Speech Therapy Task Checklist

Initiate at time of Eval and Complete By D/C

Name:_____ **Dx:**_____ **DC Location:**_____ **DC Date**_____

Therapist Completing Form:_____ **Therapist Reviewing Form:**_____

SKILL	✓ = pt performing at highest fxnl level N/A = Not Applicable	SKILL	✓ = pt performing at highest fxnl level N/A = Not Applicable
Safe Swallow		**Communication (cont.)**	
Proper Positioning/Posture		Voice Volume	
Bite size		Formation of phrases and sentences	
Swallowing ability		Accuracy of Yes/No response	
Dysphagia		Oral motor excercises	
Swallow Time/Delay time		Discourse	
Pocketing/Coughing		Language usage	
Pharyngeal/laryngeal			
Vocal quality		**Comprehension**	
		Ability to make eye contact	
Diet		Reading ability	
Proper Diet consistency		Following instructions	
Independence with various food textures		Following 1,2,multi step commands	
Liquid consistency		Sequencing	
		Attention Span/	
Cognition			
Short term memory		**Education**	
Long term memory		Caregiver Education	
Problem solving		Equipment need	
Orientation		Home Exc Program	
Attention		Diet at time of DC	
Sequencing			
Safety awareness		**Other**	
Topic maintenance		Trach/Vent	
		Passy muir	
Communication		Vital Stim	
Verbalization			
Naming Objects		Other:	
Word Recall		Other:	
Intelligible Articulation		Other:	