-Language Screening  Audiological Screening  
 Speech-Language Treatment  Audiological Evaluation  
 Consultation

3. How would you rate the services provided by the University of Wyoming Speech and Hearing Clinic?

Excellent  Average  Poor  
 Good  Fair  Other \_\_\_\_\_

4. What did you like *best* about the services you or your family member received?

5. What did you like the *least* about the services you or your family member received?

6. If you have received speech-language or hearing services elsewhere, how would you compare our services to others?

Better Than  Equal To  Poorer Than

7. What improvements could be made to provide better services?

8. Was the cost for our services reasonable?

Yes  No

9. Would you recommend others to seek services from the University of Wyoming Speech and Hearing Clinic?

Yes  No

10. Please rate your difficulty in finding a parking space within reasonable distance of the clinic.

Impossible  Difficult  Some Difficulty  No Problem

**APPENDIX 1c-11.**  
**CLIENT INTENTION LETTER**

**Date:** *Enter date form is presented*

**To:** *Enter name of client*

**From:** Erin Page, Clinic Coordinator /Supervisor

**Re:** End of the semester

Thank you for supporting the Division of Communication Disorders graduate program. Please be reminded that the last day for graduate student clinicians to treat clients at the UW Speech and Hearing Clinic will be on *enter last day of semester*. End of the semester progress reports will be *presented* to you on or before this date and later mailed to you with a client questionnaire form.

University speech/language services will resume after *enter start date of next semester* for the next semester. Please indicate at the bottom of this form your intentions to continue services. **Return the bottom half of this form to your graduate clinician as soon as possible.**

.....

\_\_\_\_\_ I intend to continue speech/language services for the \_\_\_\_\_ semester.

\_\_\_\_\_ I do **NOT** intend to continue speech/language services for the \_\_\_\_\_ semester but would like to be considered for the \_\_\_\_\_ semester.

**Client's name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Parent/Guardian name: \_\_\_\_\_

**Scheduling preferences** (*list days and times available*):

Contact preferences

Email:

Phone: (indicate cell or home)

## APPENDIX 1e-1

### PROFESSIONAL WRITING TIPS

Below is a collection of suggestions or ‘tips’, and *do’s and don’ts* for clinical writing compiled by previous and current supervisors. They are not written in a hierarchical form and should be used as a **checklist** as you evaluate your own writing. They are in no way comprehensive for all that is possible in clinical writing but merely a *guide*.

- Think/write (CLEAR)
  - C** = CLEAR
  - L** = LOGICAL
  - E** = EVIDENCE / ENOUGH
  - A** = ACCURATE
  - R** = RELEVANT
- Chronological age is marked by using a **semi-colon** not a colon. In narrative format, it is acceptable to write: *Mary is a 13-year-old student* **or** *Mary is a 13 years, 7 months old student*.
- Do not use contractions or personal pronouns (I, we).
- Write in 3<sup>rd</sup> person, referring to yourself as ‘the clinician’ or ‘the examiner’.
- Use a consistent format when referring to the client: either ‘the client’ or their initials but not both.
- It is better to make two CLEAR sentences than one convoluted sentence that may confuse the reader.
- Be careful with the phrases, "x appeared to" or "x seemed to". Focus instead on what you observed, e.g., "x smiled" rather than, "x *appeared* to be happy".
- Instead of referring to sounds with this notation: /s/, use "the /s/ sound, "e.g., Joey has been working on improving his productions of the /r/ *sound*. Delineate graphemes for spelling by other brackets e.g., [r] or {r}.
- Always keep in mind the audience to whom you are writing.
- Write it simply first (be CLEAR in what your message is) and then re-write, using a thesaurus if necessary.
- Give the full name of an assessment first, then the acronym (e.g., Test of Problem Solving (TOPS)) and then refer to acronym from that point forward. The same applies for names of organizations, e.g., American Speech and Hearing Association (ASHA).
- Refer to a person as ‘*who*’ not ‘*that*’ (e.g., He is a client *who* needs assistance as opposed to, He is a client *that* needs assistance.)
- Develop a system that helps you address **all supervisor** comments on a written draft. Some students use highlighters and mark each item as they have thought about and fixed an issue. If you disagree with your supervisor, it is helpful to write a note about what you are thinking.
- Be certain of the spelling of client names, titles, and check **all** dates (i.e., DOB) for accuracy.
- Write phonetic symbols with examples (e.g., /a/ as in *father*) to clarify meaning.
- An unacceptable phrase is, "xx was able to sing 3 notes". By itself it does not say that he *actually* sang. It only says he was *able* to sing. One can be able to do something without doing it.
- Watch verb tense switching throughout document. Keep tenses consistent within a section of the report (e.g., the progress report is written in past tense as the semester/sessions have been completed.)
- The information structure of English sentences is old information first, new information last. Generally go with that:

## APPENDIX 1e-2

### ACCEPTABLE NOTATIONS FOR USE IN SOAP NOTES

DX diagnosis

TX treatment (do not use therapy)

Cln. Clinician

Cl. Client

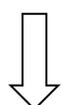
D/C Discharge or discontinue

Info. Information

R/O Rule out

 Change

 Increase or improve

 Decrease or worsen

%ile Percentile

$\overline{C}$  with

$\overline{S}$  without

$\overline{a}$  before

Lt left

L left

Rt right

R right

 No or none

I independently

DNT did not test

Eval evaluation

c/o concerned of or complains of

WNL within normal limits

DOB date of birth

Min minimum

Mod moderate

Max maximum

N/A not applicable

LTG long term goal

STG short term goal

s/c self-corrected

PLOP present level of performance

**\*\*When referencing any acronym the first time it is used in a written communication, it should be spelled out completely. For example, Semester Treatment Plan (STP), Test of Problem Solving (TOPS), Attention Deficit Disorder (ADD), etc.\*\***

**APPENDIX 1e-3**  
**SOAP Explanatory Template**

University of Wyoming  
 Speech and Hearing Clinic  
**SOAP NOTE**  
**CONFIDENTIAL**

<b>CLIENT NAME: H                      P</b> *use initials on notes until placed into permanent file, then fill in client's complete name
<b>SEMESTER GOALS AND OBJECTIVES:</b> <b>GOAL 1:</b> Type goals here exactly as they appear in the STP (make sure you substitute client's name with their initials) 1a. Type objectives here exactly as they appear in the STP 1b. 1c. <b>GOAL 2:</b> 2a. 2b. 2c. <b>GOAL 3:</b> 3a. 3b. 3c.

Date/Code		Entry
MM/DD/YYYY I - 30	<b>S:</b>	This section describes pertinent info about the client's mood, state of mind, physical condition, motivation and/or attitude, as it relates to the performance described in "O." This may include direct quotes from client or family members.  e.g., XX had to excuse himself during the session for feeling ill. He reported having eaten undercooked meat the day before. e.g., XX attended the session today with a cheerful demeanor and high motivation, as evidenced by the comments, "I'm excited that I self-corrected when I said my name today at the coffee shop. I feel like these sessions are really helping me."
Codes: I = Individual G = Group	<b>O:</b>	List the objectives that were actually addressed in the session. Since the objectives are listed at the top, you may only include the objective number. State the number correct vs. number of opportunities, the percentage accuracy level, and whether the objective was met or not. Give quantitative <i>and</i> qualitative data.  e.g., Objective 1c: 105/134=78% <b>Not Met.</b> Client demonstrated difficulty with the following words: <i>doorstop, cord, sword, court, course</i> . Some generalization of /or/ words in conversational speech noted (e.g., "I don't want <u>more</u> homework.").
	<b>A:</b>	In this section you need to "analyze" the performance. What does the data mean for the big picture and when compared to previous session? Does the client continue to progress? Is he/she learning? Making functional gains? Understanding the task? Does the client's performance tell you something about particular targets? Consider information provided in "S" – was any of it related to the performance today?  e.g., XX became ill halfway through the session. His performance on objective 1c before he became ill showed improvement over last week, but after returning from the restroom, his accuracy level decreased significantly. XX demonstrated noticeably more difficulty producing /or/ in words containing following consonants, which are harder than /or/ in words containing following vowels, as the vocalic /r/ moving into a lingual consonant is more complex articulatorily.
	<b>P:</b>	State what your plan is for the next session based directly upon info presented in the A section. What is the next step? What changes are you making to increase client's success or level of independence? Be specific.

		<p>“Continue with plan of treatment as indicated on STP” is not specific enough. The “P” implies an action, so use clear (i.e., covert) verbs.</p> <p>e.g., Continue to target objective 1c, but decrease task difficulty level by separating words with vowels following /or/ from words with consonants following /or/. Teach XX to produce words with consonants following /or/ by slowing production until acoustic quality of /or/ is achieved before moving into following consonant.</p> <p>e.g., Continue to target objective 2a, but increase client’s independence in formulating present progressive tense sentences by removing written sentence models.</p>
--	--	--

Clinician signature/Graduate Student Clinician
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**APPENDIX 1e-4.**  
**CLARYIFYING STP GOALS, TREATMENT OBJECTIVES AND SESSION**  
**OBJECTIVES**

**STP goal (short-term):** The client’s best performance over a specific amount of time. The goal should state what level of performance is expected, under what conditions and state how well the client must perform over a specific time frame, such as a semester, an academic year, 8 weeks, etc., so that the GOAL can be met.

**Example:** By the end of the semester, Johnny will produce *is + verb* constructions in structured language tasks with only one prompt (e.g., “Make your sentence complete.”) with 90% accuracy.

**Treatment Objectives:** These are the *little* steps that will help the client to achieve the goal. What must be done first in order for the client to achieve the goal? They also contain the elements of performance, conditions and criteria. They may also include a *mastery statement* to indicate when the next logical step should be introduced.

**Example:** Johnny will imitate correct *is + verb* constructions after the clinician, given an action photo cue card, with 90% accuracy over 2 consecutive sessions.

**Session Objectives:** These are the logically sequenced, *incremental* steps that you hope to accomplish during one session **or** sessions for the week. As above, they contain all the elements of performance, conditions and criteria. An added feature to consider is whether or not another clinician could *replicate* what you are doing in the session, based upon the information provided in the weekly treatment plan. This may include entering the names of materials, specific games or specific cues that work well with the client and what schedule of reinforcement will be used.

**Example:** Johnny will listen to sentences spoken by the SLP and place a poker chip in the basket each time he hears the SLP use the *is + verb* construction. Twenty sentences (10 per set) will be used. Johnny needs to achieve 100% with only one repetition allowed for two sets of sentences.

- ❖ This session objective would have followed after Johnny was ***instructed*** or ***taught*** what makes a correct (vs. incorrect) sentence. This *teaching and instructions* are the clinician’s procedures/methods (including materials) that facilitate the successful completion of the session objective.

**Sample:** The dog running. *OR* The dog IS running. Which one *sounds* correct to you, Johnny? That’s right. You chose, “The dog IS running,” and this little word, ***IS***, is what we need to make our sentence sound correct when we speak it or when we write it.

**APPENDIX 1f-1**  
**Explanatory STP Template**

University of Wyoming  
Speech and Hearing Clinic  
Division of Communication Disorders  
Department 3311  
1000 E. University Avenue  
Laramie, WY 82071  
307/766-6426

**SEMESTER TREATMENT PLAN**  
**CONFIDENTIAL**

Name: \_\_\_\_\_ Semester: \_\_\_\_\_  
Date of Birth: MM/DD/YYYY Date of Report: MM/DD/YYYY  
Age: Years;Months Conference Date: MM/DD/YYYY  
Address: \_\_\_\_\_ Graduate Student Clinician: \_\_\_\_\_  
Phone: \_\_\_\_\_ Supervisor: \_\_\_\_\_  
Classification: list communication disorder

**BACKGROUND INFORMATION**

This section must include:

- Client’s name, age gender
- School/employment affiliation (if applicable)
- Relevant medical info, diagnoses, S/L disorder classification
- Previous S/L services (at UWSHC or anywhere else)
- Focus and general outcome of most recent treatment at UWSHC (for continuing clients)
- Results of any recent evaluations

Example: Sara is a four years, nine months old female who lives with her mother and younger brother and attends the Developmental Preschool in Laramie, Wyoming. Sara’s birth history was unremarkable and she reached all early developmental milestones within expected age ranges. Sara presents with a phonological disorder which impacts the intelligibility of her speech. She has been receiving speech services at the University of Wyoming Speech and Hearing Clinic (UWSHC) since February 25, 2017. She also receives IEP-based speech services through the Developmental Preschool. The focus of Sara’s treatment at UWSHC has been on the reduction of her use of age-inappropriate phonological processes. Sara has made progress in her reduction of weak syllable deletion (e.g., as in, “ephant” for ‘elephant’) and final consonant deletion (e.g., as in, “ca” for ‘cat’), and met her goals for these processes last semester. She did not meet her goal for reduction of velar fronting (i.e., substitution of /t/ for /k/ and /d/ for /g/, as in, “tee” for ‘key’ and “mud” for ‘mug’).

**PRESENT LEVEL OF PERFORMANCE**

This section must include:

- Brief explanation of baselining activities
- Baseline data
- Behavioral observations
- Any relevant quotes pertaining to client’s/family’s demeanor or general response towards attending treatment

Example: During baselining activities during the first three treatment sessions this semester, Sara’s use of velar fronting was assessed during a variety of activities including conversation during unstructured play, games (such as Memory), and picture naming. Across the three sessions, Sara used the targeted phonemes /k/, /t/, /g/, and /d/ appropriately on the percentages of opportunities presented below:

Phoneme (i.e., speech sound)	% Appropriate Usage
------------------------------	---------------------

/k/	29%
/t/	65%
/g/	13%
/d/	78%

Sara was initially reluctant to participate during the first session as evidenced by her comment, “I want to go home.” Once she was presented with a set of toys familiar to her from the previous semester, however, she engaged in play with the clinician. Over all three sessions, Sara was easily distracted as evidenced by her talking about events outside the session activities and her desire to play with materials at inappropriate times.

### AREA OF NEED

This section must include:

- Priority area(s) of need
- Expected functional gains

Example: Sara needs to reduce her age-inappropriate use of velar fronting. By doing so, she will increase her intelligibility to unfamiliar listeners.

### SEMESTER GOALS

### SEMESTER OBJECTIVES

1. Write a semester goal targeting one area of function or behavior and including condition, criterion, degree of support, and number of tasks/ sessions. Example: Sara will reduce her use of velar fronting during structured conversational activities to no more than 10% of opportunities with minimal cueing* across three consecutive sessions.	1a. Write either <b>horizontal objectives</b> targeting different skills that do not depend on each other and can be addressed simultaneously, <b>OR</b> 1b. <b>vertical objectives</b> targeting <i>different</i> skills that depend on each other and are sequential, <b>OR</b> 1c. <b>vertical objectives</b> targeting the <i>same</i> skill in increasingly difficult contexts
2. Add or delete boxes as necessary.	2a. 2b. 2c.

\*Minimal cueing is defined as no more than one verbal prompt

### TREATMENT APPROACHES AND PROCEDURES

#### Goal 1

This section must include:

- A brief description of the treatment approach(es) you plan to use
- A brief description of general treatment procedures (this *may* include steps you will follow, materials you will use, reinforcements that will be provided, behavior management techniques, etc., as applicable)

Example: A phonological approach will be taken to achieve Goal 1. A phonological approach focuses on Sara’s use of velar sounds (i.e., /k/ and /g/) versus alveolar sounds (i.e., /t/ and /d/) to differentiate word meanings (e.g., ‘date’ is a word with its own meaning, which is different from the meaning of ‘gate’). Treatment procedures will include use of minimal word pairs (i.e., words that differ by only one phoneme, and contrasted sounds differ by only one aspect of either articulatory placement, manner or voicing) such as date/gate, tea/key, mud/mug, bat/back, etc. to teach Sara to use the targeted phonemes contrastively and appropriately in meaningful words. The minimal word pairs will be used in a variety of auditory discrimination and production activities.

#### Goal 2

If the approach and procedures are the same for several goals, write about them only once (e.g., “The approach and procedures are the same for goals 1 and 2.”).

### RATIONALE FOR APPROACHES AND PROCEDURES

This section must include:

- Explanation of why approaches and procedures were chosen
- Evidence that proves they are efficacious/effective

Example: A phonological approach is different from an articulation approach, which focuses only on a client’s correct physical production of a target speech sound. An articulation approach is not appropriate for Sara because she is physically capable of

producing the sounds /k/ and /g/ with ease; she simply does not use them appropriately in conversational speech and habitually replaces them with the sounds /t/ and /d/, respectively. According to Bernthal and Bankson, a phonological approach....(evidence and year of citation included here).

**NOTICE AND AGREEMENT**

I am in agreement that the treatment plan described on this form is acceptable.

---

Name of client, parent or guardian Role (Client, Parent, or Guardian)	Date
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---

Name, Degree Graduate Student Clinician	Date
--	------

---

Name, Degree, Certification Clinic Supervisor	Date
--	------

cc: State who has written authorization (via Patient Authorization for Use or Disclosure form) to get a copy of this report. List how/when this report was delivered.  
Name  
Address  
City State Zip

Hand-delivered to client/parent/guardian on: MM/DD/YYYY; and/or Mailed to name on: MM/DD/YYYY  
(Document this information in the contact log of the permanent file.)

**APPENDIX 1f-2**  
**Explanatory Midterm Note Template**

University of Wyoming  
Speech and Hearing Clinic  
Division of Communication Disorders  
Department 3311  
1000 E. University Avenue  
Laramie, WY 82071  
307/766-6426

**MID-TERM PROGRESS NOTE**  
**CONFIDENTIAL**

**Name of Client:** \_\_\_\_\_ **Period Covered:** MM/DD/YYYY to MM/DD/YYYY

**PRESENT LEVEL OF PERFORMANCE**

**This is not the same information as your STP...we are mid- semester now**

- Did the client make progress towards STP goals?
- What has the client been working on during the reporting period?
- Present quantitative data (e.g., % accuracy level over the past 3 consecutive sessions—you may present this data in a chart or narrative format)
- Present qualitative data which may include: a description of the relevant communication skills the client demonstrates, the circumstances (e.g., context or level of support) during which relevant communication skills are demonstrated, relevant communication skills with which the client is still struggling, a statement that the client is/is not progressing at a rate adequate to meet/exceed the goal by semester end

Example: Lucy has demonstrated progress on all of her semester goals and objectives. Treatment has focused on increasing her expressive language skills through use of the following grammatical morphemes: auxiliary verbs (e.g., is, are, was, were; as in, “she *is* running”), present progressive –ing (e.g., *running*), and regular past tense –ed (e.g., *played*) and also through use of functional vocabulary terms including classroom items (e.g., *pencil, crayon, ruler, desk*), playground items (e.g., *swings, slide, jump rope, basketball*) and dining items (e.g., *fork, spoon, bowl, plate*).

With minimal prompting, Lucy uses the targeted morphemes and vocabulary terms to comment, request and answer questions with the following levels of accuracy:

	<b>Commenting</b>	<b>Requesting</b>	<b>Answering Questions</b>
Auxiliary verbs	74%	n/a	78%
Present progressive –ing	82%	n/a	87%
Regular past tense –ed	63%	n/a	72%
Classroom items	85%	86%	83%
Playground items	79%	78%	79%
Dining items	92%	92%	89%

Lucy is responsive to minimal prompting provided through either one verbal prompt (e.g., “*Add that important ending to your action word*”) or one gestural prompt (e.g., pointing to a flash card with the –ed ending printed on it). She is beginning to use the targeted words and word endings independently with rapidly increasing frequency. It is expected that Lucy will meet her goals and objectives by the end of the semester.

**CLINICAL IMPRESSIONS**

- Say something about the client’s overall responsiveness to you/treatment.
- What is the client’s functional (‘real-life’) performance?

- What factors contribute to the client’s rate of progress?
- What does the client need to continue to work on further?
- What are the client’s functional expectations and prognosis for the end of the semester?
- Describe changes that will be made to the STP goals/recommendations *if applicable* (e.g., goals/objectives that will be discontinued, modified or added).

Example: Good rapport between the clinician and Lucy was established easily early on in the semester, and Lucy has been highly responsive to treatment. It is evident that Lucy’s overall expressive language skills are increasing and allowing her to communicate her ideas, wants and needs more efficiently. Her average spoken sentence length has increased from 1 word to 3 words. Lucy’s mother reports that she’s noticed Lucy using longer sentences at home. She also reports that Lucy sometimes initiates a request of specific items during meal times and demonstrates frustration much less frequently.

Lucy’s willingness to participate in treatment activities, ability to maintain attentiveness throughout sessions, and engagement in homework activities have contributed to her excellent rate of progress. She needs to continue using the targeted words and word endings without prompting and in sentences of gradually increasing length. Lucy’s prognosis is good and it is expected that she will consistently comment, request and answer questions independently during treatment sessions and at home by the end of the semester. No changes to the semester treatment plan are recommended.

---

Name, Degree  
Graduate Student Clinician

---

Date

---

Name, Degree, Certification  
Clinic Supervisor

---

Date

cc: State who has written authorization (via Patient Authorization for Use or Disclosure form) to get a copy of this report. List how/when this report was delivered:

Name

Address

City State Zip

Hand-delivered to client/parent/guardian on: MM/DD/YYYY; and/or Mailed to name on: MM/DD/YYYY (Document this information in the contact log of the permanent file.)

\*\*ADD a page header IF document is more than one page in length.

**APPENDIX 1f-3**  
**Explanatory Final Note Template**

University of Wyoming  
Speech and Hearing Clinic  
Division of Communication Disorders  
Department 3311  
1000 E. University Avenue  
Laramie, WY 82071  
307/766-6426

**FINAL PROGRESS REPORT**  
**CONFIDENTIAL**

Name: \_\_\_\_\_ Date of Report: **MM/DD/YYYY**  
(must match the date in the page headers)

Date of Birth: **MM/DD/YYYY** Period Covered: **MM/DD/YYYY to MM/DD/YYYY**  
(dates reflect day of 1<sup>st</sup> session to last day of semester)

Age: \_\_\_\_\_ Sessions Attended: **XX of XX**  
(i.e., number of sessions attended versus number scheduled)

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Graduate Student Clinician: \_\_\_\_\_

Classification: (state communication disorder) Supervisor: \_\_\_\_\_

**PRESENT LEVEL OF PERFORMANCE**

**This is not the same information as your STP or midterm...we are at the end of the semester now**

- Give client's name, age and a general summary statement about his/her primary speech/language disorder, including severity. e.g., Mr. Thomas Miller is a 67 year-old male with a history of dysarthria with increasing severity due to a diagnosis of Parkinson's disease.
- Describe the client's treatment schedule, state how many scheduled sessions were attended and reasons for lack of attendance. e.g., AJ was treated at the University of Wyoming Speech and Hearing Clinic (UWSHC) two times a week for 30 minutes each session. He attended 8 of 15 scheduled sessions. Absences were due to illness and scheduling conflicts.
- Briefly state what skills were targeted during treatment sessions. e.g., Throughout the semester, Sofia practiced correct articulation of /s/ (e.g., as in "soup") and prevocalic /r/ (e.g., as in "rabbit") in increasingly difficult conversational contexts.
- Describe the relevant communication skills the client demonstrates, the circumstances (e.g., context or level of support) during which relevant communication skills are demonstrated and/or relevant communication skills with which the client is still struggling. e.g., Cody demonstrates decreased usage of the age-inappropriate velar fronting phonological pattern (e.g., substitution of /k/ and /g/ with /t/ and /d/, respectively) during familiar drill and play activities incorporating targeted word lists. His intelligibility during such structured activities has improved to 90%. He does not yet demonstrate generalized usage of /k/ and /g/ to novel activities and words.

**REMEDICATION PROCESS**

- Include a brief statement about the primary focus of treatment.
- Describe the general progression of treatment, including the specific methods/approaches and materials used.
- Include any parent/family education and homework given and the outcome.

- Include the results of the routine hearing screening and oral mechanism screenings. State any referrals or recommendations from these screenings *if applicable*.

e.g., Maria’s primary focus of treatment was on improving narrative language skills. Maria was taught new vocabulary and story grammar with the Text Talk program by (XXXX) and completed four storybooks this semester. Maria was also instructed with the Lindamood Phoneme Sequencing Program (LiPS) to improve her reading skills. She was taught to apply the “signal –e” spelling expectancy when reading and spelling words with this rule. Typically, she used the letter tiles that the program provides to spell and read sequences of word pairs, e.g., *kit* and *kite*. When she made a mistake, she was prompted to reflect on “the job of the ‘e’” (i.e., “it makes the vowel say its name”). With this procedure, she quickly increased her accuracy levels when reading and spelling.

Routine homework was sent each week as an extension of treatment tasks. Her mother reported that Maria was non-compliant at home but she still found time to review new vocabulary words.

Maria participated in a routine oral mechanism screening, which she passed. She failed the hearing screening and was recommended to repeat the screening next semester to monitor her hearing status.

## **PROGRESS TOWARDS SEMESTER GOALS**

The following goals and objectives were discussed and agreed upon for this semester.

**Goal 1:** State as written in the STP.

**Objective 1a:** State as written in the STP.

**Objective 1b:** State as written in the STP, etc.

### **Progress:**

- Begin with a statement as to whether or not the STP goal and objectives were met (specific dates are typically not necessary) e.g., The first STP goal and its three objectives were met.
- Provide objective results including quantitative and qualitative data e.g., Mark used adjectives in noun phrases in response to choice questions (e.g., “Do you want the long fishing pole or the short pole?”) independently 75% of the time over the past three consecutive sessions. This demonstrates significant improvement over his baseline performance of 42%. With this, he enriched his vocabulary to include three pairs of opposite adjectives (i.e., *big* and *small*, *full* and *empty*, *long* and *short*), and he used these adjectives in correct grammatical structures (i.e., noun phrases).
- If the goal/objective was not met, describe what factors (i.e., lack of attendance, decreased motivation, negative behaviors, etc.) may have contributed. Do not list “time constraints” as the sole reason an objective was not met. Also describe what *did* work well in your intervention and why. e.g., The third goal was not met due to Mr. Parker’s request to devote more time to goals one and two, as he stated that they were more of a priority to him and he was less motivated to practice goal three. When goal three was targeted, however, Mr. Parker summarized articles read in the newspaper with 60% accuracy. He was most consistent with correctly stating the main idea of the articles (80% accuracy), but did not consistently include all relevant details such as locations and persons involved in the news story (40% accuracy).
- Other things to consider: did the client ever generalize a skill beyond treatment? Did the client ever show signs of self-correction? Did family acknowledge functional gains? e.g., Kristin not only met the goal as written but showed increasing signs of generalization in spontaneous speech as reported by her parents. OR Kristin met her initial goal and began self-correcting in limited communication exchanges indicating that new skills are becoming more stabilized. Visual prompting in the form of sentence models facilitated an increase in self-correction.

Follow the same format above to document other goals and objectives from the STP.

## CLINICAL IMPRESSIONS

- **Provide a current clinical impression of the client's overall speech/language status.** e.g., Arnold made progress this semester with learning to suppress age inappropriate phonological error patterns. He continues to present with a mild to moderate phonological disorder, characterized by substituting fricative sounds, such as /s/, with stop sounds, such as /t/, when producing linguistic units larger than words and short phrases.
- **Describe the client's overall responsiveness to you/treatment.** e.g., Ms. Crane was enthusiastic, motivated, and eager to participate. She arrived prepared with her communication tools and was always in good humor (e.g., teased the clinician, told jokes, remarked about the magic "pill" to fix her). Ms. Crane demonstrated some frustration with the inability to convey intended messages, and often perseverated on her disorder, questioning why "it's in here" (pointing to her head) "but not here" (pointing to her mouth). Simple redirection from the clinician was required to refocus Ms. Carter's attention to the planned activity.
- **What is the client's functional ('real-life') performance? You may want to include statements made by the client/family members about progress** e.g., Alex is now 90% intelligible when communicating with unfamiliar listeners about a mutually identified topic. He recognizes when his communication partner has not understood him and successfully uses gestures to clarify his message. His sister states that she understands him "almost all the time" and they "have much longer conversations now."
- **What factors contributed to the client's rate of progress?** e.g., Because Joe was sick during almost a third of his scheduled sessions, not as much progress as anticipated at the beginning of the semester was made.
- **What does the client need to continue to work on further?** e.g., Jenny needs to continue expanding her expressive communication skills by using the grammatical structures targeted this semester in broader discourse contexts such as narrative and expository.
- **State the general prognosis and whether it appears that further treatment is appropriate.** e.g., Given Lacey's significant progress this semester and strong motivation, the prognosis for her to continue improving her pragmatic language skills is good. Continued treatment next semester is recommended.

## RECOMMENDATIONS

It is recommended that:

1. **State recommendations for continued treatment (frequency, type, group/individual, and duration), discharge or transfer. (Do not indicate the location of treatment as this is not as important as the treatment type and intensity).** e.g., Arnold continues treatment in an individual setting for his phonological disorder twice a week for 30 minutes each.
2. **Specify plans or recommendations for next semester's treatment, including further evaluation, referral, follow-up, further client/family education, parent counseling, parent involvement, home program, etc.** e.g., Treatment focuses on the elimination of remaining phonological error patterns and include a clinic-to-home program to allow for generalization of skills to the home environment.
3. **Include suggestions for maintenance of skills.** e.g., Mr. Tootles would likely benefit from conversational practice outside treatment sessions with unfamiliar native American English speakers to provide opportunities for application of skills targeted this semester and to further refine his listening skills.

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Name, Degree  
Graduate Student Clinician

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Date

---

Name, Degree, Certification  
Clinic Supervisor

---

Date

cc: State who has written authorization (via Patient Authorization for Use or Disclosure form) to get a copy of this report. List how/when this report was delivered.

Name

Address

City State Zip

Hand-delivered to client/parent/guardian on: MM/DD/YYYY; and/or Mailed to name on: MM/DD/YYYY

(Document this information in the contact log of the permanent file.)

**APPENDIX 1f-4**  
**Written Product Feedback form**

University of Wyoming  
Division of Communication Disorders  
Written Product Feedback

Due Date: Click or tap here to enter text. Clinician: Click or tap here to enter text. Client Initials: Click or tap here to enter text.  
Supervisor: Click or tap here to enter text.

Type: STP  Evaluation Report  Midterm note  Final progress report  SOAP note

**CALIPSO SCORING:** 1=not evident 2=emerging 3=present 4=consistent 5=automatic

EVALUATION SKILLS	Score		
	Designate Disorder area(s) here:		
6. Possesses knowledge of etiologies and characteristics for each communication and swallowing disorder			
7. Interprets and formulates diagnosis from test results, history, and other behavioral observations			
8. Makes appropriate recommendations for intervention			
10. Comprehensively summarizes client's status in a written evaluation report			
TREATMENT SKILLS	Score		
1. Develops appropriate treatment plans with measurable and achievable goals. Collaborates with clients/patients and relevant others in the planning process.			
10. Measures and evaluates patients' performance and progress			
11. Comprehensively summarizes client's status in written progress reports			
PROFESSIONAL PRACTICE, INTERACTION, AND PERSONAL QUALITIES	Score		
1. Possesses foundation for basic human communication and swallowing processes			
2. Possesses the knowledge to integrate research principles into evidence-based clinical practice			
5. Communicates effectively, recognizing the needs, values, preferred mode of communication, and cultural/linguistic background of the patient, family, caregiver, and relevant others			
9. Displays effective written communication for all professional correspondence			

**FEEDBACK RUBRIC:**

5 No changes needed		
4 Wording needs some modification		
3 Most information is complete	3 No changes needed	
2 Many changes needed	2 Most information is complete	
1 Incomplete information (too brief/broad or general)	1 Incomplete information	1 Correct
0 Information missing	0 Information missing	0 Incorrect

**Technical:**

Deadline met						1	0	N/A
Appropriate font, margins, spacing						1	0	N/A
Template format followed			3	2	1	0	0	N/A
Correct writing mechanics (spelling, punctuation, grammar)			3	2	1	0	0	N/A

**Background Information/'S' section of SOAP:**

Necessary/relevant information included	5	4	3	2	1	0	N/A
Summary of information in a reader friendly format	5	4	3	2	1	0	N/A

**Assessment Procedures/Present Level of Performance/Progress Towards**

**Semester Goals/'O' and 'A' sections of SOAP:**

Necessary/relevant information included	5	4	3	2	1	0	N/A
Description of assessments or data gathering procedures	5	4	3	2	1	0	N/A
Protocols scored correctly			3	2	1	0	N/A
Data presented in a reader-friendly format			3	2	1	0	N/A
Interpretation and integration of assessment information or baseline/goal data	5	4	3	2	1	0	N/A
Effective (i.e., clear and concise) communication to reader	5	4	3	2	1	0	N/A

**Area of Need/Goals:**

Area of need stated thoroughly but concisely	5	4	3	2	1	0	N/A
Appropriate goal and objective targets chosen	5	4	3	2	1	0	N/A



## 2. GENERAL PROCEDURES

### 2a. Scheduling

- 1) Meet with your supervisor *before* scheduling so that your session time does not conflict with supervisor's teaching, diagnostic, supervisory, office hours, etc.
- 2) Clients should **not** be scheduled when the clinic is not open.
- 3) Clinicians are responsible for keeping the master magnetic board treatment schedule, located in Rm 170, readable and current. Please Notify supervisors **and** observers immediately of any schedule or room changes.
- 4) After obtaining your supervisors' available times, review your schedule and find the times that work for both of you. Then contact the client or client's parent/guardian.

### 2b. Clinic attire

Clinicians must wear their UW name badge when working in the Clinic and with clients at other facilities. It is appropriate to remove your badge when working with a client in a public area to protect the client's association with the Clinic. Clinicians should wear appropriate attire as described in the Graduate Handbook for all sessions, including diagnostics and treatment observations. Professional dress is required. No jeans.

### 2c. Clinic attendance

Attendance in clinic is expected. If **the clinician** cancels a session you need to complete the following steps:

1. Call and discuss the matter with your supervisor. Do not notify the client or cancel the session until you have done this.
2. You and your supervisor will decide if it is appropriate and feasible to have a substitute clinician see your client or the session should be canceled. If a substitute is approved, you are responsible for making sure the substitute is prepared AND that the client has been notified of the change in advance.
3. If unable to reach a supervisor, contact the site and inform the office associate about your absence. Ensure that the client will be notified (by you or in an emergency situation by the office associate or clinic personnel).
4. The substitute clinician is responsible for a SOAP note, attendance log, and their own clock hour documentation in CALIPSO (this should be sent to the supervisor assigned for the client).
5. If a substitute is not feasible, attempt to re-schedule the client with supervisor consent.
6. Document cancellation or re-scheduling in the SOAP note and the service logbook.

If a **client** cancels:

- Inform your supervisor **and** any scheduled observers immediately.
- Document cancellation in the SOAP note and the service logbook.
- Talk to your supervisor about whether you can re-schedule the client.

### 2d. Client Homework/Behavior

To facilitate carry-over and promote a sense of pride and ownership regarding speech/language activities, it is expected that clients will be provided with outside practice opportunities (i.e., homework/ home practice). In many cases, this may require a letter to the parents/guardians and/or a *written* explicit description and demonstration of the assignments you want the client to complete, how to complete it, and when it is due. Encouraging the client to be involved in deciding what to complete for homework provides a good review of what occurred in a particular session and gives you information on how well the client can replicate the assignment on his/her own. If you are unsure what is needed for your client in this area, visit with your supervisor.

If you have problems with behavior, or need guidance on how to help your sessions run more efficiently. Please see **Appendices 2d-1 and 2d-2.**

## 2e. Observers

Undergraduates will be observing treatment and diagnostic sessions *pending approval from clients/family*. These students may ask you for client information to complete assignments. Please provide it to them in a timely manner remembering the minimum necessary rule. Students will also require you to sign their observation log. All observers must wear their observer badges during the session to obtain credit for the observation. IF an observer does not have a badge, you should dismiss the observer from watching your session. Other outside observers (e.g., visiting SLP, grandparents) are allowed *pending approval from clients/family*.

## 2f. Audiological Screenings

At UWSHC we screen client's hearing each semester, before midterms, unless there is an exceptional reason not to (if this is the case, your supervisor will let you know). Notify your supervisor *in advance* of when this is scheduled so that proper supervision is maintained. Supervisors will use a hearing screening observation checklist to document and evaluate your performance. This checklist is available to you, and when practicing this procedure should be used to ensure that you are including all the necessary steps. These screenings are conducted in the audiology suite, using the stationary equipment or a portable audiometer. You will need to schedule this screening, as the other members of your cohort will be screening in the same time frame as you. You and your supervisor can determine together whether you need assistance from an audiologist, in exceptional situations (i.e., your client is deaf, hard of hearing, wears hearing aids, etc.) Contact the audiologist *in advance* for scheduling the screening.

### Procedures:

1. Practice on several members of your cohort, several times prior to conducting client screenings.
2. Read Appendices 2f-1. through 2f-3. *Audiometric Screening Procedures and Guidelines for Referral, Procedures for Portable Audiometer Use, and the Biological Calibration of Audiometers* sheet.
3. **Be prepared.** If you have questions about procedures or equipment have them answered by a supervisor before you are scheduled to begin the screening. If a client has had a screening before, know the results of this prior screening and share with supervisor.
4. Make sure equipment is turned on, warmed-up for at least 10 minutes and functioning properly; then perform a biological calibration.
5. Make sure the otoscope is adequately charged or batteries are fresh. If they are not adequately charged, then plug them in the day before the screening and/or replace the batteries.
6. Conduct the hearing screening and fill out the hearing screening protocol completely (Appendix 2f-5) including the audiometer used (i.e., GSI-38, GSI-39).
7. Always consult supervisor concerning results before counseling clients or parents.
8. Clean and turn off equipment and otoscopes after the screening; return to test room.
9. Follow the procedures for cleaning tympanometry tips. **(See appendix 2f-4.)**
10. The screening protocol is due to the supervisor within 24 hours.
11. Supervisors will return a Hearing Screening Observation Checklist to you after they have reviewed the screening protocol for accuracy and signed it. Please double check for a signature.
12. Place the signed screening protocol (**Appendix 2f-5**) in the client's permanent file.
13. Hearing screenings are coded under **hearing** under the **evaluation** category on the CALIPSO clock hour form.
14. You will be evaluated on your screening procedures and given feedback from your supervisor using the **Screenings Feedback form (Appendix 2f-6).**

## 2g. Oral Mechanism Screenings

Perform an oral mechanism screening on your client each semester before midterms, unless there is an exceptional reason not to (if this is the case, your supervisor will let you know). Notify your supervisor *in advance* of when this is scheduled so that proper supervision is maintained. Supervisors will use an oral mechanism exam observation checklist to document and evaluate your performance. This checklist is available to you, and when practicing this procedure should be used to ensure that you are including all the necessary steps.

### **General procedures:**

1. Practice on several members of your cohort several times prior to conducting client screenings.
2. State the purpose of the oral mech screening; give a rationale for why you are conducting this routine procedure on your client.
3. Have all of the equipment ready prior to starting. This includes: gloves, flashlight, tongue depressor, nasal mirror and Q-tip swabs (IF needed).
4. Arrange your seating accordingly to get the best visual field of the client's oral structures and functions. Think about your symmetry in viewing the client.
5. When completing the form, as needed, provide a description of what was observed also.

### **Acceptable** description terminology:

- *Rhythm, speed and accuracy are judged to be inadequate as indicated by \_\_\_\_\_.*
- *Results are consistent with a diagnosis of Parkinson's disease with reduced strength and coordination noted in \_\_\_\_\_.*
- *Structures are adequate but deviation noted in function of tongue on elevation which may impact speech production for sounds such as \_\_\_\_\_.*
- *Additional key markings that are acceptable:*
  - *NR = no response from client*
  - *WNA = client would not attempt*

6. Complete the **Summary/Recommendation** at the bottom of the protocol.

### **Acceptable** terminology:

- *Structures and functions are adequate for speech production.*
- *Functions consistent with last screening on xx/xx/xxxx indicating no further regression or loss of skills.*

If needed, write a recommendation such as:

- *Follow-up screening after palate expander has been removed to assess articulation.*
- *Re-screen next semester due to lack of compliance.*

7. The screening protocol is due to your supervisor's mailbox within 24 hours.
8. Oral mech screenings are coded under **Artic** and under **evaluation** on the CALIPSO clock hour form.
9. You will be evaluated on your screening procedures and given feedback from your supervisor using the **Screenings Feedback form (Appendix 2f-6)**.

## 2h. Diagnostic Procedures

The Clinic Coordinator will assign all diagnostic evaluations. They will be distributed (in most cases, emailed) to the lead clinician. Each supervisor and diagnostic team will determine a convenient time for the diagnostic to occur, during regular Clinic hours, before calling the client or client caregiver. A team of two clinicians typically conducts diagnostic evaluations. One clinician is designated as the "lead clinician" however; both clinicians are *equally* responsible for the evaluation. Observers are assigned once the evaluation date/time has been confirmed.

It is the goal of the Clinic Coordinator to assign every clinician as a lead and as a partner in at least one diagnostic each semester, however, there is no way to predict how many diagnostic evaluations we will have in a semester, or how many will cancel.

A diagnostic plan is filled out by both clinicians, prior to meeting with the supervisor. See **Appendix 2h-1**. This form is completed by the diagnostic team and reviewed with the supervisor at least ONE WEEK prior to the date of the evaluation. It is retained in the client's permanent file with the evaluation report.

The "lead" clinician has the primary responsibility of coordinating the rest of the diagnostic team. This clinician is the primary person who will retrieve the Diagnostic Intake Sheet and is the main contact for the client and is the person to whom all of the diagnostic reports from the supervisor will be sent. It is the lead clinician's job to make sure her/his diagnostic partner is informed of all communications from the Clinic Coordinator and/or supervisor.

### **Diagnostic Grading**

Although it is the lead clinician's responsibility for making sure the evaluation runs smoothly, it is up to all team members to work together for a successful outcome. Typically, the same evaluation score (refer to Evaluation Checklist and/or CALIPSO form) is assigned for the entire team's performance and for the diagnostic report. *It is the supervisor's discretion to adjust this policy.*

### **The Steps for Conducting a Diagnostic:**

- The Clinic Coordinator will assign all diagnostic evaluations.
- An informational sheet will be distributed to the lead clinician from the supervisor.
- Each supervisor and diagnostic team will determine a convenient time for the diagnostic during regular Clinic hours. Evaluations are scheduled for 2 hour blocks.
- Contact the client/parent and introduce yourself. State the reason for the call and inform them about *possible* appointment times. Ask them what day and time is most convenient for them to come in for the evaluation. This is also a good time to ask follow-up questions, confirm address, telephone, discuss having observers and Clinic fees, etc.
- Initiate a record of all contact with prospective client on a **Contact Log (2h-2.)** form and complete a **Face Sheet (2h-3.)** and place both in a (red) permanent file folder. (If the client will return to the UW Clinic for treatment, a permanent (**grey**) folder will be made and the red diagnostic folder recycled.)
  - **The Contact Log** is used with ALL clinic clients. This form is used to document all correspondence with clients/parents or others directly involved with client management, including evaluations. This includes documenting when information is received and sent by fax or by other means (e.g., e-mail, phone calls made, copies of information delivered by client/parent). It also includes the dates of when STP/IEP conferences are held, etc.
    - Printed e-mail correspondence can be referenced in the contact log and placed underneath the contact log sheets, with the most recent on top.
    - This form is not used to document weekly meetings between supervisors and graduate students nor is it to record the events of an evaluation or treatment session.
  - The **Face Sheet** documents the client's biographical data and treatment/assessment history, including the graduate clinician's name, and any meetings with client/parents (e.g., IEP, staffing, conferences, etc.) This information should be updated each semester.
    - Additional pages may be added, with the most current Face Sheet on top.
    - Never discard older Face Sheet documents.

- Complete the phone contact by stating that you will call them back with a **confirmation** of day and time. Confirm a current address and contact person's name. Tell them that you will send them a form (e.g., case history) to complete before the evaluation. They should bring the completed form with them on the day of the evaluation OR mail them back in the self-addressed stamped envelope **OR** send by e-mail, **if** there is sufficient time before the evaluation. Discuss the fee for the evaluation and complete the **Diagnostic Agreement form (Appendix 2h-6)** at the time of the evaluation. Refer to the Clinic fee schedule for sliding fee scale information. Discuss any special payment arrangements with the Clinic Coordinator.
  - **The Diagnostic Agreement form** is completed for every diagnostic evaluation. The form is signed by the client/parent, lead clinician, and supervisor. It is the financial agreement between the UW Clinic and the client/parent to pay for the services provided. Use the current SLP fee schedule to complete the 'charge' and fee schedule level on the form. Discuss any questions you have about billing with your supervisor before you present the form to clients. Once signed by the supervisor and a copy is made for the client, return this completed form to the Clinic office manager so she is informed of the evaluation charge. The original is placed in the client's permanent folder. If the client is on Medicaid, indicate on the line where 'charge' is, "bill Medicaid".
- Once the appointment has been **confirmed**, send a diagnostic packet (e.g., case history form, fee schedule, campus map, etc.) to the client at least **one week** in advance. Include a return self-addressed stamped envelope with your last name in the upper left corner so that the information will be returned directly to you.
- Document the date this was completed on the **Diagnostic Plan Sheet (Appendix 2h-1.)**
- Secure a room for the diagnostic. Most evaluations are video-taped so use a room with cameras ready. Place a temporary post-it note on the master schedule board to indicate the day and time of the diagnostic.
- The lead clinician informs the supervisor AND Clinic Coordinator of the day, time, and location of the diagnostic once it is finalized.
- **Observers** are assigned once the evaluation date/time has been confirmed. Observers are expected to be actively taking data on assessments and noting observations. Observers will turn in their protocols to the supervisors first and then they will be returned to the diagnostic team for their review.
- Contact the audiology supervisors **if** you plan to do an audiological screening using the equipment/booth OR need their assistance. The audiology screening is a routine part of any SLP diagnostic evaluation and there is no need to involve the audiology supervisors. There are portable audiometers for conducting hearing screenings. However, if the screening requires an audiometric booth, visual reinforcement audiometry, etc. then contact an audiology supervisor to schedule a convenient time.
- The supervisors require a planning meeting at least **ONE WEEK** before the diagnostic to review the Diagnostic Plan form and discuss any concerns or questions you might have about the evaluation. *Consider* choosing assessments which you have not previously administered as a way to broaden your diagnostic skills.
- Submit the completed Diagnostic Plan, and if the client/parent has completed/returned, the **Case History form** (there are 2 sample case history forms in **Appendices 2h-4 and 2h-5**, and several more on WYOCOURSES that are disorder/impairment specific) to the supervisor at the planning session inside a **red** diagnostic file folder. This red diagnostic folder is NOT to be removed from the Clinic.
- You must review and practice all assessment materials and procedures **thoroughly** before administration!
- Assigned **observers** should be informed of what their role will be during the evaluation after the planning meeting.
- The client/parent should be contacted the day before the diagnostic to confirm the appointment. Remind the client/parent to bring the case history or other pertinent forms with them and remind them where to

park. This is the time to remind them about student observers and videotaping. Obtain written permission to have observers and to videotape the session before the evaluation begins.

- Prepare the room for the diagnostic **at least 30** minutes ahead of time. Remain with your diagnostic team until the diagnostic is completed and all materials and equipment have been returned.
- On the day of the diagnostic, go to the Clinic waiting room at the scheduled time to meet the client/parent. Introduce yourself and your team member to the client/parent. **ALWAYS** wear your name badge for a diagnostic. Parents should be encouraged to observe in the observation room and not remain in the diagnostic session unless they are needed due to separation anxiety or for to be interviewed. Show them how to operate the head sets and volume controls in the observation room.
- If the case history form was not been completed beforehand, allow for sufficient time for the client/parent to complete the form during the diagnostic. After reviewing the case history form with the client/parents, place it in the observation room for your supervisor and observers to review.
- Before beginning the diagnostic, leave copies of each assessment protocol and the (red) diagnostic folder containing the signed forms and case history in the observation room for the supervisor and observers.
- **Evaluations should be audio and/or video-recorded for later review and analysis.** When administering any assessment (formal or informal), all clinicians, including observers, should record all responses, phonetically transcribe speech productions and document observations of the client's behavior and demeanor. Clinicians are encouraged to take on-line data during the evaluation for immediate analysis and examples to present during the oral summary at the end.
- When administering a standardized assessment, record the responses immediately and directly on the assessment protocol. Use a **pen** when scoring the protocol as there is little time to re-copy the results if written in pencil. ***Never*** turn in an assessment protocol without all heading information completed. All other forms (including both clinicians' notes) should also have the same identifying information, including which clinician scored a particular protocol, client name, date of evaluation, etc.
- At the end of the diagnostic, the supervisor and diagnostic team will meet away from the client/parent to discuss their findings and complete a Diagnostic Summary Sheet. This is a good time to allow the client/parents to stretch, use the restrooms, or for your team to observe natural interactions between client and parent.
- A **copy** of the **Summary of Diagnostic Evaluation sheet (Appendix 2h-8)** is given to the client/parent and the *original* is retained in the permanent folder.
  - A *copy* of this summary is given to the client/parents after completion of the evaluation. The original is retained in the permanent file with the evaluation report. It serves as the outline for the full diagnostic report.
- When conducting the oral diagnostic/summary with the client and family, each clinician should report on his/her findings. The clinician should lead the discussion and field any questions that arise. Be aware of the time as this is often when clients/family are most fatigued.
- Following the final summary, the clinicians should escort the client/parent back to the Clinic waiting room to complete any payment with the Clinic manager based upon the Diagnostic Agreement form. The Clinic manager will also need the SLP (green) Service Code Sheet to prepare a billing statement.
- **All** diagnostic information including diagnostic intake sheet, diagnostic plan, diagnostic summary, diagnostic report, assessment protocols, language samples, interview questions, case history information, clinician's personal notes, permission slips, etc. must be submitted to the supervisor within **48 (working) hours** of the evaluation. Supervisors may request to see the observer's data collection sheets too. For ease, it is best to submit the entire evaluation contents inside the red folder for review by the supervisor. Supervisors may also request the examiner's manual accompany the diagnostic packet.
- The *original* diagnostic report is retained in the red permanent file folder. A **copy** of the report is given to the client/parent or others who are listed on the signed Release of Information form. Typically,

assessment protocols are not appended to the report unless specifically requested by a facility or as directed by a supervisor.

- Send a **Client Questionnaire (Appendix 1c-10)** with a self-addressed stamped envelope when the report copy is sent. Indicate in the contact log of the permanent folder the date when the copy was mailed or hand-delivered to the recipients.

### **Diagnostic Reports: General Information**

A **diagnostic report** is a systematic, written description of a client's overall communicative performance. In this report, the clinician states the assessment procedures administered and then describes the client's strengths, weaknesses, and present level of functioning. From this information, a diagnosis and recommendations are made. *The report must stand on its own merit as often the clinician is not present to defend it. The written report is viewed in parts but must read as a whole unit. It must also convey enough information for the reader to understand as if they were present during the evaluation.*

- For some clients, you must evaluate all aspects of communication. For other clients, only selected aspects of communication need to be assessed. Make those sections that relate directly to the primary reason for the referral first and the most specific. Other sections can be more general.
- In some instances, you will be asked to determine whether or not a communication disorder exists (e.g., articulation, language, dysphagia, etc.). In such cases, your information will: a) explain the nature, cause, and extent of the disorder, and b) serve as a foundation or support for your recommendations.
- In other cases (e.g., stuttering, and aphasia) you and the client **know** that a disorder exists. Thus, your job is to *describe* the parameters of the disorder and target goals for treating the disorder.
- In virtually all cases, your diagnostic information will be used as a **baseline** measurement of performance against which progress in treatment will be measured.
- Clients, parents, educators, physicians, and other professionals read diagnostic reports. Thus, the report is a reflection of you, your supervisor, and the University's credibility. Therefore, accuracy of content is important!
- When writing the report, refer to the client by name. **Always** use a title (Mr., Mrs., and Miss) when referring to an adult client unless otherwise indicated by your supervisor. Use the same format when referring to the parents of a child (e.g., Mrs. Smith, John's mother, etc.)
- **VERIFY** all assessment scores and be certain that all information on the assessment protocols (including name, birthdate, date of evaluation, scores, etc.) is correct. There are times when copies of the assessment protocols are requested with the report so information must be accurate.
- Reports should be written with the primary audience in mind (i.e., client and parents). Terminology contained within the report should be supported with examples and/or explanations. Reports that are being sent to other professionals (i.e., SLP, teacher, physician) may contain more specific information and may differ slightly in terminology.
- Sometimes a client is referred to our Clinic to seek an "objective second opinion". In these instances, it is wise to make your observations more specific (by providing examples) and concrete since you are typically unable to support your findings in person.

### **Diagnostic Reports: UWSHC Specific**

- The **team** is responsible for the written report. The lead clinician assigned for each evaluation will be responsible for turning the **total report packet** (i.e., the **red** diagnostic folder) in to the supervisor within **48** hours following the diagnostic. A total report includes: the written report, completed assessment protocols, case history form, permission forms for evaluation, interview notes, Diagnostic Plan, Diagnostic Summary, observer's data, and any other information obtained during the diagnostic. See **Appendix 2h-7** for an explanatory report template. The **Written Product Feedback sheet** will be used to evaluate your performance on the report.

- Report writing should be done with both clinicians present. Reports should be password protected, **backed up** to a flash drive and saved following established computer policies. Never leave the information on the computer hard drive as this is a breach of confidentiality.
- When disposing of any client report or drafts, shred the documents. You may request to retain any reports in your personal possession for future reference, **after** confidential information has been blackened out **and** with permission from your supervisor.
- Single-space your drafts, and turn them in, in their final form. When re-submitting any draft, check with your supervisor about turning in the same Written Product Feedback form and **all** previous drafts. Do **not** shred corrected drafts until you have turned in your final version to your supervisor to be signed.
- **All** drafts are due **24** hours after the first draft is returned. (The goal is to write the first draft well so that it does not need to be re-written.) All drafts will be returned to the lead clinician. This person is responsible for routinely checking his/her mailbox and alerting the other team member to whatever corrections must be made. Lateness will be considered when evaluating your performance and midterm and/or final grading periods.
- Ideally, the report should be ready for final printing *within* a week to ten days from the date of the diagnostic session because the client and families are anxious to know the results!
- After obtaining all signatures, mail a copy of the report **and** a Client Questionnaire with a self-addressed stamped envelope to the client/parent and appropriate recipients as listed on the Release of Information form. Place the original report and all assessment information in the client's permanent (green or red) file according to the permanent file set-up guidelines.

## 2i. Clean-Up

The materials room will be unlocked during normal clinic hours so that you can conveniently check things in and out. This policy will change if materials are not put back and checked in correctly. If that occurs, we will need to implement check-in/check-out hours (that are not very convenient, as they are based on a student employee's available hours). As long as we are operating on "open hours", student clinicians will need to sign-up, in pairs, for 1-2 Fridays each semester. On their designated Friday, students will need to ensure that materials have been checked-out properly and returned properly. They will also organize all materials. If check-in/check-out procedures are followed, Friday shifts should be easy!

Each clinician will donate ½ to **one** hour during the last week of each semester to clean-up the Clinic areas, including the Clinic Lab, treatment, observation and graduate rooms. A notice will be posted in the Clinic Lab to describe each job and when the job must be finished. Supervisors will check on the status of this job at the final conference. All jobs must be completed before final grades will be posted.

## APPENIDIX 2d-1. BEHAVIOR MANAGEMENT GUIDELINES

*The suggestions below are designed to be a general guide for how to manage behavior problems that are encountered during sessions. Consult with your supervisor for specific suggestions that may facilitate optimal behavior from your client.*

**Behavior Management Definition:** Shaping appropriate behavior.

This includes creating a desire in the client to be on task and work on the skills that are important for him to achieve his goals/objectives.

Suggestions for successful behavior management:

- Use interesting and age appropriate materials and treatment techniques/methods.
- Keep things simple. Elaborate materials (i.e., games, crafts, etc.) may detract from treatment objectives and be over stimulating to the client.
- Keep the focus therapeutic. Games and activities are just the “means to the end” and not the outcome of your treatment.
- Be well organized. Prepare everything, including the room/environment, *before* the client begins treatment.
- Be prepared for more than you think you will need. Vary materials if necessary but do not feel compelled to use everything that you have prepared.
- Positive reinforcement is more powerful in shaping behavior than negative reinforcement.  
**Example:** “*I like the way you are looking at me Billy. I can tell you are ready to work.*”  
Instead of: “Billy, look at me and stop fooling around so we can get started.”
- Resist showing anger or losing your temper. It may frighten your client and/or make the client misbehave even further.
- Be consistent. The client must know what to expect from each task or session. Do not have one set of “rules” one day and another set the next session. Consistency will also help to decrease power struggles.
- Limit “negotiations” with the client, as this may be an avoidance tactic. Maintaining a matter-of-fact attitude about accomplishing the session’s task may be helpful. **Example:** “I’m sorry that you are feeling tired but this is our scheduled time to work, so let’s get to it!”
- Keep the client’s attention. Some ways to refocus a client are to: whisper, a touch on the shoulder or arm, silence while looking at the client, and a positive comment to the client who is on task.
- Actions often speak louder than words. State the rules and consequences but limit the amount of warnings or directives and then quickly move on to the task planned.
- Follow through with the appropriate action/consequence.  
**Example:** “I would like you to say your practice word correctly 3 times and then you can shoot the basketball into the hoop.” If the client does not meet the expectation, then the reward should not be given. At the same time, keep your end of the deal by following through on what you say (e.g., stickers at the end of a session regardless of performance).
- Keep the client’s welfare paramount. This may mean keeping the client safe from harm by terminating a given task or the session entirely.

**APPENIDIX 2d-2.**  
**BEHAVIORAL GUIDANCE**  
**Strategies to use with individual young children and in groups**

- 1. In giving directions:** Be sure the child understands. Get to the child's level when you give a directive; both in your choice of words and physically (stoop down).
- 2. Be matter-of-fact:** Take compliance for granted, -- "We all do this."
- 3. Suggest what to do:** Give a few choices when asked, "What can I do now?"
- 4. Be quiet in manner and tone:** Move slowly, talk softly, be in the background as much as possible.
- 5. Let the child learn by experience:** Help him/her only when it is necessary to avoid a feeling of failure or discouragement. Help him find out by him/herself. With older children, structure the learning process for inductive learning as much as possible.
- 6. Praise the type of behavior you wish continued:** It is better to emphasize the good things and let the bad drop out of sight. If you must attend to the bad behavior, attend to the behavior not the person.
- 7. Be consistent:** Praise or disapproval should be given consistently for a definite behavior.
- 8. Suggest the next specific act when a child dawdles:** When a child continues with one activity for too long, say for instance, "Where is the lid to the box?" to terminate the activity.
- 9. Give the child a choice of action when feasible:** Asking, "Where would you like to put your train, here or there?" gives the child a personal interest in the situation and develops his initiative and independence.
- 10. Give the child a choice only when you can accept his negative reply:** Do not say, "Do you want to do X?" or "Can you do X?" State the expectation without asking.
- 11. When children are in social conflict situation, let them work it through if they can.** Step in when it is necessary to avoid injury or to suggest a socially approved solution of a difficulty.
- 12. Discourage the child from coming to you too often in a social conflict:** Tell the child, "Tell John we don't hit our friends," or whatever the case may be. Do not let children get into the habit of letting you solve their problems for them.
- 13. Don't interrupt anything the child is doing without giving him a fair warning:** Prepare him/her in advance that, "Soon it will be time to pick up."
- 14. If necessary, remove the child who interferes with a routine activity:** In certain activities, such as story or music time, more control of the children is necessary. If one or two are not conforming, it is best to take them to another activity for the benefit of the group. Once control is lost, it is hard to regain.
- 15. Use the affirmative:** Say, "Sit at the table with your juice, Mary." Not, "Don't carry your juice and don't spill."
- 16. Have confidence in yourself:** Children feel your uncertainty and act on it. A hurried decision is better than losing a child's attention with uncertainty.

*Modified from information received from Christiane Dechert, M.A., CCC-SLP and the Moscow Day School in Idaho.*

## APPENDIX 2f-1.

### Audiometric Screening Procedures and Guidelines for Referral

#### Otoscopy

Visualize the external ear (skin tags/pits, malformed pinna, absence of a pinna, absence of an ear canal), ear canal (foreign body, blood, drainage, excessive wax, tube) and TM (perforation, tube placement, redness) and note any abnormalities. If things do not look normal, or you have questions about what you are observing, have your supervisor look.

#### **Acceptable terminology:**

- *Otoscopy results are unremarkable.*
- *Otoscopy results show the ear canals to be clear.*
- *Otoscopy results show excessive cerumen (i.e., ear wax) that did not allow for a clear view of the tympanic membrane (i.e., ear drum).*

**Unacceptable terminology:** Otoscopy is WNL.

#### Tympanometry

Complete a screening tympanogram on each ear. Tympanometric width (TW) should be equal or less than 200 daPa to pass the screening (ASHA, 1997, p. 17). TW is sometimes referred to as a gradient (GR). Normal range for peak pressure (daPa) is +100 to -200, for admittance (cm<sup>3</sup>) it is 0.2 to 1.8. Ear canal volume (ECV) will vary greatly, but average ECV are .42 to .97 for children and .63 to 1.46 for adults. If you get a flat tympanogram, reposition the probe and repeat the screening or have your supervisor do it. Flat tympanograms must be interpreted in conjunction with ECV readings.

#### **Interpretation samples:**

- Flat tymp (NP, NP) with normal average ECV may suggest middle ear pathology (e.g., otitis media).
- Flat tymp with a small ECV may suggest that the ear canal is occluded with wax/debris (which would have been visualized in otoscopy) or that the immittance probe is pushed against the side of the ear canal.
- Flat tymp with large ECV suggests a patent pressure equalization tube (pe tube) or perforation of the tympanic membrane.

#### **Acceptable terminology:**

- *Tympanometry results are within normal limits.*
- *Tympanometry results indicate negative middle ear pressure with normal admittance; (or if admittance is low) reduced admittance.*
- *Tympanometry results indicate flat tympanogram with normal ECV.*
- *Tympanometry results indicate flat tympanogram with large ECV, suggesting patent pe tube, perforated tympanic membrane (depending on what otoscopy revealed or patient/parents report). Otoscopy results are unremarkable.*

#### Pure Tone Screening – Children

Pure tones are presented to each ear separately at **20** dB at the frequencies of 1000 Hz, 2000 Hz, and 4000 Hz. If you are screening in a sound booth, you can also screen at 500 Hz. To be considered a pass they must respond to all frequencies in both ears. For small children you may need to perform conditioned play audiometry. It is also important to vary the pure tone presentation rate to avoid the child from guessing.

**Acceptable terminology:** *Passed/failed the hearing screening in the both/X ear at X frequency*

#### Pure Tone Screening – Adults

Pure tones are presented to each ear separately at **25** dB at the frequencies of 1000 Hz, 2000 Hz, and 4000 Hz. If you are screening in a sound booth, you can also screen at 500 Hz.

**Acceptable terminology:** *Passed/failed the hearing screening in the both/X ear at X frequency*

### **Guidelines for Referral**

- Red bulging TM - medical referral after consulting your supervisor
- Wax occluding ear canal, with flat tympanogram, and failing the pure tones at one or more frequency - medical referral after consulting your supervisor
- Foreign body in ear canal - medical referral after consulting your supervisor
- Tympanometric width (TW) or gradient (GR) > 200 daPa – rescreen in 3 to 5 weeks
- Flat tympanogram with normal looking ear canal and TM – rescreen in 3 to 5 weeks
- Negative middle ear pressure (beyond -200 daPa) – rescreen in 3 to 5 weeks
- Failure to respond to the pure tones at any frequency - rescreen in 3 to 5 weeks or at the discretion of your supervisor
- PE tubes: if the ECV is outside the normal range but with a flat peak (i.e., NP) and the tube is visible, the tube is likely working; if the ECV is within normal range with a normal peak and/or flat and tube is visible, the tube is likely not working.
- **If you are unsure about the recommendation, consult your supervisor!**

## **APPENDIX 2f-2.**

### **Procedures for Portable Audiometer Use**

All of the portable audiometers (two **GSI-38s** and one **GSI-39**) are kept in the test room (HS182). These audiometers are used when conducting individual and/or group hearing screenings. The Audiology Clinic Coordinator will arrange the annual calibration of these audiometers.

- The power switch is located on the back of the audiometer.
- Before beginning a hearing screening, **always** perform a biological calibration. This means that the Clinician should check the operation of the immittance probe and both earphones at the frequencies to be assessed. Refer to *Biological Calibration of Audiometers* sheet. A copy of this sheet should be in each portable audiometer case. Notify the materials room manager if the biological calibration sheet is missing.
- The audiometer default is always set to begin with immittance testing. The probe lights indicate the following operation mode: flashing green = ready for testing; solid green = adequate seal obtained; yellow = occlusion; red = no seal obtained. Only use the button marked “t ymp” for the immittance test **not** the button marked “t ymp reflex”.
- Carefully return tympanometry probe to its protected sleeve during and after the t ymp screening. It is a sensitive piece of equipment that should be handled with care.
- The Clinician should plot on the audiogram screening form (see form this section) the results of the immittance test. The following indicates the results of the immittance test and should be plotted on the audiogram:
  - ECV (physical volume) = ear canal volume; cm<sup>3</sup> (admittance) = height of the peak; daPa = air pressure.
- Clean the probe tips according to designated procedures.
- For audiometric screenings, the audiometer default is set to begin in the right ear at 1000 Hertz, 0 dBHL and with a steady tone.
- Use the dial knobs to make changes with the intensity and right/left ears. It is recommended to use a steady tone for all screenings.
- Perform the audiometric screening at 1000, 2000, and 4000 Hz at 20 dB (children) or 25dB (adults).
- Indicate the results on the audiogram form with a P = pass or F = fail and the hearing level tested.
- The GSI 38 Audiometer is capable of printing out results and has a memory to store up to eight screenings. Use the printing option only when the results are questionable and need to be evaluated by an audiology supervisor. Otherwise, record all data from the screening directly onto the audiogram form. A blinking M8 light will appear in the LCD display indicating that the memory is full and previous tests must be deleted/cleared to continue.
- Refer to the GSI-38 Quick Reference Guide (see form) for other operating instructions or consult an audiology supervisor.
- Notify either the AUD or SLP Clinic Coordinators **in writing** if supplies for the audiometer are low or the machine needs attention.

**APPENDIX 2f-3.**  
**Biological Calibration of Audiometers**

1. Check power.
2. Check cords for signs of wearing and cracking, and listen to earphones while moving and twisting cords; check for signal intermittency when wires are twisted gently.
3. Check dials and switches for looseness or misalignment.
4. Check operation of interrupter switch/bar.
5. When tones are presented, listen for audible clicks or other sounds that might cue listener, both with and without earphones.
6. With attenuator set to audible level, change frequency on frequency selector. Listen to determine the presence of different and appropriate pitches; do this for both earphones. Listen for any hum, static, distortion (sound quality).
7. Do a rough check of linearity of attenuator by making sure that intensity/loudness is consistent with attenuator settings.
8. Listen for crosstalk between earphones; can disconnect earphone that is being fed a signal; listen to opposite earphone.
9. Check own thresholds or those of another person with known HLs, using both earphones. Levels should be within  $\pm 10$  dB of known thresholds.

**Added 2014 by MJCH**

**APPENDIX 2f-4.**  
**Procedures for Audiometer Ear Tip Cleaning**

Reusable tympanometry ear tips will be available in each portable audiometer. Once the tip is used, put it in the plastic container marked 'Dirty ear tips'.

**When the 'Dirty Ear Tip' container is full:**

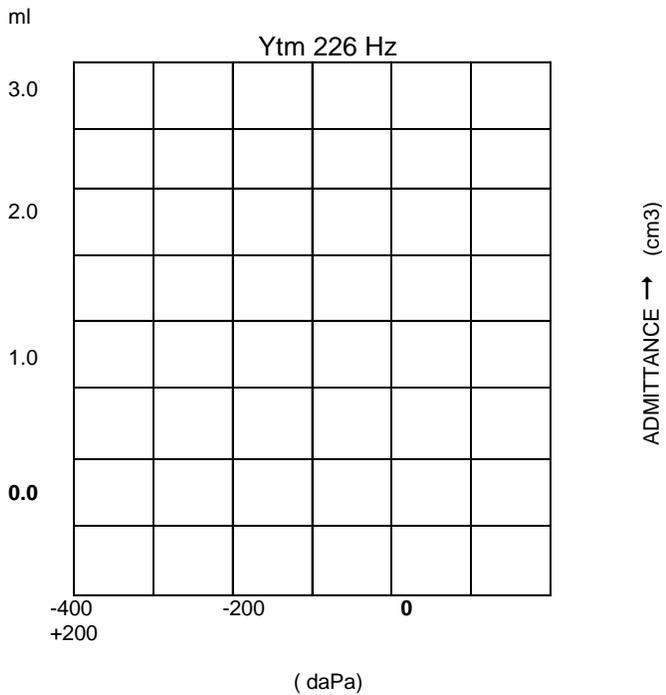
1. Notify the materials room attendant that the 'dirty ear tip' container is full.
2. Place the 'dirty ear tip' container in HS 185.
3. Complete the CLINICIAN'S portion of the '**Dirty Ear Tip Drop-off Log**', located in cleaning room HS 185.
4. Replace a new container labeled 'dirty ear tips' into the portable audiometer bag for others to use.

<b>Clinician</b>			<b>Materials Room Worker</b>		
<b>Date &amp; Time</b> ear tips dropped off	Clinician's initials		Time tips <b>put in</b> solution	Time tips <b>taken out</b> of solution	Material room attendant's initials

## APPENDIX 2f-5

Last Name	First Name	Sex	Date of Birth	Age	Date of Exam:	Tested by:	Audiometer <b>GSI</b> - _____
Address				Phone:		Referred by: <span style="color: magenta;">Routine semester screening</span>	

### Tympanogram



( daPa)  
← AIR PRESSURE →

ECV (ear canal volume)  
Right \_\_\_\_\_ Left \_\_\_\_\_

Admittance (cm3)  
Right \_\_\_\_\_ Left \_\_\_\_\_

Air Pressure (daPa)  
Right \_\_\_\_\_ Left \_\_\_\_\_

Tympanic Width (TW) or Gradient (GR)  
Right \_\_\_\_\_ Left \_\_\_\_\_

\*Normal range cm3= 0.2 to 1.8; daPa= +100 to -200

### Pure Tone Screening

Mark **(P)** for frequencies passed  
and **(F)** for frequencies failed

	1000Hz	2000Hz	4000 Hz
Right	_____	_____	_____
Left	_____	_____	_____

Screened at \_\_\_\_\_ dB

\*If patient fails at any frequency, recommend re-screen or complete evaluation.

\*DNT= did not test  
\*CNT= could not test

### Recommendations:

Medical Referral \_\_\_\_\_ for \_\_\_\_\_

Re-Screen \_\_\_\_\_ in \_\_\_\_\_

Complete Audiological Evaluation \_\_\_\_\_

Screening within normal limits \_\_\_\_\_

**Remarks:**

## APPENDIX 2f-6

University of Wyoming  
Division of Communication Disorders  
Screenings Feedback

**Date:** Click or tap here to enter text. **Clinician:** Click or tap here to enter text. **Client Initials:** Click or tap here to enter text.  
**Supervisor:** Click or tap here to enter text. **Total time observed:** Click or tap here to enter text.

**CALIPSO SCORING:** 1=not evident 2=emerging 3=present 4=consistent 5=automatic

EVALUATION SKILLS	Score	
	Artic (O-M)	Hearing
1. Conducts screening and prevention procedures		
2. Performs chart review and collects case history from interviewing patient and/or relevant others		
5. Adapts evaluation procedures to meet patient needs		
6. Possesses knowledge of etiologies and characteristics for each communication and swallowing disorder		
9. Completes administrative functions and documentation necessary to support evaluation		
11. Makes appropriate recommendations for patient referrals		

**Oral Mechanism Screening checklist:**

- Information from previous screenings considered in planning
- Environment arranged to meet observer needs (speakers on, in view of window, checklist available)
- Materials ready (tongue depressors, light, mirror)
- Rationale for screening given to client
- Hands washed before and after procedure
- Gloves worn for all invasive procedures
- Brief and meaningful instructions given to client
- Lips (protrusion, retraction, alternation, bite lower lip, lip seal) assessed
- DDK tasks (repetitions of /pʌ/, /tʌ/, /kʌ/, and /pʌtʌkʌ/ assessed)
- Velopharyngeal function (sustained /u/ with occlusion of nares) assessed
- Tongue (protrusion, lateralization, elevation, ant-post sweep) assessed
- Teeth/occlusion assessed
- Soft palate (sustained /a/ and repeated /ha/) assessed
- Used tongue depressor returned to cover or wrapped in paper towel
- Hard palate palpated
- Procedures modified when indicated
- Appropriate responses made to client's comments/behaviors
- Screening tasks conducted efficiently
- Brief summary of findings given to client/parent
- Questions from client/parent encouraged
- Protocol completed accurately

**Hearing Screening checklist:**

- Information from previous screenings considered in planning
- Materials ready (otoscope, audiometer, ear tips, headphones)
- Rationale for screening given
- Hands washed before and after procedure
- Client asked about hearing status
- Prevention measures (e.g., ear protection, noise exposure) offered
- Instructions and client expectations clearly stated
- Otoscopy performed
- Bridging/bracing techniques used
- Tympanometry performed
- Clean/dirty ear tips kept separate
- Pure-tone screening performed (20dB for children, 25 dB for adults)
- Play audiometry or conditioning used as needed
- Procedures modified when indicated
- Appropriate responses made to client's comments/behaviors
- General feedback given after each task
- Brief summary of findings provided
- Appropriate referrals made
- Questions from client/parent encouraged
- Protocol completed accurately

**Comments:**

# APPENDIX 2h-1

## UNIVERSITY OF WYOMING DIVISION OF COMMUNICATION DISORDERS DIAGNOSTIC PLAN

Client's Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Referral Source: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Appointment: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Clinicians: \_\_\_\_\_

Brief history and reason for referral:

Interview conducted by:

Formal and informal assessments and who will perform them:

Audiological screening given by:

Oral mechanism exam given by:

**Report due by:**

Approved: YES or NO \_\_\_\_\_ Date: \_\_\_\_\_

Clinical Supervisor

Comments:

Date Clinic office manager notified about diagnostic and paperwork sent: \_\_\_\_\_



# Appendix 2h-3

## FACE SHEET FOR PERMANENT FOLDER

CLIENT NAME: \_\_\_\_\_

DISORDER: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ FACILITY NAME: \_\_\_\_\_

PARENTS: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
(Home) E-MAIL: \_\_\_\_\_  
(Work) CELL: \_\_\_\_\_

### TREATMENT HISTORY

SEMESTER/YEAR	CLINICIAN	START	END
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

### ASSESSMENT HISTORY

ASSESSMENT NAME	DATE GIVEN	RESULTS
_____	_____	_____
_____	_____	_____
_____	_____	_____

### CONFERENCES HELD (IEP, STP, FINAL, ETC.)

DATE	COMMENTS	RECOMMENDATIONS	CLINICIAN INITIALS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

## Appendix 2h-4

University of Wyoming  
Speech and Hearing Clinic  
Division of Communication Disorders  
Department 3311  
1000 E. University Avenue  
Laramie, WY 82071  
307/766-6426

### CASE HISTORY FORM CHILD

#### I. IDENTIFICATION

Client's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Parent's Names: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ E-mail address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_ Grade/School Name: \_\_\_\_\_

Other children in family: (List name, age and grade) \_\_\_\_\_  
\_\_\_\_\_

Others living in the same house: (List name, age, and relationship) \_\_\_\_\_

Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Referral Source: \_\_\_\_\_ Person completing form: \_\_\_\_\_

Insurance Information: \_\_\_\_\_

Describe any concerns about your child's communication skills (i.e., speech, language, hearing, social interactions, etc.)

#### II. CASE HISTORY

*Answers to the following questions can help with your child's diagnosis and in understanding how best to assist him. Please disregard questions that you believe are not applicable.*

## APPENDIX 2h-5

University of Wyoming  
Speech and Hearing Clinic  
Division of Communication Disorders  
Department 3311  
1000 E. University Avenue  
Laramie, WY 82071  
307/766-6426

### CASE HISTORY FORM

#### Adult

#### I. IDENTIFICATION

Client's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ E-mail address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_ Occupation/Education: \_\_\_\_\_

Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Referral Source: \_\_\_\_\_ Person completing form: \_\_\_\_\_

Insurance Information: \_\_\_\_\_

Describe any concerns about your communication skills. Include difficulties encountered socially, academically, vocationally, etc.

#### I. CASE HISTORY

*Provide as much detail as you feel is appropriate for the following areas.*

What do you believe is the cause of the problem?

When did you first become concerned or notice the problem? When and who noticed the problem?

Has the problem become better or worse? Describe or provide an example.

Describe the severity of the problem. Does the severity change? (e.g., time of day, speaking situations, etc.)?

How does the problem affect your daily life (e.g., with your family, at your job, social relationships, etc.)?

Do you avoid speaking situations or social interactions because of this problem?

Do you have difficulties with chewing or swallowing? If yes, please describe difficulty including textures or types of foods that cause the most difficulty.

Have you received previous medical or speech-language treatment or consulted any other professional about these concerns? If yes, please list dates and outcome.

#### Medical History

Describe any medical factors (conditions, diseases, injuries, special evaluations, hospitalizations, counseling, treatment, etc.). Give dates of occurrence and outcomes.

Describe your health as a *child* with regard to diseases, injuries, surgeries, and approximate dates of occurrence.

Are you currently taking any medications? If yes, please list medication, dosage, and reason you are taking it.

When was the last time you had your hearing checked? What were the results?

List any other concerns you may have that you would like addressed today during the evaluation.

**APPENDIX 2h-6**

University of Wyoming  
Speech and Hearing Clinic  
Division of Communication Disorders  
Department 3311  
1000 E. University Avenue  
Laramie, WY 82071  
307/766-6426

**DIAGNOSTIC AGREEMENT**

Client: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ Age Code: \_\_\_\_\_

Phone: \_\_\_\_\_

Type of diagnostic: \_\_\_\_\_

Date of diagnostic: \_\_\_\_\_

Charge for evaluation: \_\_\_\_\_ Sliding fee level \_\_\_\_\_  
(documentation required)

Graduate student clinician: \_\_\_\_\_

Supervisor signature: \_\_\_\_\_

Comments: \_\_\_\_\_

**\*Billing statements are sent at the end of each month so that clients may submit charges to their insurance company. Services for each semester should be paid in full before initiating services for the next semester.**  
Insurance coverage: \_\_\_ Great West Life \_\_\_ Medicare \_\_\_ Medicaid \_\_\_ Other (name: \_\_\_\_\_)

\_\_\_\_\_  
Client/Parent/Guardian Signature Date  
*Give a copy of this form to client*

Age Codes: 1= 0.1 -5.0; 2= 5.1-13.0; 3= 13.1-19.0; 4= 19/1-50.0; 5= 50.1 +

**Initiated 8/2015**

# Appendix 2h-7

## Evaluation Report Explanatory Template

University of Wyoming  
Speech and Hearing Clinic  
Division of Communication Disorders  
Department 3311  
1000 E. University Avenue  
Laramie, WY 82071  
307/766-6426

### SPEECH-LANGUAGE (or other type of evaluation e.g., VOICE) EVALUATION REPORT CONFIDENTIAL

Name:	Date of Report: MM/DD/YYYY (date first submitted to supervisor; stays same regardless of drafts)
Date of Birth:	Classification: (state disorder area)
Age:	Referred By: (include title as needed e.g., Edna Smith, classroom teacher)
Address:	Case History Informant: (include relation e.g., Mrs. Penny Jones, spouse)
Phone:	Examiner (s): (name, degree, GSC)
Date of Evaluation: (date of actual evaluation)	Supervisor: (name, degree, CCC-SLP)

#### BACKGROUND INFORMATION

- Provide a *brief* history including the main reason why the client is seeking assistance
- Identify the referral source and reason
- Identify the primary informant (i.e., who completed the case history form and answered verbal questions about the client during the evaluation). IF there was no personal informant, the report should state where the information was obtained (e.g., permanent file, school records, telephone conversation with physician, etc.)
- Describe relevant medical, vocational, educational, and previous treatment history, if applicable
- Describe results of previous SLP evaluations, if applicable
- You *may* use sub-headings (e.g., birth, medical, family, social and educational history, etc.). IF no sub-headings are included, the history should flow in a chronological and logical manner.

Example: Joe Lewis is an 8 year old male third grade student at Prairie Elementary School, who was referred for a speech/ language evaluation by his School Building Intervention Team (SBIT) [spell out acronyms the first time they are used] because he is reading at a first grade level, despite having had much intervention by his teacher and having participated in the Title 1 reading program for 3 years.

According to his case history, which was provided by his mother, Ms. Joanna Lewis, Joe was born prematurely at 7 months, and was delayed in reaching speech and motor milestones. He began walking at 16 months and spoke his first word (“Dada”) at 17 months. He has a history of ear infections and received pressure equalization (PE) tubes at 3 years of age. The PE tubes fell out as expected and he experienced no subsequent ear infections. Joe has been in generally good health throughout his childhood. Joe repeated Kindergarten because he did not meet end-of year reading and math benchmarks. He passed all subsequent school years, but has needed “a significant amount of help with reading and writing.” Additionally, his mother reports that Joe “does not like school and gets in a lot of fights with his classmates.” Joe has not received speech/language evaluation or treatment in the past.

#### ASSESSMENT PROCEDURES

- Give a general statement about how the client responded to the diagnostic setting, the examiners, separation from parents, etc.
- State your observations about the client's cooperation, level of involvement, attentiveness, and the overall reliability of your diagnostic results (i.e., was this evaluation a valid indicator of the client's true communicative abilities, according to client/parent?) For adults, it may not be necessary to comment on all of the above areas.
- Use sub-headings to reflect exactly what was assessed. Give the name of the assessment (if applicable), a brief explanation of the procedures, and the purpose. If there are areas not specifically assessed but *observed* during the

evaluation, and these areas were found to be within normal limits, then a general statement should be made to reflect such an observation.

**Example:** Jamal reacted pleasantly when introduced to the examiners by smiling and saying, “Hi!” He did not hesitate to begin completing a puzzle with one clinician while the other clinician conducted a parent interview with Mrs. Quatar. He promptly responded to all stimuli and actively participated throughout the evaluation. Mrs. Quatar indicated that Jamal’s performance was typical of what she has observed at home; therefore, it is considered to be a reliable example of his communication abilities.

Jamal’s language, voice, and fluency were judged to be adequate for communication. He demonstrated numerous speech sound errors, so his skills in the areas of articulation and phonology were assessed with a variety of formal, norm-referenced and informal, criterion-referenced assessment instruments and procedures. The evaluation took place over a 2-hour period. Jamal participated in all assessment procedures cooperatively and with good effort; therefore, the results of this evaluation are considered valid. Each assessment procedure and its corresponding results are described below.

Examples of possible sub-headings (lower case, bolded):

- Language Sample Analysis**
- Conversational Speech Sample**
- Classroom Observations**
- Formal Articulation Assessment**
- Formal Language Assessment**
- Voice Assessment**
- Fluency Assessment**
- Clinical Evaluation of Swallowing**
- Oral Mechanism Examination**
- Hearing Screening**

For all assessments, the following information should be included:

- Name of assessment instrument (capitalize, do not underline assessment name) and area(s) the assessment addresses (e.g., language, articulation, etc.). e.g., The Goldman Fristoe Test of Articulation, 3rd Edition (GFTA-3) was administered to assess Suzy’s production of consonant sounds in words and sentences.
- Brief description and/or an example of the task(s) included in the assessment. e.g., Suzy was prompted to name a variety of familiar items when presented with a picture and then to repeat a story read to her by the examiner one sentence at a time.
- Report what kinds of scores are provided and how to interpret these scores. e.g., The GFTA-3 provides a raw score (i.e., total number of errors) which is converted to a standard score and percentile rank. The standard score allows for comparison of the examinee’s performance with the performance of his/her same-aged peers. The standard score average is 100 with a standard deviation of 15 points; therefore, the range of scores that fall within normal limits is 85 to 115. The percentile rank represents the percent of children in the age group who received scores equal to or lower than examinee’s score. In other words, if the examinee scores in the 73<sup>rd</sup> percentile rank, that means that he/she scored as well as or better than 73% of his/her same-aged peers.
- Report results including observations, norm-referenced or criterion-referenced scores, qualitative data, etc. You may present scores in a table, but must include interpretation of the scores in words. e.g., Suzy received the following scores:

<b>GFTA-3</b>	<b>Standard Score</b>	<b>Percentile Rank</b>
Sounds-in-Words	78	7
Sounds-in-Sentences	78	7

On both the Sounds-in-Words and Sounds-in-Sentences subtests, Suzy’s production of /s/ (e.g., as in, “slide”) in all word positions was distorted. Her performance falls below the normal range for her age and is indicative of a mild articulation disorder. These results indicate that she may have some difficulty making herself be understood in the classroom.

- For speech sound assessments, list all errored phonemes. If there were many, present them in a table.
- Provide a few examples of the client’s responses, especially if they demonstrate a noteworthy error that should be addressed in treatment.

**\*\*Note:** Subtests within an assessment may assess different language functions. Be sure to list each subtest in the appropriate section of your report (i.e., receptive vs. expressive language vs. written language).

## **CLINICAL IMPRESSIONS**

This section provides a diagnostic summary which should pull all the information from each section together and should be able to stand alone for quick reference when being read by a family member or healthcare/education professional. This section should include:

- A general diagnostic statement including a qualitative estimate of disability severity (i.e., mild, moderate, severe, profound).

- State the components of the disability (e.g., The areas of function on which the disability has a negative impact such as intelligibility, reading comprehension, narrative discourse, etc.).
- Give potentially related factors *if applicable* (e.g., neuromuscular issues, auditory issues, medical history, etc.).

Example: Katie exhibits a moderate phonological disorder. She uses age-inappropriate phonological processes characterized by substitution of alveolar consonants for velar consonants (e.g., “tup” for *cup*) and substitution of stop consonants for fricative consonants (e.g., as in “dipper” for *zipper*). Katie’s conversational speech is judged to be about 70% intelligible with careful listening. It is likely that due to her phonological disorder and poor intelligibility, she may experience difficulty participating in academic and social speaking situations. It should also be noted that Katie failed the hearing screening and experiences frequent ear infections, which may have a negative impact on her speech development.

**RECOMMENDATIONS**

- State whether or not treatment is warranted.
- List the type, frequency, intensity, and main focus.
- List any referrals and state why ~ all of which should be supported in the body of the document

Example: It is recommended that:

- Katie receives treatment for improving her speech intelligibility twice a week for 30 minutes each.
- Treatment should focus on reducing her use of age-inappropriate phonological processes.
- Parents should consult with Katie’s physician or an ear-nose-throat doctor to diagnose and treat ear infections. They should also consult with an audiologist to further evaluate and monitor her hearing status.
- Parents and teachers should continue to provide an appropriate model of speech.

\_\_\_\_\_  
 Name, Degree  
 Graduate Student Clinician

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Name, Degree, Certification  
 Clinic Supervisor

\_\_\_\_\_  
 Date

cc: State who has written authorization (via Patient Authorization for Use or Disclosure form) to get a copy of this report. List how/when this report was delivered.  
 Name  
 Address  
 City State Zip

Hand-delivered to client/parent/guardian on: MM/DD/YYYY; and/or Mailed to name on: MM/DD/YYYY  
 (Document this information in the contact log of the permanent file.)

## Appendix 2h-8

University of Wyoming  
Speech and Hearing Clinic  
Division of Communication Disorders  
Department 3311  
1000 E. University Avenue  
Laramie, WY 82071  
307/766-6426

### SUMMARY OF DIAGNOSTIC EVALUATION

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE: \_\_\_\_\_

#### GENERAL FINDINGS:

Typically, these are bulleted points covering the main reason the client was evaluated and the general findings. For example:

- Hearing screening passed at 25dB for both ears across 1000, 2000, and 4000 Hz
- Language skills appropriate for age
- Articulation errors consisting of: t/k (tootie for cookie) and d/g (dough for go)

#### RECOMMENDATIONS:

This section should include treatment options if recommended, including frequency and amount of time. For example:

- Speech treatment 2 times 30 minutes per week focusing on supressing process of fronting

#### REFERRALS:

These are general referrals (e.g., audiological evaluation) as opposed to a referral to a specific location or person. If there are no referrals, use 'N/A' here. For example:

- Follow-up with ENT to rule out possible vocal pathology

\_\_\_\_\_  
Graduate Student Clinician

\_\_\_\_\_  
Graduate Student Clinician

\_\_\_\_\_  
Clinical Supervisor

Full diagnostic report to follow.

### 3. CORRESPONDENCE

#### In general:

- Password protect all electronic client sensitive material. All supervisors have their own password for all documents sent to or from them. They will provide you with their password at the start of the semester to ensure protection when e-mailing confidential documents.
- Graduate students should only use the computers in the Clinic Lab (HS 170) or graduate room (429) for all client sensitive work (e.g., reports, SOAPs, or correspondence with identifying or sensitive information regarding your client).
- Computers in 170 and 429 are maintained by the Information Technology (IT) department. Problems with the computers should be reported immediately to the *Division* office associate.
- Use a quality and reliable memory device ('jump' drive) to save documents. Under no circumstances should client information be left on the hard drives of the computers.
- Every time you communicate with your client or with someone regarding your client, outside the clinic, you need to log it in the Contact Log (**APPENDIX 3a-1**).

**3a. Telephone** confidentiality is important. Students may use the telephones in the Clinic, Clinic Lab, treatment rooms, and graduate room to make calls to clients pending room availability. Long distance phone calls cannot be made from these rooms so it is appropriate to use the Clinic phone or a supervisor's phone to make long distance calls (you may *choose* to use your cell phone). Properly identify yourself and your affiliation with the University of Wyoming Speech and Hearing Clinic. Leave only the *minimum necessary* information on voice mail for clients to return your call. Clients should return calls to the Clinic number unless the clinician chooses to give an alternate phone number.

**3b. E-Mail** correspondence between a supervisor and graduate clinician OR client and graduate student should be kept confidential by only using initials when referencing the client and disclosing only the *minimum necessary* information. Again, password protection is **required** when sending private health information (including SOAPs and reports) or any document with the client's full name. Consult the Graduate Handbook regarding violations of confidentiality.

**3c. Mailboxes (HS 268)** are used to exchange documents with client's private health information or the client's full name between clinicians and supervisors. Documents should be placed into a large envelope and put in the supervisors' mailbox.. Return delivery from supervisors to students will be handled in the same manner.

**3d. Mail for clinic purposes** is placed in either the wire mail basket in the clinic office area or on the shelf in the 2<sup>nd</sup> floor copy room. Use the Clinic/Division envelopes for outgoing mail that is for clients. When using a return *self-addressed stamped envelope*, place your **last** name in the return address label so that the document can be returned directly to you.

Please refer to **Appendices 3d-1** for a Sample Letter of Discontinuation. This is a sample letter for dismissing a client due to lack of or poor attendance. Use the UW Clinic letterhead for the letter and it must be signed by immediate supervisor and Clinic Coordinator. A copy is retained in the client's permanent file. **Appendix 3d-2** is a Sample Correspondence Letter if necessary.

*For both, note in contact log when letter was mailed.*

**APPENIDIX 3d-1**  
Sample Letter- Discontinuation

# UNIVERSITY OF WYOMING

July 8, 2011

Dear Ms. XX,

In reviewing XX's attendance record for the past year, she attended 50% of treatment sessions for this summer 2011, 92% attendance for spring 2011, 70% for fall 2010, and 71% for spring 2010. As per the Client Attendance Policy form which you signed, the UW Speech and Hearing Clinic requires clients to maintain a 90% attendance rate. For the past year, XX has met this requirement one out of 4 semesters. The 90% attendance requirement permits our students to provide the best treatment plus meet our clinic needs and responsibilities. Since this is a training facility, this attendance is important to allow our graduate clinicians the experiences and clinical hours in addition to providing consistent services to our clients.

Based on this lack of attendance and compliance with our policy, we will not continue to provide services to XX for the remainder of the summer semester and we are not recommending XX be placed on the fall clinic roster. We do recommend that you continue speech-language services at her elementary school.

Thank you for the opportunity to work with XX.

Sincerely,

Catherine L. Ross, M.S., CCC-SLP  
Supervisor of Clinical Services in Speech-Language Pathology

Lynda D. Coyle, M.S., CCC-SLP  
Director of Clinical Services

Appendix 3d-2  
**SAMPLE CORRESPONDENCE LETTER**  
(Use UW Letterhead)

DATE

NAME OF CLIENT  
ADDRESS  
CITY, STATE, ZIP

DEAR MR./MRS./MS. \_\_\_\_\_

We have made several attempts to contact you by telephone to arrange a treatment schedule for the \_\_\_\_\_ semester at the University of Wyoming's Speech-Language-Hearing Clinic. Last semester you indicated your intention to attend treatment for the \_\_\_\_\_ semester. If you are still interested in treatment, it is important that you contact us immediately so that a schedule can be arranged. If you are not planning to attend treatment for the \_\_\_\_\_ semester, but are still interested in receiving services in the future, please let us know that as well.

Please call the UW Clinic at 766-6426 between the hours of 8:00 and 5:00 to inform us of your decision.

Sincerely,

\_\_\_\_\_  
YOUR NAME, DEGREE, TITLE

\_\_\_\_\_  
SUPERVISOR'S NAME, DEGREE, TITLE

Revised 8/2003

## 4. FACILITIES/MATERIALS

### 4a. Lock-up Procedures

The clinic office associate typically completes all the lock-up procedures prior to departing by 5:00 pm. However, many times students/supervisors are the last people in the clinic area. Therefore, all students and supervisors should follow these procedures if they are the last person to leave the clinic area. (See **Appendix 4a-1**. for these specific procedures.)

### 4b. Treatment Rooms

The clinician is responsible for initiating and concluding treatment sessions *on time*. This includes cleaning and disinfecting the room. Another clinician may be scheduled for a session immediately following your session so please be conscientious and professional with your time management. As a general rule, you should review/close your session *about 5 minutes before* the actual ending time. The clinician is to remove materials and equipment and return them to the proper location immediately upon conclusion of the treatment/diagnostic session. Be considerate as other clinicians may need the same materials for their sessions. Sometimes, equipment (such as an audiometer) needs to be used during the same time slot. Be professional and discuss this with your fellow clinician before a conflict arises. If your session starts late because the clinician before you continually ends late, please discuss this with him/her first. If the problem is not resolved, speak with your supervisor. (Remember that this may happen in an unusual or emergency situation, and if it happens one time, it is not a problem yet. On the other hand, do not let the tardiness affecting your client, develop into a habit!)

### 4c. Clinic Waiting Room

When you conclude a session, do **NOT** leave the client (especially small children) unattended in the waiting room. If you have another client, either ask another clinician to assume the responsibility for this client, or notify your supervisor. Under no circumstances should you leave the client unattended or left with the Clinic office associate. If your client being picked up late is continually a problem, have a respectful conversation with the client/parent/guardian/transport person about this. If it persists, talk with your supervisor.

### 4d. FM Listening Device

Each observation room has been equipped with its own FM listening device that allows supervisors to communicate with clinicians in a less disruptive way during a session. Please discuss with your supervisor whether they want you to have this device ready and available for your session.

If so, be certain that the equipment is turned **off** after use and replaced correctly into the re-charging unit (green light should be lit). Do not mix-up FM systems e.g., “H” unit belongs with “H”. Each clinician should obtain a personal ear piece cover from the materials room OR elect to use their personal earphone set to use with these units.

### 4e. Assessment and Treatment Materials

*Prior to checking out any clinic materials, you must complete a brief training and sign a completion of training form.* Most materials and equipment are located in rooms 182, 183 and 185.

*\*\*do not remove anything from these rooms without checking it out first\*\**

There will be open hours to check-out/check in materials for your convenience. If procedures are not being followed properly, we will have scheduled hours of operation (Refer to the Clean-up section (1c) of this document). These scheduled hours will be based on the clinic student employee’s class schedule and will require you to plan ahead.

Other materials such as toys and larger items are located in observation rooms 169 and 175 and have a separate sign-out sheet for each room. The person who has checked out an item is responsible for the item. An

“incomplete” grade or other monetary consequences may be imposed if material/equipment is not returned by the person responsible. An inventory of all material/equipment/books has been compiled for your use and is located at the back of the check-out binder.

- **Videotapes and Audiocassette Tapes** are also available for you to check out. If you fail to return any tape, then you must replace the tape with one of similar quality.
- **Flip cameras** have a 24-hour check out limit.
- **All other materials** should be returned when not in use.

Please see **Appendices 4e-1. & 4e-2.** for specific check-out procedures.

#### **4f. Training Videotapes/DVDs**

When checking out training videotapes or DVDs from the Clinic library or faculty/staff libraries, you must follow the same procedures as above. There is a **separate** sign out book for the training videotapes and DVDs and this media has a limited check-out amount and time.

**APPENDIX 4a-1.**  
**UW Clinic Lock-Up Procedures**

The clinic office associate typically completes all the lock-up procedures prior to departing by 5:00 pm. However, many times students/supervisors are the last people in the clinic area. Therefore, all students and supervisors should follow these procedures if they are the last person to leave the clinic area.

- All audio-visual recording equipment should be turned off in the observation rooms. Computers in observation rooms may remain on.
- All the lights in the treatment rooms, observation rooms, and waiting room area should be turned off. There is a ‘safety’ light in the main hallway that remains on at all times.
- The door leading to the clinic records / front counter area must be locked.
- Only the observation rooms (165, 169, 175 and 170) get locked; treatment rooms (163, 167, 171, and 173) do not get locked.
- Front door of the clinic must have the locking button pushed in to be locked. Be sure that the door closes completely upon leaving. Some air drafts tend to keep it from closing completely unless pulled shut.
- The doors leading out into the stairwell should be locked. Be sure that the steel doors close completely upon leaving. Some air drafts tend to keep it from closing completely unless pushed shut.
- The back door to the clinic (nearest room 175) does not get locked but should be closed upon departure.
- The door to room 170 should never be propped open and should be locked prior to any student departure.

**APPENDIX 4e-1.**  
**Procedures to Check-Out Clinic Materials**

*Remember these simple rules when using any materials:*

- *if you open it, close it*
- *if you turn it on, turn it off*
- *if you break it, fix/replace it (or tell your supervisor!)*
- *if you take it out, bring it back*

- 1) Use **one** “out card” per item. Clearly print the item name, your name, date out, (or date returned) and condition on the lines provided. If something needs replacing, including batteries, this is the place to indicate it.
- 2) Sign-out the item in the appropriate section of the binder or the clipboards AND from the appropriate rooms (182, 186, 185, 169 and 175). Write which item you are taking and then place the completed “out card” in the spot where the item is kept. There are different sized ‘out’ cards for smaller items.
- 3) Sign-in the item back into the correct binder or clipboard. Do **NOT** remove the “out card”! This will be done by the materials room attendant. **All** materials/equipment, etc. should be returned to the wire baskets on the countertop of the materials room OR returned to the **same** location in rooms 169 and 175.
- 4) Do NOT loan materials that are checked out to you to another clinician. Check them in and have the other clinician check them out. If your name is listed in the checkout binder, you are responsible for the item. Final semester grades may be withheld until all items have been returned.
- 5) Assessment instruments/manuals needed for diagnostics may be checked out up to **two days** following an evaluation for writing the diagnostic report. Please remember that others use these materials, so be considerate for a timely return.
- 6) **PLEASE do not use** the **last** protocol of an assessment or Clinic form. Make a copy of the last form and notify the materials room attendant or Clinic Coordinator immediately using the protocol re-order form located inside the assessment file folder.
- 7) The Training Videotape Library has a separate log book for signing tapes in and out. Do **not** use the materials binder to sign these **confidential** tapes out. There is a limit to the number of tapes you may take out and for how long you may keep them.
- 8) The Division of Communication Disorders will provide *general* supplies for use with your clients. Most of these materials are kept in rooms 169, 175 and 185. Notify the materials room attendant OR Clinic Coordinator or when supplies are low.

**APPENDIX 4e-2.**  
**Procedures for iPad Checkout**

1. If you are not familiar with the iPad operation, ask someone before using it!
2. iPads must be checked out from the Clinic office associate.
3. Students must sign in and out each iPad in the appropriate log book in the Clinic office.
4. Students should not pass an iPad to another clinician. The student who last signed it out is responsible for it.
5. iPads must be returned immediately following a session **or** by 8:00 am the next morning if sessions run past 5:00 pm.
6. Do not clean the iPad screen with anything other than the provided cleaner cloth.
7. Do not download “apps”. If you have a suggestion for an “app” notify your supervisor.
8. Do not re-configure the folders or “app” locations.
9. Notify your supervisor or the Clinic Coordinator immediately if something on the iPad is not working or needs attention.

**Revised 08/2017**

## 5. GRADING & ASHA CLOCK HOURS

Earning clock hours requires three major aspects, 1) that those hours are supervised by a licensed and certified SLP, 2) that you record your hours (minutes) and 2) that you pass your clinical practicum.

ASHA says, “Supervised practicum must include experience with client/patient populations across the life span and from culturally/linguistically diverse backgrounds. Practicum must include experience with client/patient populations with various types and severities of communication and/or related disorders, differences, and disabilities...**The [student] must demonstrate direct client/patient clinical experiences in both assessment and intervention with both children and adults from the range of disorders and differences.**” This means that we ensure you get diverse client experience while enrolled in our graduate program. To do this, we try to vary the types/ages of clients you see while you are completing on campus clinical hours AND that we give you diverse off-campus experiences.

Your clock hours and clinic grades are managed in a system called CALIPSO. You will need to sign up for this service. How to do this, as well as how to record sessions will be reviewed at orientation.

### 5a. Clock Hour Requirements

All your clock hours must be logged into CALIPSO. These entries must be completed by Friday at noon, following the session. You may make an entry for each session or one for each week (by adding your session times together). However, each client will have to be logged separately, even if you have the same supervisor for both two clients! Please note the dates and times for each session in the *comment* section of your entries. **(See Appendix 5a-1.)**

**ASHA requires: 400 hours *minimum*** for the Certification of Clinical Competence

Applicants for certification under the current standards will be required to complete a minimum of 400 clock hours of supervised clinical experience. At least 25 hours must have been spent in clinical observation and at least 375 clock hours must have been spent in direct client/patient contact. 325 of those must be at the graduate level. Only direct contact with the client or the client's family in assessment, management, and/or counseling can be counted toward the practicum requirement.

The [Council for Clinical Certification in Audiology and Speech-Language Pathology](#) (CFCC) defines 1 clinical practicum hour as equal to 60 minutes. When counting clinical practicum hours for purposes of ASHA certification, experiences/sessions that total less than 60 minutes (e.g., 45 minutes or 50 minutes) cannot be rounded up to count as 1 hour.

While there are no minimum hours in different categories... every attempt is made to have direct contact time listed in each of the big 9 categories for children and/or adults in treatment and/or evaluation with appropriate supervision.

- Hours must reflect the “breadth of the life span” and demonstrate multi-cultural aspects and severity levels
- Hours should reflect direct services in prevention, screening, evaluation and treatment
- “Big 9” disorder categories include:
  1. **Articulation**
  2. **Fluency**
  3. **Voice and Resonance, including respiration and phonation**

4. **Receptive and Expressive language (phonology, morphology, syntax, semantics, pragmatics, prelinguistic communication, and paralinguistic communication) in speaking, listening, reading, and writing**
5. **Hearing (including impact on speech and language)**
6. **Swallowing (oral, pharyngeal, esophageal, and related functions, including oral function for feeding, orofacial myology)**
7. **Cognitive Aspects of Communication (attention, memory, sequencing, problem-solving, executive functioning)**
8. **Social Aspects of Communication (including challenging behavior, ineffective social skills, and lack of communication opportunities)**
9. **Augmentative and alternative communication modalities**

NOTE: Clients seen for accent modification services fall under the articulation category. IEP/STP conferences are part of treatment *or* the evaluation/screening category. Clinicians should strive to utilize all categories whenever possible. For example, if a client has more than one disorder, split the service time on your clock hour sheet accordingly e.g., 15 minutes in fluency and 15 minutes in articulation for a total of 30 minutes of treatment.

### **5b. Your supervisor(s)**

The graduate clinician's major goal and responsibility in the clinical process is to provide quality service to their clients. This means planning effective assessments and treatment to the best of one's ability. It includes documentation, analysis and interpretation of collected data, and modifying treatment/recommendations as needed for the best possible outcome. The clinician should be an **active participant** in the supervision process. This includes critical reflection, self-evaluation of clinical behavior and an on-going collaboration with the clinic supervisor. To be an active part of the supervision process, it is essential that the clinician openly express his/her thoughts, concerns, needs and ideas with their supervisor. It is best to go directly to your supervisor for clarification on expectations before consulting another supervisor or the Clinic Coordinator.

While you are enrolled in graduate school you will have many different supervisors, who require or prefer procedures and documentation to be done in specific ways. This will differ between supervisors and may be confusing at times. Embrace these differences as a way to learn to do things many different ways, contributing to your professional knowledge base as well as your ability to maintain flexibility as a clinician!

In your first two semesters you will have several (if not all!) supervisors that work here at the UWSHC clinic. After that time, you will have supervisors at external placements (community placements and externships).

Please note: **Some supervisors may be more hands-on and take over parts of your session or speak to you during your session over an FM system, while others will quietly observe and never enter the treatment room.** These different styles are **based on** many things (e.g., the client's needs/behavior, the supervisor's relationship with the client, the supervisor's clinical style, your relationship with the client, etc.) Do not make judgments about your clinical performance based on the supervisory style, rather, read/listen and implement the feedback you are given from your supervisor. If you are unsure about how you are doing clinically set up a time to talk to your supervisor(s).

Supervisors may elect to have clinicians present the mid-semester progress note as an oral summary versus a written one. This review is typically held at mid-term in the semester and allows clinician and client to assess whether they are on track for meeting the STP goals by the end of the semester. Goals/objectives may be added or deleted from the original semester plan and progress on new goals/objectives should be addressed in the final progress report at the end of the semester.

**Final progress conferences with client/parents should be scheduled during the last week of clinic, following the same general procedures as in the STP conferences. It is common that the final progress report is mailed to clients upon conclusion of the semester to allow for final data and analysis to be included but an oral presentation of progress made is expected by the clinician during the final week of clinic.**

### **5c. Supervision Requirements**

Supervision must be provided by individuals who hold the Certificate of Clinical Competence from ASHA. ASHA states that, “The amount of direct supervision must be commensurate with the student's knowledge, skills, and experience, must not be less than 25% of the student's total contact with each client/patient, and must take place periodically throughout the practicum. Supervision must be sufficient to ensure the welfare of the client/patient.”

This means:

- that our supervision has to be in real time (not watching recordings of you after the session, though we can do that...it just doesn't count as direct supervision time!). This may take place in the room with you or from the observation room.
- supervisors must be available to consult with a student providing clinical services to the supervisor's client. In order to meet this ASHA requirement, we hold weekly group meetings and are also available to meet with you individually (you just need to schedule a time or come to office hours)

### **5d. Feedback**

Supervisors will provide written feedback about clinician's performance and may offer data or observations about clients' performance. Electronic feedback is the most common way, but different supervisors may elect to give you feedback in different ways. Information from this feedback form (i.e., minutes supervised) should be entered into the CALIPSO weekly clock hour form. An alternative to general feedback is the CHECKLISTS for specific procedures (oral mech and hearing screening, evaluation, treatment, etc). The scores given on these forms correspond with the 5-point rating scale used in CALIPSO.

Your supervisors will all provide you with feedback about your clinical performance. At UWSHC, we provide you with more feedback than you will have at external placements. This is because you are new clinicians, but please note that this will be done differently by each supervisor. You may not receive feedback in the same way (e.g., email versus hardcopy), and you may not receive feedback on the same time schedule (e.g., every time they observe vs. weekly). This feedback is informal and is not graded, but is designed for you to learn from and to use to advance your clinical skills. We also use this for our records to ensure that we are giving you enough direction and/or information, and to ensure that you are implementing the feedback we give you.

**Please remember not to compare yourself to others (or how well you *think* others are doing). Rather, compare your current performance to your past performance...** Are you gaining more skills? Are you getting better (i.e., more effective, more natural, and/or incorporating more meaningful content) with providing an intervention? Are you improving in the way you describe procedures to your client, or the way you talk to caregivers/spouses/parents? ...etc.

### **5e. Grading/conferences** *(there is more detailed information about this in your SPPA 5030 Syllabus)*

Students and supervisors will have regular conferences. This includes the initial planning, weekly, mid-term conference and final check-out (Appendix 5e-1). Prepare for all supervisory conferences. Adequate preparation demonstrates responsibility and initiative by the clinician. Come to the conferences with items to discuss and *lead* the discussion. Present ideas about areas upon which you would like to improve your clinical skills. Discuss some of the solutions to solve the problems you are encountering with your client or the overall clinic process. Developing clinical skills takes time. Thus, the supervisory conference should focus as much as

possible, on clients, instructionally related topics, and clinician-specific skills. Other topics and general procedures can be discussed during regularly scheduled weekly group meetings.

You must be evaluated by all of your supervisors on your clinical skills with dx and tx procedures, your professionalism, and your adherence to the ASHA Code of Ethics (**Appendix 8**). The criteria on which we evaluate you does not change and is in CALIPSO. Our expectations on how well you meet these changes overtime does change. That is, we expect to see you grow in proficiency in all areas as you gain more and more clinical experience. Your grades in clinic are satisfactory/unsatisfactory. A letter grade is not assigned, although, numerical scores are given in CALIPSO. A numerical range, corresponded to satisfactory/unsatisfactory is provided for you in your SPPA 5030 syllabus, where there is detailed grading information. Also please see **Appendix 5e-2**.

You WILL be evaluated formally at midterm and final points of each semester by each supervisor to whom you are assigned until you graduate our program. This is done using the same CALIPSO form, which you can view, using the same grading scale and criteria. You will be able to view this evaluation and you will have a grading conference at each time point with each supervisor evaluating you. Mid-semester and final conferences are held with a supervisor to discuss your *overall* clinical performance. These conferences are assigned at mid-term (during mid-term week) and at the final (during finals week).

Recording your midterm evaluation is required, however, these are not permanently recorded. Only your final semester evaluations are used to determine a satisfactory/unsatisfactory grade for the semester. It is very possible for a student who is not passing at midterm, to improve and pass at the final evaluation...it often just takes some focused work and good communication!

If a student fails a semester of SPPA 5030:

- 1) He/she cannot count the clinical hours for the semester (this is an ASHA stipulation)
- 2) He/she must comply with a remediation plan. An initial remediation plan is determined by any or all of the following individuals:
  - Clinical supervisor assigning the failing grade
  - Clinical supervisors also assigned to the student
  - Clinic Coordinator
  - Division Director
  - Graduate program Chair
  - Faculty or clinical supervisors with specific content knowledge regarding the client/case/disorder

## **APPENDIX 5a-1.**

### **Recording Clock Hours On Calipso**

At the end of each week, enter and **submit** clock hours on CALIPSO by **Friday at 4:30 (12:00 in summer)** to each supervisor. See attached CALIPSO sample in the **Appendix** section. You must include notes to supervisors in the “Comment” box regarding client initials, time supervised, etc. to ensure adequate supervision of *no less than 25%* of a client’s total SLP services.

#### **Special Notes**

**Baseline hours** can be counted under the “evaluation” category for the first 1-3 sessions at the start of the semester. Interviewing and counseling *during* a **speech-language evaluation** (i.e., “time spent giving information, counseling, or training for a home program”) are also considered evaluation hours. Clinical management and counseling during an **audiological evaluation** are considered treatment.

Discussions regarding progress of treatment or other meetings (IEP/STP) with parents/clients are considered **treatment** clock hours *unless* it is an initial evaluation OR a triennial evaluation then it is more appropriate under the **evaluation** code.

For clients receiving accent modification services, use the disorder code that best describes the services provided (e.g., articulation, voice/resonance, language, etc.) For clients with an orofacial-myofunctional disorder (i.e., deviant swallowing pattern) use the code for swallowing.

Routine semester **oral mechanism screenings** are coded under **Artic** and as **evaluation** in CALIPSO. **Audiological hearing screenings** are coded as evaluations under hearing.

#### **Clarification on diagnostic evaluations**

- ASHA states that, "Clinical practicum hours should be assigned only to the student who provides direct services to the client or client's family."
- *However*, in rare situations it is possible for several students *working as a team* to receive credit for the same session depending on the specific responsibilities each student is assigned.
- For example, in a **diagnostic** session, if one student evaluates the client and another interviews the parents, both students may receive credit for the time each spent in providing each specific service. However, if one student worked with the client for 30 minutes and another student works with the same client for the next 45 minutes, each student gets credit for the time she actually worked with the client, which is 30 and 45 minutes -- not 75 minutes. It is the intent of all the supervisors to credit clinicians as many clock hours as possible and follow ASHA guidelines.
- It is acceptable to designate time under more than one disorder category during the same diagnostic evaluation. For example, if you are primarily assessing language with a child, you should also be noticing/observing (formally or informally) if there are other concerns/problems with voice, fluency, and articulation. Therefore, as part of the overall language assessment you could designate 5-10 minutes as assessment of speech and indicate this on your clock hour form.

**APPENIDIX 5e-1**  
**Final Check-Out Procedures Checklist**

Clinician: \_\_\_\_\_

Date: \_\_\_\_\_

**WHAT TO BRING WITH YOU TO FINAL CONFERENCE**

1. Working, permanent and diagnostic folders for *each* client.
2. Completed (CALIPSO) self-evaluation.
3. Final diagnostic or progress reports, and cover letters that require a supervisor's signature.
4. Borrowed materials from **all** materials rooms (including audio and videotapes) and/or from supervisors.
5. Site preferences, types of disorders or age groups, etc., you would "prefer" for next semester/summer.
  - 1.
  - 2.
6. Paperwork not previously turned in (hearing and O-M screenings, etc.).
7. CORE clinical skills form, *if applicable*.

**CHECKLIST FOR PERMANENT FOLDERS (DX and TX)**

1. Face sheet (including conference/assessment section) completed. \_\_\_\_\_
2. Signatures/initials on all SOAP notes, contact logs, permission forms \_\_\_\_\_
3. Client's complete name and complete dates on work samples \_\_\_\_\_
4. *Actual* contact time with client logged in SO note margin \_\_\_\_\_
5. All SOAP notes placed in permanent file \_\_\_\_\_
6. All paperwork flowing in the same direction/holes aligned \_\_\_\_\_

**CHECKLIST FOR WORKING FOLDERS**

1. Condition of working folder(s). \_\_\_\_\_ replace \_\_\_\_\_ adequate \_\_\_\_\_
3. *Up to* two weekly treatment plans kept in the working folder \_\_\_\_\_

**OTHER ISSUES**

1. Locker key returned to Division Office Associate, *if applicable* \_\_\_\_\_
2. Locker, mailbox, refrigerator, and 189/429 clear of personal belongings \_\_\_\_\_
3. Clinic clean-up job (\_\_\_\_\_ ) completed \_\_\_\_\_

**DEFICIENCIES/COMMENTS**

Supervisor initials: \_\_\_\_\_

## **APPENDIX 5e-2**

### **CALIPSO student performance evaluations**

All clinical courses with the prefix **SPPA 5030, SPPA 5270 and SPPA 5290** use an S/U grading system. Each semester of the clinical courses has a separate cut-off to achieve either an **S** or **U** for mid-term and final grading. The scale is graduated to reflect the increasing student expected performance (i.e., competency) over all clinical experiences.

#### **CALIPSO GRADING:**

- 1 **Skill not evident.** In the context of the student's clinical experience and SLP training/education, the student does not demonstrate expected skills, despite a previous history of supervisor feedback. Supervisor must provide a maximal level of support via modeling, demonstration, direct instruction, etc. Student does not demonstrate awareness of behaviors needing to be addressed or attempts to resolve clinical problems.
- 2 **Skill is emerging.** In the context of the student's clinical experience and SLP training/education, the student demonstrates emerging skills inconsistently. Supervisor must provide a moderate level of support via verbal reminders, prompts, cues, etc. Student demonstrates awareness of behaviors needing to be addressed or attempts to resolve clinical problems, but requires supervisor guidance and support to do so.
- 3 **Skill is present.** In the context of the student's clinical experience and SLP training/education, the student demonstrates expected skills, but further development or refinement of skills is required to achieve efficiency. Supervisor must provide on-going feedback or monitoring. Student demonstrates awareness of behaviors needing to be addressed and attempts to resolve clinical problems during sessions.
- 4 **Skill is consistent.** In the context of the student's clinical experience and SLP training/education, the student demonstrates skills that are well-developed and implemented consistently. Supervisor acts as a collaborator in treatment planning. Student is aware and can modify behavior in-session and self-evaluate after the session. Supervisor is needed to suggest possible alternatives. Student's problem solving shows evidence of critical thinking.
- 5 **Skill is automatic.** In the context of the student's clinical experience in various settings, and completion of SLP training/education, the student demonstrates expected skills independently and efficiently. Supervisor serves as a consultant/colleague. Student demonstrates independent case management and problem solving in multiple settings to address a caseload of diverse client needs.

## 6. CLINIC SAFETY POLICIES AND PROCEDURES

*\* All clinical staff and students should follow these guidelines \**

### 6a. Equipment

Decontamination, cleaning, disinfection, and sterilization of multiple use equipment before reuse should be carried out according to specific infection control policies and procedures (as detailed in the Exposure Control Plan).

**All** clinical materials (e.g., assessment items, audiometer earphones, tympanometry probe tips, hearing lab tools or instruments, toys) and work surfaces (e.g., table tops, arm rests on chairs, mirrors) should be cleaned and disinfected after **each** use. Clinical materials may be cleaned with an approved disinfectant or household bleach solution (these are kept in each treatment room).

Audiological equipment, i.e., tympanometry probe tips and hearing instrument tools, must be cleaned/disinfected following the Clinic Equipment Cleaning Protocol. For each new client, disposable items such as otoscope tips and headphone covers should be used and then properly discarded in a waste container.

### 6b. Hand washing

- Wash hands immediately if they are potentially contaminated with blood or body fluids containing visible blood.
- Wash hands before and after treating patients/clients.
- Wash hands after removing gloves.
- Wash hands after cleaning/disinfecting room and materials.
- Follow the basic hand washing technique:
  - vigorous mechanical action whether or not a skin cleanser is used
  - use of antiseptic or ordinary soap under running water
  - rinsing for at least 20 seconds thorough hand drying with a disposable paper or towel to help eliminate germs
- An alternative when hand-washing is not feasible is to use an alcohol-based disinfectant gel.

### 6c. Gloves

- Wear gloves when touching blood or other body fluids containing visible blood.
- Wear gloves when performing **invasive** procedures on all patients/clients. This includes performing an examination of the oral speech mechanism; using a laryngeal mirror, oral endoscope, or nasoendoscope; and assisting with oral-myofunctional tasks.
- Wear gloves to clean/disinfect all equipment, unless otherwise indicated.
- Change gloves after contact with each patient/client.
- If a glove is torn, remove the glove and use a new glove as promptly as patient/client safety permits.
- After removing gloves, wash hands immediately.
- Discard gloves in the room before exiting.

## 6d. Spills

### Cleaning and decontaminating spills and/or splashes of blood or other bodily fluids.

- Maintain a barrier between the spill and your own body. Wear a pair of gloves, and eye protection (safety glasses are located in HS 178 and 185.)
- Surround spill with disinfectant.
- Cover with paper towel.
- Saturate paper towel with disinfectant.
- Allow for contact time per disinfectant instructions.
- Paper towels can be thrown in regular waste.
- Clean surface with a freshly prepared 1:9 hydrochloride (e.g., household bleach solution).
- Notify clinic supervisor and/or Clinic Coordinator immediately.
- In the event of a large spill or when items cannot be completely disinfected (e.g., items that are disposable such as fabric chair seat or carpet), call Environmental Health and Safety (EHS) at (6-3277) and the Physical Plant Blood Team at (6-6225).

## 6e. Human Blood Borne Pathogen Exposure Incident Instructions

- 1) Rinse or wash affected surface immediately and apply first aid.
- 2) Report incident to supervisor immediately.
- 3) Report to student health to seek medical attention.
- 4) Return copy of the incident report and all relevant medical reports to the Division office
- 5) A copy of the report should be sent to the EHS office

## 6f. Clinic Equipment Cleaning Protocol

*\* Gloves and protective eyewear must be worn during all cleaning/disinfecting processes unless otherwise indicated \**

### Disinfectants

- A fresh mixture of household bleach and water (1:9 parts) is mixed each week for use in each clinic treatment area. At the end of each week, the mixture is disposed of allowing the containers holding the mixture to air dry before each new mixture is made.
- It is not necessary to wear personal protective equipment (PPE) when using this solution.
- This solution is changed each week by the materials room attendant.

### Sporox

- The Sporox is premixed and ready to use in HS178 (Hearing Aid Lab) and HS185 (Cleaning room).
- Pour two cups of Sporox liquid into the clearly marked container.
- The Sporox should be changed every **21** days. The materials room attendant will change the solution and log the date on the sheet posted near the container.
- Dispose of used Sporox into the Hearing Aid Lab or Cleaning room sinks.
- Should you have any reaction from contact with the Sporox, refer to the warnings and precautions sheet posted inside the cabinet where the container is located and notify the

appropriate Clinic Coordinator immediately.

### **Maxicide**

- The Maxicide solution must be mixed before use. The two agents (one powder one liquid) become active once mixed.
- After Maxicide mixture is made, pour the designated amount into the marked tubes in the Cleaning room.
- The Maxicide in the tubes and any unused solution should be discarded after 21 days into the sink. Log the date when the mixture is made on the container and place the same information on the base of the tubes with the Maxicide mixture.
- Should you have any reaction from contact with the Maxicide, refer to the warnings and precautions sheet posted directly on the container and notify the Clinic Coordinator immediately.

### **6g. Universal Precautions**

1. Assume all human blood, bodily fluids and unfixed tissues are contaminated with Human Immunodeficiency Viruses (HIV), hepatitis viruses including Hepatitis B Viruses (HBV), Hepatitis C Virus (HCV), and other Blood Borne pathogens. Pathogens are disease-producing microbes. These human materials are thus considered biohazardous in any workplace.
2. Any direct physical contact with human biohazardous materials is to be avoided. Maintain a barrier between yourself and the potential contaminant. Use personal protective devices such as gloves and eye protection when appropriate. Gloves should be worn during all invasive procedures, including oral peripheral examinations and otoscopic examinations. Protective glasses should be worn when grinding hearing aids.
3. Know the signs and symptoms of Hepatitis B Virus, and Human Immunodeficiency Virus infections. Report unexplained significant illnesses, rashes and fevers to your supervisor if you have handled human biohazardous materials.
4. Understand the biohazardous tasks you must do in your job classification or category as detailed to you in the Blood Borne Pathogen training.
5. Become proficient at using personal protection (e.g., gloves, masks, eye shields, etc.) *before* becoming in contact with biohazardous materials.
6. It is highly recommended that you obtain the vaccination against Hepatitis B. Notify Clinic Coordinators when this series has been completed.
7. Avoid needle sticks, cuts, abrasions, and splashes in work associated with human hazardous materials. Protect face and broken, irritated or abraded skin from human materials, and avoid aerosols.
8. Always use good hygiene work practices including antiseptic techniques, spill clean-up, medical waste containment and **regular, thorough hand washing** with soap and water and/or non-water hand sanitizers, especially after removing gloves or when leaving your work area.
9. Dispose of biohazardous human materials and contaminated, disposable lab ware properly. Contaminated recyclable lab equipment must be sterilized. Protect yourself, patients/clients, staff and visitors from accidental exposure.
10. Decontaminate all reusable protective gear immediately after use following specific clinic procedures.

11. Clean work areas thoroughly with disinfectant or a mixture of household bleach before leaving your work area.
12. Report all accidental exposures to Clinic Coordinators and supervisors and seek medical follow-up. The attending healthcare professional will want to know the individual's name who was the source of the contaminate, if possible. Do NOT save specimens for HIV or HBV testing.
13. Obtain proper biosafety training and become proficient in performing all biohazardous tasks assigned to you.

*\* These Universal Precautions must be strictly followed by all Division supervisors, graduate clinicians, and student observers in all settings \**

**The two forms of training must be completed by you:**

1. Blood Borne Pathogen Training Form (APPENDIX 6a-1.)
2. Hepatitis B Vaccination Verification Form (APPENDIX 6a-2.)

**...signed and returned to the Clinic Coordinator within the first 2 weeks of starting the graduate program.**

### **6h. Hepatitis B Vaccine**

Most off-campus sites require a Hepatitis B vaccine *before* initiating a practicum at that site. Since students may not know their site's requirements until it is too late to order the serum, it is strongly advised that all students obtain the Hepatitis B vaccine while on campus during the first three semesters.

If students choose to receive the Hepatitis B vaccine, they will receive a series of three shots across a six-month period. The Hepatitis B series takes at least 6 months to complete, so plan accordingly or run the risk of the externship being delayed. Students may receive both vaccines at the University of Wyoming Student Health Center. Students are responsible for the cost of this vaccine.

### **6i. Health Insurance**

Graduate students enrolled in at least 4.5 credit hours of campus instruction are charged automatically each semester unless a waiver is signed. The deadline for signing the waiver will vary for each semester. Students who are on externship (enrolled in section 80) **are not** automatically enrolled for health insurance (this includes campus track students enrolled in 5270 and 5290 externships and Orals in their final semester). To obtain health insurance, you must a) petition for the optional student fee package through the graduate school, and then b) complete an enrollment form in the Student Health Insurance office. Contact the Student Health Insurance offices at 307/766-3025 for further information.

### **6j. Liability Insurance**

The University of Wyoming provides general and professional liability coverage for clinical undergraduate observation students and graduate students in the Division of Communication Disorders for a nominal fee. Such coverage shall not apply to activities on the part of students which are not part of or are beyond the scope of the educational program.

Recently, an increasing number of externship sites have been requesting *higher* liability coverage than what is offered through UW. If the student wishes to complete an externship in one of these sites, this additional professional liability insurance coverage is the responsibility of the student.

Verification of this additional liability insurance must be provided to the Clinic Coordinator by submitting a photocopy of the page(s) from the insurance policy, which indicates who the coverage is with and effective dates of the policy. Students who fail to provide written verification of this additional coverage will not be allowed to start their externship at the site requesting additional coverage until verification is complete. A relatively easy and inexpensive way to obtain additional personal liability insurance is through the National Student Speech Language and Hearing Association (NSSLHA). Contact them at their web site: [www.nsslha.org](http://www.nsslha.org).

#### **6k. Emergency Response Procedure**

Client welfare and safety are paramount while clients are attending the UW Speech and Hearing Clinic. The following steps are procedures that should be followed to ensure the client safety is maintained.

##### **If an emergency arises that is client-centered:**

- Stay with the client
- Call/yell for assistance (e.g., open door and yell for help)
- Use phone in treatment room and call **9-1-1**
- Offer client assistance (e.g., first aid, CPR, etc.)
- Stay with client until medical assistance arrives
- After situation is resolved, report incident to clinical supervisor/director
- Supervisor/director will follow-up with Risk Management and others as needed

##### **If an emergency arises that is environmental (fire, tornado, etc.)**

- Remove or assist client away from the building
- Move client to a safe location away from windows/debris if a tornado
- Remain with the client
- Call **9-1-1** to report situation (use a cell phone)
- After the situation has resolved, report incident to clinical supervisor

Return to building only after an “all clear” has been given by the authorities.

**APPENDIX 6a-1.**

University of Wyoming  
Division of Communication Disorders  
Department 3311  
1000 E. University Avenue  
Laramie, WY 82071  
307/766-6426

**BLOODBORNE PATHOGENS TRAINING FORM**

**ACKNOWLEDGEMENT OF RECEIVING AND REVIEWING BIOSAFETY  
INFORMATION ON UNIVERSAL PRECAUTIONS IN HANDLING and COMING IN  
CONTACT WITH HUMAN BLOOD, BODY FLUIDS, AND TISSUES.**

**Date of Training:** \_\_\_\_\_ **Instructor:** \_\_\_\_\_

I, \_\_\_\_\_, acknowledge that I am familiar

with the Universal Precautions for handling and coming in contact with human blood, body fluids and tissues and the OSHA Standard on Bloodborne Pathogens.

I understand that my clinical assignment *may* involve work with human blood, body fluids or tissues and that I must adhere to the biosafety practices set forth in the OSHA Standards on Bloodborne Pathogens, and the Division of Communication Disorder’s Exposure Control Plan for Bloodborne Pathogens.

I understand these safety procedures and their application to my clinical experience. I have had an opportunity to ask questions of my instructor and clinical supervisor about my clinical experience and the correct use of these procedures in performing my work assignments.

I understand that I am expected to ask my clinical supervisor for instruction in any new procedures that arise in future applications of these safety procedures before initiating such activities.

\_\_\_\_\_  
Name (print or type)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

***Signed form is to be placed in the student’s permanent file.***

*Revised 05/2012*

**APPENDIX 6a-2.**

University of Wyoming  
Division of Communication Disorders  
Department 3311  
1000 E. University Avenue  
Laramie, WY 82071  
307/766-6426

**HEPATITIS B VACCINATION FORM**

\_\_\_\_\_  
Student Name (last, middle, first)

\_\_\_\_\_  
Social Security Number

**CONSENT FOR HEPATITIS B VACCINATION**

I have knowledge of Hepatitis B and the Hepatitis B vaccination. I have had an opportunity to ask questions of a qualified health care professional and understand the benefits and risks of the Hepatitis B vaccination. I understand that I must have three (3) doses of the vaccine to obtain immunity. However, as with all medical treatment, there is no guarantee that I will become immune or that I will not experience side effects from the vaccine. I give my consent to be vaccinated for Hepatitis B.

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

**HEPATITIS B VACCINE DECLINATION**

I understand that due to my clinical exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. It has been *recommended* that I receive the Hepatitis B vaccine; however, I **decline** Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease.

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

**RELEASE FOR HEPATITIS B MEDICAL INFORMATION**

I hereby authorize \_\_\_\_\_ to release to the Division of Communication Disorders at the University of Wyoming, Hepatitis B vaccination information. I give my permission for this Hepatitis B vaccination and related Hepatitis B information to be given to the Division for my student file. I authorize release of Hepatitis B status to the health care provider in case of an exposure incident.

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

*Signed form is to be placed in the student's permanent file.*

## 7. EXTERNAL CLINICAL PLACEMENTS

### SPPA 5270/5290

The externships are viewed as an *extension* of academic and clinical experiences. Clinical instruction continues in these experiences. A student's academic and clinical performance may be shared with external supervisors to enable them to best support the student's learning.

Graduate students complete **two** full-time, **twelve-week externships** following completion of coursework and SPPA 5030 requirements. Students register for one externship in the Spring and one in the Summer semester, but the beginning and ending dates do not align with semesters. One externship is to occur in an **educational setting** (a school or early childhood program), and one is to occur in a **medical or clinical setting**. Most students will complete the educational internship first. The order of externships are arranged and determined by the student and Externship Coordinator.

Determination of a student's preparedness for externships is subject to approval by the clinical supervisors and the faculty. This may include meeting a required number of clinic hours and/or demonstrating the knowledge and skills appropriate for the externship (e.g. successfully completion of coursework). Thesis students must complete the prospectus meeting *before* entering into externships.

Students will be expected to perform in a professional manner and demonstrate growth toward a life of professional service. These externships are more like work settings, although clinical guidance and supervision continues. From their practica and externships, the student needs to gain experiences covering the breadth of the lifespan across the Big 9 disorder categories. If a student is dismissed from an externship, they automatically receive a U and must enroll to repeat the externship in a future semester.

Students are expected to be able to relocate in order to complete these externships. Travel and living arrangements for the externships are the student's responsibility. A letter to financial aid for loan repayment purposes can be issued by the Division indicating the practica are full-time experiences despite their part-time credit hour status (i.e., 6 SCH).

Community Placement and Externship Supervisors may be unfamiliar with CALIPSO. If this is the case:

- Supervisors will be added in CALIPSO as needed. Students should guide their supervisors through the CALIPSO one-time registration process and assist in answering any questions that may arise.
- A *copy* of all supervisors' ASHA certification cards and, if applicable, state licenses must be given to the Clinic Coordinator before the end of each clinical rotation. CALIPSO allows for these documents to be uploaded too.
- Students should include notes to supervisors in the "Comment" box regarding client initials, time supervised, etc. to ensure adequate supervision amounts are met.

### 7a. Process of Securing an Externship

#### General Information on Externships

The program will provide opportunities for two externships. In order to complete the program on time, students will need to work with our existent framework and processes described below. Our program does not allow students to "make their own" externship opportunity, as you will see

below externships are complicated agreements that involve many parties and aspects beyond student-supervisor. Students are an integral part of the externship process but never to arrange their own externships.

**Medical externships** include hospitals, medical sites, skilled nursing facilities, outpatient therapy, and clinics (this can include in the home Part C services). For our program, medical externships are available only at established sites listed in the Externship Listings, OR in rare circumstances the Externship Coordinator will inquire with an additional site if the site is in the “Mountain-West region.” A cooperative education agreement (i.e., contract) must be approved by the University and externship facility, and hospital /medical/clinic sites have restrictions and several layers of approval. Typically, it takes 8-12 months to execute a contract in one of these sites, and general counsel and legal consultation expenses make this a costly process. These sites in particular have been increasingly difficult to secure, and we have been turned away from sites outside the region because they simply prefer to train students who are from local programs or who are residents in the area. Bottom line: **Students should plan on completing their medical externship at one of our existent sites from the Externship Listings.**

**Educational externships** include schools, preschools, and early intervention programs. Our program has more than enough cooperative education agreements with educational externship sites to meet the needs of our students. We strongly encourage students to select from our existent sites, however- we will make up to 2 inquiries if a student would like to request an educational internship in a given educational site for which we do not currently hold a agreement. Consult with the Externship Coordinator prior to completing your Externship Request.

### **Process/Steps**

Students will follow the externship application processes as established by the Externship Coordinator.

**SharePoint** will be used to organize this process.

Within SharePoint you will find:

- Externship Listings
- Externship Request ( an electronic form)

Students should bear in mind that each externship request and each student’s circumstances are unique and the timing for all aspects will vary depending on the site. Many of the educational sites will not be able to commit or respond to requests until the academic year has begun. Some of the medical sites may interview or screen in March while other may do this in September or not at all.

### **7b. Externship Guidelines**

The Externship Coordinator will work from the student’s externship requests, students may not make changes to these requests or begin to pursue other opportunities.

The Coordinator will make inquiries, and in some instances will be required to select 1 or 2 students who are given greenlight to inquire or apply for an externship.

As the internship matching process occurs, students may learn 1) a site is not accepting students 2) students were already selected 3) he/she was not matched or selected to apply to a site 4) or

other issues arise or the site is not a viable option. Students will need to consider alternate options in order to graduate on time, including options that he/she may not have included in his/her externship request.

The implementation of the Higher Education Act and current state authorization regulations has affected clinical practicum choices. At this time, the Division of Communication Disorders will not be placing students in clinical practica in certain states. We have adopted this policy to comply with regulations in these states. See the Division website for the list of eligible states (<http://www.uwyo.edu/comdis/graduate-study/state%20reauthorization-licensure.html>).

The Externship Coordinator decides on the steps for all externship requests. Students must have approval or “greenlight” prior to making any contact with any externship site/possible supervisor. We have been “shut out” of sites in the past because multiple students made requests without approval. In some instances sites have rules about who is contacted and what information is shared, the Externship Coordinator will navigate this process not the student.

Upon approval, graduate students may make *initial inquiries* with sites that they are considering for an externship. This means that they can obtain the name, telephone, or e-mail address of a contact person or a possible supervisor at the facility so that the Externship Coordinator can make contact. After the initial contact, the Externship Coordinator will provide the student with further instructions regarding the externship application process. Some sites may require electronic application in order to be considered for an externship- and some applications require a fee.

There have been instances where the University does not approve a site because of the site’s contracting wording or legal requirements. Students will need to work with the Externship Coordinator at considering alternatives if this should occur.

There also are occasions where a site that was secured unexpectedly “falls through.” Students will need to work with the Externship Coordinator at considering alternatives if this should occur.

Some sites handle multiple requests from students, and may have an interviewing process or a process by which students apply over email with a cover letter and resume. Students will be informed if they have the greenlight to apply to these sites, and they will be provided with general timelines and possibly with deadlines. Some sites will limit the number of students who can apply from a given program, the Externship Coordinator will select who has the greenlight.

Students should refrain from writing the Externship Coordinator to request updates on externship status. As information is available, the Externship Coordinator will update the student.

Many sites will require completing documentation *before* the externship begins, including another criminal background check, drug screening and finger-printing, or purchase of facility attire, such as scrubs or lab coat. Students are responsible for the cost of these extra requirements and documentations.

### **7c. Supervisor Requirements**

Like the University supervisors, the externship supervisor(s) must hold the following minimum credentials:

- a) A Master's degree in Speech-Language Pathology
- b) Certificate of Clinical Competence in Speech-Language Pathology

c) State license and/or Department of Education Endorsement (if applicable)

A copy of the supervisor's current ASHA certification card and state license, if applicable, must be given to the Externship Coordinator within the first 6 weeks of the externship. This applies to all supervisors that participate in clinical education during the externship. The supervisor must supervise a minimum of **25%** of each client's total treatment and/or evaluations (including screenings). It is the **student's** responsibility to notify the Externship Coordinator if the externship supervisor is not maintaining the proper levels of supervision. Clock hours that are not properly supervised will **not** be counted in your accumulation of ASHA hours. Weekly clock hours of client contact are recorded on CALIPSO.

Mid-term conference calls will be held during each externships. This conference will parallel the documentation of the student's overall mid-term performance using the CALIPSO Performance Evaluation form. At mid-term the student must be informed of current grade (S/U) and an understanding of what is needed to improve performance. A final evaluation (CALIPSO) of the student's overall performance is required from the supervisor and should be returned to the Externship Coordinator by the end of the externship. Note that expectations after the midterm continue to increase, and students who do not perform to expectation or who are struggling should inform the Externship Coordinator as soon as possible so that conference calls and remediation can be discussed. Students who fail an externship do not receive any clock hours for that site, and must apply and enroll for a repeat of the externship in a subsequent semester. Additional remediation steps will be required.

#### **7d. Student – Externship Supervisor Communication**

Each student should be familiar with the externship site's policy regarding lines of communication and professional responsibilities. Site supervisors bear the ethical and professional responsibility for management of clients seen by the student. This means that the site supervisor must approve all recommendations, referrals, and discussions regarding client management before they are implemented. The Externship Coordinator is responsible for communicating proper supervision practices to the supervisor prior to the start of the externship and if needed, re-assigning a graduate student to another site or supervisor if supervision is not adequate.

Respect for professional lines of communication is essential to good client management and avoids placing the student and clients in the position of having to respond to competing and contradictory messages. To gain maximum benefit from this clinical training, students need to maintain open lines of communication with their supervisors. Many unnecessary days of anxiety and difficult situations can be avoided if the supervisor (and Externship Coordinator) are kept informed.

Treat this experience as it is your first professional job. For example, if you are going to be absent, your supervisor must be notified. Any missed days are expected to be made up. However, the student is not expected to "fill-in" for an absent certified clinician nor manage a caseload that is not commensurate with his or her clinical competency. Regardless of what has been learned previously, approach externships as opportunities to develop emerging competencies and acquire new ones.

#### **7e. Student Expectations for Externships...being a Student and a Professional**

Although each externship site is unique and may have specific guidelines for students to follow, some *general* guidelines are meant to serve as recommendations for professional behavior in any site. Students should consult their immediate site supervisor to discuss expectations during the externship. Doing this early can avoid many unnecessary miscommunications for the student and the supervisor. If issues are not resolved, the student should notify the Externship Coordinator so interventions can be made.

- Only the clinical supervisor has been granted clinical privileges at their site. The site supervisor must approve all clinical services you provide.
- These extensions of your academic and clinical education are to provide you with opportunities to learn and not solely to fulfill the required clock hours for graduation. *Be an equal partner in the responsibility of your learning.*
- Treat the externship as you would a job. Demonstrate a positive work ethic. Adhere to the work hours followed by your supervisor.
- Attend the externship for the scheduled duration. Do not arrange time off for vacations or study.
- Be prepared and ready to work with clients.
- Show up on time and where and when you are expected to be someplace. Be accountable to your supervisor when you are on the job.
- Notify your supervisor and office staff **immediately** of any absence. Offer to make up any missed days if the supervisor's schedule allows.
- During any "downtime" from client care, engage in learning opportunities such as treatment planning, studying evaluations, reviewing suggested readings, practicing writing notes or evaluations and helping with miscellaneous facility needs.
- Be involved and absorbed in the site you are participating in. Do not turn down an opportunity to gain more experience because you have already obtained the required clock hours for a particular disorder category.
- Participate and share in your learning by offering to conduct an in-service or share your recent academic background with your supervisor or other related staff. Reciprocal teaching is one of the small 'perks' our program can offer to supervisors for their service.
- Maintain a professional demeanor. Dress and act professionally. Be aware of what you say in front of clients, family members and other staff members and how it may be perceived.
- Remember that you are representing yourself, the University of Wyoming, the Division of Communication Disorders, and the particular site and supervisor with whom you are working when you are working with clients. *What impression will you leave each of them?*

## **7f. Supervisor Expectations for Externships**

Although each externship site is unique and may have specific guidelines for students to follow, these *general* principals are meant to serve as recommendations for site supervisors about the overall clinical learning process. Students' learning will be commensurate with the opportunities provided by each particular site. The Division recommends that supervisors consult with their students early in the externship to discuss their expectations. This may avoid many unnecessary miscommunications between the student and the supervisor. If issues are not resolved, it is

important that the supervisor notify the Externship Coordinator immediately so adjustments can be made.

- Only the clinical supervisor has been granted clinical privileges at their site. The site supervisor is expected to approve all clinical services provided by the graduate student.
- This *extension* of academic and clinical education is to provide students with opportunities to learn, gain hands-on exposure, and to fulfill the required clock hours for graduation and ASHA certification. Supervisors should assist the student by providing a well-balanced clinical experience (treatment, screenings and evaluations).
- Repeated opportunities to learn are a hallmark of any externship. Supervisors should feel confident in providing students with ample opportunities to improve knowledge and skills regardless if the student has obtained “required clock hours” for a particular disorder category.
- The externship should be treated like a job. Supervisors should not require students to perform duties in their absence to “make-up” for lost productivity nor should supervisors expect students to compensate for staffing shortages by being “free labor”. Supervisors should notify their students if they are to be absent. Coverage by another certified SLP within the facility is acceptable. *If the supervisor’s schedule allows*, students should offer to make-up any missed days. Supervisors should contact the Externship Coordinator if attendance is a concern.
- During any “downtime” from client care, supervisors should assign students learning opportunities such as treatment planning, studying evaluations, reviewing suggested readings, practicing report and note writing and learning about the practical aspects of billing and administration of their particular facility.
- Supervisors may request that students extend their learning by having them conduct an in-service or share their academic or clinical knowledge with supervisors or other related staff.
- Supervisors should submit all documentation required by the Division in a timely manner. This includes a copy of ASHA Certification cards, state license, *if applicable*, bi-weekly feedback forms, and mid-term and final performance evaluations on CALIPSO.

**Appendix 7**  
**ASHA Code of Ethics**  
<http://www.asha.org/Code-of-Ethics/>  
(Effective March 1, 2016)

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## **Preamble**

The American Speech-Language-Hearing Association (ASHA; hereafter, also known as "The Association") has been committed to a framework of common principles and standards of practice since ASHA's inception in 1925. This commitment was formalized in 1952 as the Association's first Code of Ethics. This Code has been modified and adapted as society and the professions have changed. The Code of Ethics reflects what we value as professionals and establishes expectations for our scientific and clinical practice based on principles of duty, accountability, fairness, and responsibility. The ASHA Code of Ethics is intended to ensure the welfare of the consumer and to protect the reputation and integrity of the professions.

The ASHA Code of Ethics is a framework and focused guide for professionals in support of day-to-day decision making related to professional conduct. The Code is partly obligatory and disciplinary and partly aspirational and descriptive in that it defines the professional's role. The Code educates professionals in the discipline, as well as students, other professionals, and the public, regarding ethical principles and standards that direct professional conduct.

The preservation of the highest standards of integrity and ethical principles is vital to the responsible discharge of obligations by audiologists, speech-language pathologists, and speech, language, and hearing scientists who serve as clinicians, educators, mentors, researchers, supervisors, and administrators. This Code of Ethics sets forth the fundamental principles and rules considered essential to this purpose and is [applicable to the following individuals](#):

- a member of the American Speech-Language-Hearing Association holding the Certificate of Clinical Competence (CCC)
- a member of the Association not holding the Certificate of Clinical Competence (CCC)
- a nonmember of the Association holding the Certificate of Clinical Competence (CCC)
- an applicant for certification, or for membership and certification

By holding ASHA certification or membership, or through application for such, all individuals are automatically subject to the jurisdiction of the Board of Ethics for ethics complaint adjudication. Individuals who provide clinical services and who also desire membership in the Association must hold the CCC.

The fundamentals of ethical conduct are described by Principles of Ethics and by Rules of Ethics. The four Principles of Ethics form the underlying philosophical basis for the Code of Ethics and are reflected in the following areas: (I) responsibility to persons served professionally and to research participants, both human and animal; (II) responsibility for one's professional competence; (III)

responsibility to the public; and (IV) responsibility for professional relationships. Individuals shall honor and abide by these Principles as affirmative obligations under all conditions of applicable professional activity. Rules of Ethics are specific statements of minimally acceptable as well as unacceptable professional conduct.

The Code is designed to provide guidance to members, applicants, and certified individuals as they make professional decisions. Because the Code is not intended to address specific situations and is not inclusive of all possible ethical dilemmas, professionals are expected to follow the written provisions and to uphold the spirit and purpose of the Code. Adherence to the Code of Ethics and its enforcement results in respect for the professions and positive outcomes for individuals who benefit from the work of audiologists, speech-language pathologists, and speech, language, and hearing scientists.

## **Terminology**

### **ASHA Standards and Ethics**

The mailing address for self-reporting in writing is American Speech-Language-Hearing Association, Standards and Ethics, 2200 Research Blvd., #313, Rockville, MD 20850.

### **advertising**

Any form of communication with the public about services, therapies, products, or publications.

### **conflict of interest**

An opposition between the private interests and the official or professional responsibilities of a person in a position of trust, power, and/or authority.

### **crime**

Any felony; or any misdemeanor involving dishonesty, physical harm to the person or property of another, or a threat of physical harm to the person or property of another. For more details, see the "Disclosure Information" section of applications for ASHA certification found on [www.asha.org/certification/AudCertification/](http://www.asha.org/certification/AudCertification/) and [www.asha.org/certification/SLPCertification/](http://www.asha.org/certification/SLPCertification/).

### **diminished decision-making ability**

Any condition that renders a person unable to form the specific intent necessary to determine a reasonable course of action.

### **fraud**

Any act, expression, omission, or concealment—the intent of which is either actual or constructive—calculated to deceive others to their disadvantage.

### **impaired practitioner**

An individual whose professional practice is adversely affected by addiction, substance abuse, or health-related and/or mental health-related conditions.

### **individuals**

Members and/or certificate holders, including applicants for certification.

### **informed consent**

May be verbal, unless written consent is required; constitutes consent by persons served, research participants engaged, or parents and/or guardians of persons served to a proposed

course of action after the communication of adequate information regarding expected outcomes and potential risks.

**jurisdiction**

The "personal jurisdiction" and authority of the ASHA Board of Ethics over an individual holding ASHA certification and/or membership, regardless of the individual's geographic location.

**know, known, or knowingly**

Having or reflecting knowledge.

**may vs. shall**

*May* denotes an allowance for discretion; *shall* denotes no discretion.

**misrepresentation**

Any statement by words or other conduct that, under the circumstances, amounts to an assertion that is false or erroneous (i.e., not in accordance with the facts); any statement made with conscious ignorance or a reckless disregard for the truth.

**negligence**

Breaching of a duty owed to another, which occurs because of a failure to conform to a requirement, and this failure has caused harm to another individual, which led to damages to this person(s); failure to exercise the care toward others that a reasonable or prudent person would take in the circumstances, or taking actions that such a reasonable person would not.

**nolo contendere**

No contest.

**plagiarism**

False representation of another person's idea, research, presentation, result, or product as one's own through irresponsible citation, attribution, or paraphrasing; ethical misconduct does not include honest error or differences of opinion.

**publicly sanctioned**

A formal disciplinary action of public record, excluding actions due to insufficient continuing education, checks returned for insufficient funds, or late payment of fees not resulting in unlicensed practice.

**reasonable or reasonably**

Supported or justified by fact or circumstance and being in accordance with reason, fairness, duty, or prudence.

**self-report**

A professional obligation of self-disclosure that requires (a) notifying ASHA Standards and Ethics and (b) mailing a hard copy of a certified document to ASHA Standards and Ethics (see term above). All self-reports are subject to a separate ASHA Certification review process, which, depending on the seriousness of the self-reported information, takes additional processing time.

**shall vs. may**

*Shall* denotes no discretion; *may* denotes an allowance for discretion.

**support personnel**

Those providing support to audiologists, speech-language pathologists, or speech, language, and hearing scientists (e.g., technician, paraprofessional, aide, or assistant in audiology, speech-language pathology, or communication sciences and disorders). For more information, read the Issues in Ethics Statements on [Audiology Assistants](#) and/or [Speech-Language Pathology Assistants](#).

### **telepractice, teletherapy**

Application of telecommunications technology to the delivery of audiology and speech-language pathology professional services at a distance by linking clinician to client/patient or clinician to clinician for assessment, intervention, and/or consultation. The quality of the service should be equivalent to in-person service. For more information, [see the telepractice section](#) on the ASHA Practice Portal.

### **written**

Encompasses both electronic and hard-copy writings or communications.

## **Principle of Ethics I**

Individuals shall honor their responsibility to hold paramount the welfare of persons they serve professionally or who are participants in research and scholarly activities, and they shall treat animals involved in research in a humane manner.

### **Rules of Ethics**

- A. Individuals shall provide all clinical services and scientific activities competently.
- B. Individuals shall use every resource, including referral and/or interprofessional collaboration when appropriate, to ensure that quality service is provided.
- C. Individuals shall not discriminate in the delivery of professional services or in the conduct of research and scholarly activities on the basis of race, ethnicity, sex, gender identity/gender expression, sexual orientation, age, religion, national origin, disability, culture, language, or dialect.
- D. Individuals shall not misrepresent the credentials of aides, assistants, technicians, support personnel, students, research interns, Clinical Fellows, or any others under their supervision, and they shall inform those they serve professionally of the name, role, and professional credentials of persons providing services.
- E. Individuals who hold the Certificate of Clinical Competence may delegate tasks related to the provision of clinical services to aides, assistants, technicians, support personnel, or any other persons only if those persons are adequately prepared and are appropriately supervised. The responsibility for the welfare of those being served remains with the certified individual.
- F. Individuals who hold the Certificate of Clinical Competence shall not delegate tasks that require the unique skills, knowledge, judgment, or credentials that are within the scope of their profession to aides, assistants, technicians, support personnel, or any nonprofessionals over whom they have supervisory responsibility.
- G. Individuals who hold the Certificate of Clinical Competence may delegate to students tasks related to the provision of clinical services that require the unique skills, knowledge, and judgment that are within the scope of practice of their profession only if those students are

adequately prepared and are appropriately supervised. The responsibility for the welfare of those being served remains with the certified individual.

- H. Individuals shall obtain informed consent from the persons they serve about the nature and possible risks and effects of services provided, technology employed, and products dispensed. This obligation also includes informing persons served about possible effects of not engaging in treatment or not following clinical recommendations. If diminished decision-making ability of persons served is suspected, individuals should seek appropriate authorization for services, such as authorization from a spouse, other family member, or legally authorized/appointed representative.
- I. Individuals shall enroll and include persons as participants in research or teaching demonstrations only if participation is voluntary, without coercion, and with informed consent.
- J. Individuals shall accurately represent the intended purpose of a service, product, or research endeavor and shall abide by established guidelines for clinical practice and the responsible conduct of research.
- K. Individuals who hold the Certificate of Clinical Competence shall evaluate the effectiveness of services provided, technology employed, and products dispensed, and they shall provide services or dispense products only when benefit can reasonably be expected.
- L. Individuals may make a reasonable statement of prognosis, but they shall not guarantee—directly or by implication—the results of any treatment or procedure.
- M. Individuals who hold the Certificate of Clinical Competence shall use independent and evidence-based clinical judgment, keeping paramount the best interests of those being served.
- N. Individuals who hold the Certificate of Clinical Competence shall not provide clinical services solely by correspondence, but may provide services via telepractice consistent with professional standards and state and federal regulations.
- O. Individuals shall protect the confidentiality and security of records of professional services provided, research and scholarly activities conducted, and products dispensed. Access to these records shall be allowed only when doing so is necessary to protect the welfare of the person or of the community, is legally authorized, or is otherwise required by law.
- P. Individuals shall protect the confidentiality of any professional or personal information about persons served professionally or participants involved in research and scholarly activities and may disclose confidential information only when doing so is necessary to protect the welfare of the person or of the community, is legally authorized, or is otherwise required by law.
- Q. Individuals shall maintain timely records and accurately record and bill for services provided and products dispensed and shall not misrepresent services provided, products dispensed, or research and scholarly activities conducted.
- R. Individuals whose professional practice is adversely affected by substance abuse, addiction, or other health-related conditions are impaired practitioners and shall seek professional assistance and, where appropriate, withdraw from the affected areas of practice.
- S. Individuals who have knowledge that a colleague is unable to provide professional services with reasonable skill and safety shall report this information to the appropriate authority, internally if a mechanism exists and, otherwise, externally.

- T. Individuals shall provide reasonable notice and information about alternatives for obtaining care in the event that they can no longer provide professional services.

## **Principle of Ethics II**

Individuals shall honor their responsibility to achieve and maintain the highest level of professional competence and performance.

### **Rules of Ethics**

- A. Individuals who hold the Certificate of Clinical Competence shall engage in only those aspects of the professions that are within the scope of their professional practice and competence, considering their certification status, education, training, and experience.
- B. Members who do not hold the Certificate of Clinical Competence may not engage in the provision of clinical services; however, individuals who are in the certification application process may engage in the provision of clinical services consistent with current local and state laws and regulations and with ASHA certification requirements.
- C. Individuals who engage in research shall comply with all institutional, state, and federal regulations that address any aspects of research, including those that involve human participants and animals.
- D. Individuals shall enhance and refine their professional competence and expertise through engagement in lifelong learning applicable to their professional activities and skills.
- E. Individuals in administrative or supervisory roles shall not require or permit their professional staff to provide services or conduct research activities that exceed the staff member's certification status, competence, education, training, and experience.
- F. Individuals in administrative or supervisory roles shall not require or permit their professional staff to provide services or conduct clinical activities that compromise the staff member's independent and objective professional judgment.
- G. Individuals shall make use of technology and instrumentation consistent with accepted professional guidelines in their areas of practice. When such technology is not available, an appropriate referral may be made.
- H. Individuals shall ensure that all technology and instrumentation used to provide services or to conduct research and scholarly activities are in proper working order and are properly calibrated.

## **Principle of Ethics III**

Individuals shall honor their responsibility to the public when advocating for the unmet communication and swallowing needs of the public and shall provide accurate information involving any aspect of the professions.

### **Rules of Ethics**

- A. Individuals shall not misrepresent their credentials, competence, education, training, experience, and scholarly contributions.

- B. Individuals shall avoid engaging in conflicts of interest whereby personal, financial, or other considerations have the potential to influence or compromise professional judgment and objectivity.
- C. Individuals shall not misrepresent research and scholarly activities, diagnostic information, services provided, results of services provided, products dispensed, or the effects of products dispensed.
- D. Individuals shall not defraud through intent, ignorance, or negligence or engage in any scheme to defraud in connection with obtaining payment, reimbursement, or grants and contracts for services provided, research conducted, or products dispensed.
- E. Individuals' statements to the public shall provide accurate and complete information about the nature and management of communication disorders, about the professions, about professional services, about products for sale, and about research and scholarly activities.
- F. Individuals' statements to the public shall adhere to prevailing professional norms and shall not contain misrepresentations when advertising, announcing, and promoting their professional services and products and when reporting research results.
- G. Individuals shall not knowingly make false financial or nonfinancial statements and shall complete all materials honestly and without omission.

## **Principle of Ethics IV**

Individuals shall uphold the dignity and autonomy of the professions, maintain collaborative and harmonious interprofessional and intraprofessional relationships, and accept the professions' self-imposed standards.

### **Rules of Ethics**

- A. Individuals shall work collaboratively, when appropriate, with members of one's own profession and/or members of other professions to deliver the highest quality of care.
- B. Individuals shall exercise independent professional judgment in recommending and providing professional services when an administrative mandate, referral source, or prescription prevents keeping the welfare of persons served paramount.
- C. Individuals' statements to colleagues about professional services, research results, and products shall adhere to prevailing professional standards and shall contain no misrepresentations.
- D. Individuals shall not engage in any form of conduct that adversely reflects on the professions or on the individual's fitness to serve persons professionally.
- E. Individuals shall not engage in dishonesty, negligence, fraud, deceit, or misrepresentation.
- F. Applicants for certification or membership, and individuals making disclosures, shall not knowingly make false statements and shall complete all application and disclosure materials honestly and without omission.
- G. Individuals shall not engage in any form of harassment, power abuse, or sexual harassment.

- H. Individuals shall not engage in sexual activities with individuals (other than a spouse or other individual with whom a prior consensual relationship exists) over whom they exercise professional authority or power, including persons receiving services, assistants, students, or research participants.
- I. Individuals shall not knowingly allow anyone under their supervision to engage in any practice that violates the Code of Ethics.
- J. Individuals shall assign credit only to those who have contributed to a publication, presentation, process, or product. Credit shall be assigned in proportion to the contribution and only with the contributor's consent.
- K. Individuals shall reference the source when using other persons' ideas, research, presentations, results, or products in written, oral, or any other media presentation or summary. To do otherwise constitutes plagiarism.
- L. Individuals shall not discriminate in their relationships with colleagues, assistants, students, support personnel, and members of other professions and disciplines on the basis of race, ethnicity, sex, gender identity/gender expression, sexual orientation, age, religion, national origin, disability, culture, language, dialect, or socioeconomic status.
- M. Individuals with evidence that the Code of Ethics may have been violated have the responsibility to work collaboratively to resolve the situation where possible or to inform the Board of Ethics through its established procedures.
- N. Individuals shall report members of other professions who they know have violated standards of care to the appropriate professional licensing authority or board, other professional regulatory body, or professional association when such violation compromises the welfare of persons served and/or research participants.
- O. Individuals shall not file or encourage others to file complaints that disregard or ignore facts that would disprove the allegation; the Code of Ethics shall not be used for personal reprisal, as a means of addressing personal animosity, or as a vehicle for retaliation.
- P. Individuals making and responding to complaints shall comply fully with the policies of the Board of Ethics in its consideration, adjudication, and resolution of complaints of alleged violations of the Code of Ethics.
- Q. Individuals involved in ethics complaints shall not knowingly make false statements of fact or withhold relevant facts necessary to fairly adjudicate the complaints.
- R. Individuals shall comply with local, state, and federal laws and regulations applicable to professional practice, research ethics, and the responsible conduct of research.
- S. Individuals who have been convicted; been found guilty; or entered a plea of guilty or nolo contendere to (1) any misdemeanor involving dishonesty, physical harm—or the threat of physical harm—to the person or property of another, or (2) any felony, shall self-report by notifying ASHA Standards and Ethics (see Terminology for mailing address) in writing within 30 days of the conviction, plea, or finding of guilt. Individuals shall also provide a certified copy of the conviction, plea, nolo contendere record, or docket entry to ASHA Standards and Ethics within 30 days of self-reporting.
- T. Individuals who have been publicly sanctioned or denied a license or a professional credential by any professional association, professional licensing authority or board, or other

professional regulatory body shall self-report by notifying ASHA Standards and Ethics (see Terminology for mailing address) in writing within 30 days of the final action or disposition. Individuals shall also provide a certified copy of the final action, sanction, or disposition to ASHA Standards and Ethics within 30 days of self-reporting.