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INTRODUCTION

Welcome to your Diagnostic Practicum experience. This manual is designed to assist you in becoming familiar with the procedures involved in client assessment, both pediatric and adult, at the Marywood University Speech-Language-Hearing Clinic. Another purpose of this manual is to provide you with a reference guide for any questions that may arise during your practicum. If you have any questions after referring to this manual, please contact your Diagnostic Practicum Supervisor, hereafter referred to as your Clinical Supervisor. If additional questions or concerns remain, contact Ms. Renee Jourdanais, Clinic Director.

During the practicum, students will be assigned to work with other clinicians during diagnostic evaluations. Team members will work alone or with another student clinician, as well as a Clinical Supervisor for each evaluation. Your assignments will include screenings as well as pediatric and adult assessments. The diagnostic team assignment will be based on the established schedule as well as the client’s availability. In addition to scheduled screenings and evaluations throughout the course of the semester, each team will also have scheduled meeting times to prepare for evaluations, complete documentation, and meet with supervisors. Specific time requirements will be discussed during initial meetings with Clinical Supervisors.

Again, welcome to the diagnostic practicum of your graduate clinical preparation program.

INITIAL CONTACT

When a family contacts the Marywood University Speech-Language-Hearing Clinic, a clinical services referral form is filled out by the Clinic Director. A case history and release forms as well as a clinic brochure and informational packet of clinic policies/procedures are then sent to the family, and an appointment is scheduled by the Clinic Director. Once the client’s file has been compiled it will be transferred to the filing cabinet in the clinic preparation room. The Clinical Supervisors and clinicians will be updated as new additions or changes are made on the diagnostic schedule by the Clinic Director.

Please note that all release forms must be signed and returned to the client’s file before information/reports may be released and evaluation/treatment sessions may be video and/or audio taped. (Please see following pages for examples of above-mentioned forms.)
Client’s Name: ___________________________ Date: __________________

Client’s Address: ___________________________

D.O.B. _____________ Age: ______ Sex: Male _____ Female ______

Medical DX: ___________ S/L DX: ________________

Contact Name: ___________________________ Telephone #: __________________

Referral Source: __________________________ Physician: __________________________

**Insurance:**

BC/BS: __________________________ Pay: __________________________

GHMO: __________________________ Other: __________________________

Scheduling Deposit Fee Paid: __________________________

Day preference: (circle) Monday Tuesday Wednesday Thursday

Time preference: (circle) 9:00 10:00 11:00 1:00 2:00 3:00 4:00

Reason for Referral: _____ Speech/Language _____ Fluency _____ Voice

_____ Other (specify): __________________________

Additional comments: __________________________

____________________________________________

Case History Form Sent: __________ Date Returned: ________________

Clinical Recommendation: __________________________

Semester: __________________________ First Billable TX Date ________________

Signature: __________________________

*Forward copy to department assistant*

*Revised Fall 2015*
The Speech-Language-Hearing Clinic is operated in conjunction with the Marywood University Department of Communication Sciences and Disorders. It is a supervised training experience for undergraduate and graduate student clinicians. Periodically, audio/video tape samples of individual clients may be made to assist students in the learning process. The exchange of any or all information obtained in connection with the rendering of clinical services at the Speech-Language-Hearing Clinic will be made available confidentially for academic, clinical, and/or scientific purposes.

Date:________________________ Client’s Name:______________________________________________
Signature: __________________________________________________________
Relationship to Client: ________________________________________________
Marywood University, 2300 Adams Avenue, Scranton, Pennsylvania, 18509.

Signature: ________________________________

Relationship to Client: ________________________________

Date: ________________________________
Date ___________________

I hereby give permission to the Marywood University Speech-Language-Hearing Clinic to release information on

________________________________________

________________________________________

________________________________________

To:

________________________________________

________________________________________

________________________________________

Signature:________________________________________

Relationship to Client:______________________________
MARYWOOD UNIVERSITY
DEPARTMENT OF COMMUNICATION SCIENCES AND DISORDERS
SPEECH-LANGUAGE-HEARING CLINIC
Case History (Child)

The following questions are asked so that we may better understand your child. Please read them carefully and answer as fully as possible. If you are not sure how to answer some of the questions, please tell us and we will discuss them. If you need more space, use the back of the sheet.

Please Print
Date ________________________________

Your child’s full name _____________________________________ Date of Birth __________________________

Address ________________________________________________
(Number) (Street) (City) (State) (Zip)

Telephone __________________________ School (Preschool) ___________________________ Grade _______

Name of person completing our questionnaire ______________________________ Relationship to child __________

Family Physician ______________________________

Address of Physician ______________________________________

HISTORY OF PREGNANCY AND BIRTH

1. Is mother Rh negative? _________ Were there illnesses during her pregnancy with this child? ______

Did mother have to stay in bed? _________ Take medications (other than vitamins)? _________

Any complications during pregnancy? _________

If yes to any of these please explain: _____________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________

2. Length of pregnancy __________________________ Was labor very long or especially short? _________

If yes, estimate time __________________________ Was the birth of this child without complication? _________

Any notable trauma? _________ If so, please explain: ________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________
What was the child’s weight at birth? __________________________________________________________

3. Did the child have any trouble breathing after birth? ____________ Was the child kept in an
   incubator after birth? __________ Why? ______________________________________________________

Did the child look blue or yellow after birth? ______ How long? ________________ Did the
   child come home from the hospital with the mother? ____________ If not, why? _________________________

4. Is this child adopted? ______________ How old was he/she when adopted? ___________________________

DEVELOPMENTAL HISTORY

1. At what age did the child sit alone? ____________ Crawl? __________ Walk by himself? __________
   Was this child very active as a baby? __________________________________________________________

2. Was feeding the child a problem? ____________ Why? __________________________________________
   When was he/she taken off the bottle or breast? ________________________ Was this a problem? ______

3. Is the child a fussy or “picky” eater now? ______ Does he seem to have any trouble swallowing? _____
   Chewing? __________ Does the child eat with a spoon? __________ Fork? __________ Both? ______

4. Was toilet training a problem? ____________ When was the child completely trained? __________
   Does the child wet the bed at night now? __________ How frequently? _____________________________
   Does the child wet or soil himself during the day? __________ How often? __________________________

5. Does the child dress himself completely? __________ Partially? __________
   Does he/she button? ________ Tie shoes? __________

6. Does the child fall frequently? __________ How well can he/she climb? _________________________
   Throw a ball? ____________ Ride a tricycle? ____________ Ride a two wheel bike? ____________ Run? __________

7. Which hand does the child use to eat with? _________________ Draw or write? ______________________
   Throw a ball? ______________________________
MEDICAL HISTORY

1. Has the child been back in the hospital since birth? ______________ If so, explain (operations, accidents, etc.), and give age and date of occurrence. __________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

2. Has the child had other serious illnesses? ________________ If so, describe. ______________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

3. Has the child ever fainted or passed out? _____________ Has he ever had a convulsion? ______
How many? __________ Describe __________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

4. Does the child have any problem hearing? __________ Has he/she had ear infections, running ears, ear aches? ____________ If yes, explain. _____________________________________________________________

________________________________________________________________________________________

5. Does the child see normally? __________ Does he/she wear glasses? ______________

6. Is this child allergic to anything? __________ If yes, what? _____________________________

7. Does the child take any medicine regularly except vitamins? __________ If so, what and why?

8. Does he/she seem to display an “overly” active behavior or lack of attention? ________________

9. Does the child receive an “excess” amount of sugar or sweets? ________________________________
10. Has the child ever been seen by a specialist? ___________ If so, describe the circumstances _________

_________________________________________________________________________________________

SPEECH AND LANGUAGE DEVELOPMENT

1. Was the child very quiet as a baby (did not babble and coo as most babies)? _____________________

Did he/she cry excessively? _________________________________________________________________

2. What is the primary language spoken in the home?__________________________________________

3. How old was the child when he began to say words? _______________________________
How old was the child when he/she began putting 2 or 3 words together in a phrase? _________________

4. How much does the child talk now? ______________________________________________________

5. How much of this speech can parents understand?  All? ________  Most? _______  Some? _______
How much can other adults understand?  All? _________  Most? _________ Some? _________ None? _____

6. How much does the child use gestures to help others understand? _______________________________

7. Has the child learned to say nursery rhymes? _________  Prayers? _________ Sing songs? _________

8. Do parents feel the child stutters or stammers? ____________________________________________

If so, when did this begin? ________________ Is the child aware? _____________________________

9. Does child’s voice sound like other children’s voices? _________ If no, describe: Very soft _________
Very loud _________  Hoarse _________  Nasal _________  Other ______________

10. Does the child have any reading difficulties?________________________________________________

11. Have parents done anything to help child with his/her speech? _________ If so, explain _____________

_________________________________________________________________________________________

12. Did the speech learning ever seem to stop for a period? ___________ When? _________________

13. Has there been a change in his/her speech in the last six months?__________________________

14. Has he/she ever talked better than he/she does now? ___________ When? _________________

15. What is the self reaction to his/her speech? _______________________________________________
FAMILY

1. Are parents now separated? ______________ Divorced? ______________ If so, how old was the child when this occurred? ______________ Has either parent been married previously? ______________ Which one? ______________ Is either parent deceased? ______________

2. Father’s name _______________________________________________________ Age __________
   Occupation ______________________________________ Level of education ________________________

3. Mother’s name ______________________________________________________ Age __________
   Occupation ______________________________________ Level of education ________________________
   If mother works, who takes care of the child? ____________________________________________
   How old was the child when mother went to work? ________________________________________

4. Give names and ages of other children in the family. ____________________________
   ________________________________________________________________________________
   ________________________________________________________________________________
   ________________________________________________________________________________

5. Are there relatives, on either side of the family, who have had:
   _____ Trouble speaking clearly or who have been late in learning to talk?
   _____ Trouble with their hearing?
   _____ Trouble learning in school so that they left school or failed several grades, or who have had real trouble learning to read?
   _____ Problems like epilepsy, intellectual disabilities, cerebral palsy etc. If so, describe problem.

ADDITIONAL INFORMATION

1. Describe this child’s behavior (i.e. quiet, moody, independent, etc.) __________________________
   ________________________________________________________________________________
   ________________________________________________________________________________
   ________________________________________________________________________________

2. Does the child enjoy having books read to him or read by himself/herself? ____________________

3. What are the child’s interests/favorite activities? ________________________________________
4. Does the child play well alone? ______________ With younger children? _______________
With older children? _______________ With his brothers and sisters? _______________

What do you feel is this child’s problem? ____________________________________________

Please list any doctors, clinics, hospitals or any other agencies plus dates where your child has been evaluated.

_________________________________________________________________________________________

_________________________________________________________________________________________

_________________________________________________________________________________________

EDUCATIONAL HISTORY

1. Preschool _______________ Public School ___________ Private School _______________

2. Has the child had any previous speech or language therapy? _________ When? _______________
Where? __________________________________________________ Please describe the problem or therapy.

_________________________________________________________________________________________

3. Is the child in a mainstreamed in a regular education classroom? _____________ Is the child in a
learning support classroom? ____________ Does the child have an aide while at school? _______________
Please Print  
Date ____________________________

Name ____________________________
(Last) (First) (Middle) 

Address ____________________________
(Number) (Street) (City) (State) (Zip) 

Date of Birth ____________________________ Telephone ____________________________
(Month) (Day) (Year) (Area Code) (Number) 

Name of Person Completing this Questionnaire ____________________________

Relationship to Client ____________________________

Family Physician ____________________________

Address of Physician ____________________________
(Number) (Street) (City) (State) (Zip) 

Name of person who referred you to this Clinic ____________________________

Why has an appointment been requested? ____________________________

MEDICAL HISTORY

List illnesses, injuries, childhood diseases, operations, and medications. Please give dates and length of disability. Include any physical handicaps, prolonged fevers, convulsions, etc.

(Illness, injury, operation, or medication) ____________________________ (Date) ____________________________

(Illness, injury, operation, or medication) ____________________________

(Illness, injury, operation, or medication) ____________________________

(Illness, injury, operation, or medication) ____________________________
Do you feel you have a hearing problem? No_____ Yes____
If yes, explain

________________________________________________________
________________________________________________________

Do you have a history of hearing loss, ear infections, drainage from your ears, etc.? No_______ Yes_______
If yes, please explain

________________________________________________________
________________________________________________________

Do you ever have any difficulty swallowing foods or liquids? No_______ Yes_______
If yes, explain

________________________________________________________
________________________________________________________

Have you ever received therapy for your swallowing difficulty, or utilized any type of compensatory strategies or diet/liquid modifications to assist in swallowing? No________ Yes________
If yes, please explain

________________________________________________________
________________________________________________________

EDUCATION AND SOCIAL HISTORY
Are you retired? Yes_______ No_______
If employed, what is your occupation?

________________________________________________________

How long have you been employed in your present position?

________________________________________________________

Please indicate the highest level of education you have attained:

Grade School ________ College Graduate ________
High School ________ Graduate School ________
College ________ Other ________
If other, please explain

________________________________________________________
Please indicate your marital status: Single ________ Married _____

Divorced _____ Separated _____

Please list names and ages of your children:

_________________________________________________________________________

_________________________________________________________________________

Do you reside with anyone? ______ If so, list ____________________________________________

HISTORY OF SPEECH PROBLEM
(To include any speech, language, cognitive, fluency, and voice difficulties)

Native Language: ____________________ Primary language spoken in home: _______________________

Describe your communication problem_____________________________________________________

_________________________________________________________________________

_________________________________________________________________________

The date of onset of the communication problem? ________________________________

Have you ever been treated for your communication problem? No______ Yes______

If yes, please explain___________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

What have you done to improve your communication problem?________________________________

_________________________________________________________________________

_________________________________________________________________________

Have your communication skills become better or worse during the past six months? ________________

Under what circumstances, if any, does your communication improve? ________________________________

_________________________________________________________________________
Are there relatives, on either side of the family, who have had communication difficulties? If so, please explain.

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

Please list any doctors, clinics, hospitals, or any other agencies where you have been seen for previous therapy.

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________
MARYWOOD UNIVERSITY
DEPARTMENT OF COMMUNICATION SCIENCES AND DISORDERS
SPEECH-LANGUAGE-HEARING CLINIC
Accent Modification- Adult Case History

Name: _______________________________ Date: _______________________________
Address: _______________________________
____________________________________
Home Phone: __________________________
Cell Phone: __________________________
E-Mail Address: _________________________ Date of Birth: _______________________

Occupation: ___________________________ Employer: ___________________________
Highest Level of Education Completed: ___________________________________________
If a Student, List University and Major: ___________________________________________

Marital Status: _________________________
Name of Spouse or Nearest Relative: _______________________________________________

Native Language: _________________________ Primary Language: ___________________

1. Please explain why you wish to be evaluated in our clinic?

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

2. What do you hope to gain through using our services?

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

3. Have you ever received previous instruction for your speech production and/or language skills? If so, please include when and where.

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

4. When did you begin to study English? ________________________________

5. How long have you been speaking English? ________________________________

6. How long have you lived in the United States? ________________________________

7. How often do you speak English? (e.g. only in class / at work, only occasionally with English speaking peers, etc.) ________________________________
8. What language do you speak when you are with others from your native country?
______________________________________________________________________________

9. How confident are you in your ability to speak English?
   Confident-----------------Somewhat Confident-----------------Not Confident
   5  4  3  2  1

10. How confident are you in your use of English vocabulary?
    Confident-----------------Somewhat Confident-----------------Not Confident
    5  4  3  2  1

11. How confident are you in the use of grammatical structures of standard American English?
    Confident-----------------Somewhat Confident-----------------Not Confident
    5  4  3  2  1

12. How easily is your speech understood by native English speakers?
    Easily Understood-----------------Usually Understood-----------------Not Understood
    5  4  3  2  1

13. In what situations, if any, do you have to speak in front of others?
______________________________________________________________________________
______________________________________________________________________________

14. Do you feel like you know the vocabulary needed to adequately express yourself? If no, please explain.
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

15. Which English speech sounds are the most difficult for you to produce?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

16. What speaking situations do you feel most confident?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

17. When speaking English, what speaking situations make you most nervous?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

18. Do you have difficulty understanding individuals who speak English as their first language? If yes, please explain.
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
19. What do you do when a listener does not understand you?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

20. Do you have any medical conditions that may impact your speech and/or language? If yes, please explain.
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

21. Do you have any history of hearing loss or hearing deficits? If yes, please explain.
______________________________________________________________________________
______________________________________________________________________________
The following questions are asked so that we may better understand your child. Please read them carefully and answer as fully as possible. If you are not sure how to answer some of the questions, please tell us and we will discuss them. If you need more space, use an additional piece of paper.

Please Print
Date _____________________

Your child’s full name __________________________________Date of Birth __________________________

Address ____________________________________________
(    Number)    (    Street)    (    City)    (    State)    (    Zip)

Telephone ____________________ School (Preschool) ____________________________ Grade __________

Name of person completing our questionnaire ________________________________________________

Relationship to child _____________________ Family Physician ________________________________

Address of Physician ________________________________________________________________

Who is your referral source? ______________________________________________________________

What is the reason for your referral? _______________________________________________________

List any medical diagnoses: ______________________________________________________________

When he/she was first diagnosed with that condition? _________________________________________

With whom does the child live? ___________________________________________________________

What do you hope to accomplish by coming to the Clinic? ____________________________________

____________________________________________________________________________________

____________________________________________________________________________________
COMMUNICATION STATUS

1. How would you describe the child’s current communication ability (indicate using rating scale below)?

1: Almost never  2: Sometimes  3: Frequently

___ Is very easy for me to understand when I know the topic of conversation
___ Is fairly easy for me to understand when I know the topic of conversation
___ Is difficult for me to understand when I know the topic of conversation
___ Is very easy for me to understand if I DON’T know the topic of conversation
___ Is fairly easy for me to understand if I DON’T know the topic of conversation
___ Is difficult for me to understand if I DON’T know the topic of conversation
___ Is usually understood by other people who don't know him/her well
___ Is usually NOT understood by other people who don't know him/her well

2. Please describe how the child communicates the following:
   a) Wants and needs:
      __________________________________________________
      __________________________________________________
      __________________________________________________
      __________________________________________________

   b) Things that happened in the past or will happen in the future:
      __________________________________________________
      __________________________________________________
      __________________________________________________

   c) Gives or asks for information/help:
      __________________________________________________
      __________________________________________________
      __________________________________________________
      __________________________________________________

   d) Protests:
      __________________________________________________
      __________________________________________________
      __________________________________________________

   e) He/She communicates during play by:
      __________________________________________________
      __________________________________________________
      __________________________________________________

   f) What other things does he/she do to communicate (e.g. cry, whine, look to something he wants)?
      __________________________________________________
      __________________________________________________
      __________________________________________________

   g) What gestures does this child make (e.g. pointing, motioning to “come here”, tugging for attention, push you away to protest?)
      __________________________________________________
      __________________________________________________
      __________________________________________________

3. What sounds can the child produce? (e.g. “b”, “duh”, “ah”)
      __________________________________________________
      __________________________________________________
      __________________________________________________
4. How many words are in the child’s vocabulary? ______

5. Can the child consistently produce a word approximation (e.g., always says “ca” for “cup”)  
   ___Yes ___No  
   If yes, please list these word approximations:

______________________________________________________________________________________
______________________________________________________________________________________

6. Can the child write words? ___Yes ___No

7. Can the child copy words? ___Yes ___No

HISTORY OF PREGNANCY AND BIRTH

1. Is mother Rh negative? __________ Were there illnesses during her pregnancy with this child? ______
   Did mother have to stay in bed? __________ Take medications (other than vitamins)? __________
   Any complications during pregnancy? __________
   If yes to any of these please explain: ______________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________

2. Length of pregnancy _______________________ Was labor very long or especially short? ___________
   If yes, estimate time _________________ Was the birth of this child without complication? __________
   Any notable trauma? __________ If so, please explain: _________________________________________
   ______________________________________________________________________________________

3. Did the child have any trouble breathing after birth? ____________ Was the child kept in an 
   incubator after birth? __________ Why? _____________________________________________________
   Did the child look blue or yellow after birth? _______ How long? ________________ Did the 
   child come home from the hospital with the mother? __________ If not, why? ____________________
   ______________________________________________________________________________________

4. Is this child adopted? ____________ How old was he/she when adopted? ______________________
DEVELOPMENTAL HISTORY

1. At what age did the child sit alone? ___________Crawl? ___________Walk by himself? _________
Was this child very active as a baby? ________________________________________________

2. Was feeding the child a problem? ___________Why? ____________________________________
When was he/she taken off the bottle or breast? ________________________ Was this a problem? ______

3. Is the child a fussy or “picky” eater now? ______ Does he seem to have any trouble swallowing? _____
Chewing? ___________ Does the child eat with a spoon? ___________Fork? ___________ Both? ______

4. Was toilet training a problem? ___________ When was the child completely trained? ___________
Does the child wet the bed at night now? ___________ How frequently? ______________________
Does the child wet or soil himself during the day? _______ How often? ______________________

5. Does the child dress himself completely? _______ Partially? __________
Does he/she button? ________ Tie shoes? __________

6. Does the child fall frequently? ___________ How well can he/she climb? ______________________
Throw a ball? ___________ Ride a tricycle? ________Ride a two wheel bike? ________Run? ________

7. Which hand does the child use to eat with? _________________ Draw or write? _________________
Throw a ball? ______________________________

8. Coordination: ___good ___clumsy

9. Does the child use any of the following? (Check all that apply):
   _____Wheelchair _____Walker _____Special Chair
   _____Other special equipment (describe)_________________________________________

If a wheelchair is used, please describe the following:
Make: ________________________________________________________________
Motorized: ____________________________ Manual: ____________________________
Lap Tray Measurements: ________________________________________________
10. Check all that apply to your child:

- Eating problems
- Sleeping problems
- Difficulty concentrating
- Needs a lot of discipline
- Interactive
- Excitable
- Laughs easily
- Cries a lot
- Difficult to manage
- Overactive
- Sensitive
- Gets along with adults
- Stays with an activity
- Makes friends easily
- Happy
- Irritable
- Easily frustrated
- Attentive
- Easily distracted
- Memory difficulty
- Difficulty reading
- Easy going personality
- Rigid personality
- Difficulty attending to tasks
- Difficulty attending in noisy environments
- Easily transitions between activities and environments

11. Would the child separate easily for therapy?  ____Yes____ No

MEDICAL HISTORY

1. Has the child been back in the hospital since birth? _______________ if so, explain (operations, accidents, etc.), and give age and date of occurrence. ____________________________________________________________

2. Has the child had other serious illnesses? _______________  If so, describe.  ___________________

3. Has the child ever fainted or passed out? ___________  Has he ever had a convulsion? ______________

   How many? ___________  Describe  __________________________________________________________

4. Does the child have any problem hearing? ___________  Has he/she had ear infections, ear drainage, ear aches? ___________  If yes, explain.  __________________________________________________________

5. Is visual acuity a concern? ___________  Does he/she wear glasses? ______________

6. Is this child allergic to anything? ___________  If yes, what?  __________________________________________________________

7. Does the child take any medicine regularly except vitamins? ___________  If so, what and why? _______

8. Has the child ever been seen by a specialist? ___________  If so, describe the circumstances ________
SPEECH AND LANGUAGE DEVELOPMENT

1. Describe how the child babbled and cooed as a baby______________________________________________________________

Did he/she cry excessively? If yes, please explain______________________________________________________________

2. Does your child effectively communicate in (Check all that apply):
   ___ Asking for wants/needs? ___ Getting your attention?
   ___ Labeling people, things, or pictures around him/her? ___ Asking questions?
   ___ Greeting people? ___ Asking for help?
   ___ Sharing information/commenting?

*If your child had/ has any ability to verbalize please complete #3-12:

3. How old was the child when he began to say words? ______________________ How old was the child when he/she began putting 2 or 3 words together in a phrase? ______________________

4. How much does the child talk now? ________________________________________

5. How much of this speech can parents understand? All? ______ Most? ______ Some? ______
   How much can other adults understand? All? ______ Most? ______ Some? ______ None? ______

6. Do parents feel the child stutters or stammers? ________________________________________
   If so, when did this begin? ____________ Is the child aware? _________________________________

7. Does child’s voice sound like other children’s voices? ______ If no, describe: Very soft ______
   Very loud ______ Hoarse ______ Nasal ______ Other _______________________

8. Have parents done anything to help child with his/her speech? __________ If so, explain __________

9. Did the speech learning ever seem to stop for a period? __________ When? ______________________

10. Has there been a change in his/her speech in the last six months?________________________________

11. Has he/she ever talked better than he/she does now? __________ When? ______________________

12. What is the self-reaction to his/her speech? ________________________________________________
AIDED COMMUNICATION

Please complete if your child is using/has used an augmentative system:

1. Has the child in the past, or does he/she currently use an augmentative communication device or any assistive technology at home, school, and/or private therapy? _____ yes     _____ no

If he/she has used in the past only, briefly explain why he/she is not currently using/drawbacks:
____________________________________________________________________________________
____________________________________________________________________________________

2. Who evaluated the child for the augmentative communication device or assistive technology?
____________________________________________________________________________________
Name of the device:_______________________________________  Age of the Device:____________

How long has the child been using an augmentative system ?________________________________

3. Please list all communication systems used in the past and indicate whether the system proved to be successful or unsuccessful:

<table>
<thead>
<tr>
<th>System</th>
<th>Successful</th>
<th>Unsuccessful</th>
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<tbody>
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<td>_______</td>
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</tbody>
</table>

4. If your child uses communication boards, books, devices to communicate please provide additional information regarding:

Symbol type:
___Text
___PECS (Picture Exchange Communication System)
___Mayer-Johnson PCS
___Photographs
___Other; Describe: ______________________________________________________

Number of symbols per page/display: _____

Presentation:
___Removable icons
___Static grid

Access:
___Point
___Symbol exchange
___Other;  Describe: ______________________________________________________

5. He/she primarily uses the augmentative system:
___Imitatively
___In response to questions
___In response to commands (e.g., “Show me what you want.” )
___Spontaneously (I.E., on his/her own initiative without any cueing)
6. Environments where device is used (Check all that apply)
   ___Structured school activities
   ___In therapy
   ___At home during structured tasks
   ___Most of the time spontaneously
   ___All of the time spontaneously

7. Are modifications necessary to accommodate visual impairments?  ___Yes  ___No

8. Can the child combine symbols to form a message?  ___Yes  ___No  If yes, how many? _________

9. Augmentative system use: (Check all that apply)
   ___Initiates communication with the system
   ___Uses the system to ask and answer questions
   ___Needs direction/prompting
   ___Single key is used to express a full message
   ___Able to participate in a conversation using a device
   ___Functional spelling skills
   ___Uses system as a backup to speech
   ___Makes wants/needs known with device
   ___Navigates device with assistance
   ___Navigates independently
   ___Explores the device but does not use functionally

10. Parents knowledge of device:
    ___New device, no experience
    ___Basic skills (on/off, navigation)
    ___Can program
    ___Advanced programming

11. Access: (Check all that apply)
    ___Direct selection (touchscreen, keyboard
    ___Keyguard (yes/no)
    ___Scanning:  Type of switch:___________  Type of scanning:_____________________________
    ___Joystick
    ___Headmouse
    ___Eyegaze  ___Other   Please describe:___________________________________________

12. In your opinion which can your child most easily control the movement of:
    ___Eyes  ___Head  ___Foot  ___Right hand  ___Left hand

13. Does he/she use a splint?  ___Yes  ___No  If yes, where?
__________________________________________________________________________________

FAMILY

1. Are parents now separated? ______________  Divorced? ______________ If so, how old was the child
when this occurred?___________________  Has either parent been married previously? ______________
Which one? _________________  Is either parent deceased? ________________________________

2. Father’s name _______________________________________________________   Age ___________
   Occupation ______________________________________  Level of education ______________________

3. Mother’s name ______________________________________________________  Age ____________
   Occupation ______________________________________  Level of education ______________________
If mother works, who takes care of the child? __________________________________________________
How old was the child when mother went to work? ____________________________________________

4. Give names and ages of other children in the family.______________________________
________________________________________________________________________________________

5. Are there relatives, on either side of the family, who have had:
   _____ Trouble speaking clearly or who have been late in learning to talk?
   _____ Trouble with their hearing?
   _____ Trouble learning in school so that they left school or failed several grades, or who have had real trouble learning to read?
   _____ Problems like epilepsy, intellectual disabilities, cerebral palsy etc. If so, describe problem.

   ADDITIONAL INFORMATION

1. Describe this child’s behavior (i.e. quiet, moody, independent, etc.) ___________________________
________________________________________________________________________________________
________________________________________________________________________________________

2. Does the child enjoy having books read to him or read by himself/herself? ______________________

3. What are the child’s interests/favorite activities? __________________

4. Does the child play well alone? ____________ With younger children? _______________
   With older children? _________________ With his brothers and sisters? _______________
What do you feel is this child’s problem?___________________________________________________

28
Please list any doctors, clinics, hospitals or any other agencies plus dates where your child has been evaluated.

______________________________________________________________________________
______________________________________________________________________________

5. Do you have a working computer your child uses at home? _____Yes _____No

6. How frequently does your child use the computer? _____Never _____Occasionally _____Daily
   Purpose of the computer use: (check all that apply)
   ___Educational tool
   ___Reward
   ___Communication
   ___Play games

7. How does your child access the computer? (Check all that apply)
   ___Mouse
   ___Adaptive access (E.g., IntelliKeys, touch window, etc.)
   ___Keyboard
   ___My child does not independently access the computer

EDUCATIONAL HISTORY

1. Preschool __________________ Public School ______________ Private School _________________

2. Has the child had any previous speech or language therapy? ________ When? ________________
   Where? ________________________________________________ Please describe the problem or therapy.

3. Current Placement/Grade: ________________________________________________________________

4. Does the child have an aide with him/her in school?
   _____Yes _____No
   If yes, does this aide work with your child?
   _______ All day _______ About half of the day _______ Less than half of the day
   _______ Just this child _______ Several children _______ The whole class
PRE-DIAGNOSTIC PLANNING

The diagnostic team will review the information once the client’s file is completed. Files for clients who have been previously seen at the Clinic can be requested from your Clinical Supervisor, as they are located with our archive files.

The Clinical Supervisor and members of the diagnostic team will meet one week prior to the evaluation to plan the diagnostic process for each client. The planning form is collaboratively filled out by both clinicians prior to the meeting time established, and based on the discussion that follows the case presentation. The team should also be prepared to discuss the order of the evaluation based on priorities noted on the intake form and/or documentation received from the family. The Evaluation Planning Form can be changed and/or approved by the Clinical Supervisor based on discussion at the planning meeting. (See Evaluation Planning Form that follows.)

The Clinical Supervisor in conjunction with team members will assign responsibilities to each team member, however the diagnostic team should come prepared with a decision of which team member will compete specific portions of the evaluation. The team performing the evaluation will be responsible for the initial interview, administration, scoring, and interpretation of assigned formal and informal assessment procedures, as well as review of results with the client and/or family. The team (in conjunction with the Clinical Supervisor) will contact the clinical audiologist a week prior to the diagnostic evaluation to inform them that a speech/language evaluation is taking place should their services be needed for a more comprehensive screening or if an audiological evaluation is requested by the client/family (as needed). Also, the team must be sure that a doctor’s prescription has been placed in the client’s chart and that all necessary insurance coverage information has been obtained (including precertification where appropriate).

Following the planning meeting, the team will conduct a pre-assessment contact with the client/family who will be evaluated the following week. The group should inform the Clinical Supervisor once contact and confirmation has been made, and the phone conversation should be logged and initialed on the Communication Log Sheet located in the client’s file. If a message was left and no contact was made, the clinicians should attempt to contact the client/family until confirmation of evaluation has been attained. The purpose of this contact is to:

1. Explain the purpose and procedures of the assessment process.
2. Discuss options for the family’s participation.
3. Gather and/or review pertinent case history information.
4. Discuss any other relevant information the family may need to know or provide to prepare for the assessment (Including doctor’s prescription, insurance information, billing concerns).
5. Confirm the scheduled appointment as well as the directions to the clinic.

Since each team will be responsible for audio taping an evaluation, it is important for you to be familiar with the digital recording equipment. Contact a Clinical Supervisor for further instructions.

***The Clinic Director and/or the Clinical Supervisor will notify team members of any cancellations on the day of the evaluation. It is important that your Clinical Supervisor has your current phone number for cancellations or change of information.
MARYWOOD UNIVERSITY
DEPARTMENT OF COMMUNICATION SCIENCES AND DISORDERS
SPEECH-LANGUAGE-HEARING CLINIC
Graduate Diagnostic Practicum Evaluation Planning Form

1. List relevant information obtained from case history form/previous reports from other professionals.

2. List all standardized tests planned for administration and provide a rationale for selected measures.

3. Describe all informal assessment procedures planned for administration and provide a rational for selected measures.

4. Prepare a list of questions for client/family interview based on information obtained from case history/other reports.
TESTING MATERIALS

Once the team members have decided which tests will be administered in the evaluation, they can locate them in the Student Preparation Room. It is MANDATORY to sign in and out any materials used. The Clinical Materials Log Book is located adjacent to the faculty mailboxes. Please be respectful of everyone’s need to use the materials. DIAGNOSTIC TESTS ARE ONLY TO BE REMOVED FROM THE CLINIC AREA ACCORDING TO CLINIC REGULATIONS (see last page of this manual for further information). In addition, if AAC devices/IPads are needed for the evaluation, you will need to sign these out for the time of any meeting and or the evaluation itself. (this sign out sheet is located on the bulletin board in the student preparation room. Test forms are located in the Student Preparation Room.

It is the tester’s responsibility to make one copy of the original test form. The copied form should be used as your working copy during the diagnostic. Your supervisor will also be scoring along with you during the evaluation. You should record each client response concurrently IN PENCIL onto your working copy. The working copy should be scored and submitted to your Clinical Supervisor within 24 hours from the start of the evaluation. When finalized and approved by your Clinical Supervisor, client responses can then be transferred in ink to the original test form and placed in the client’s chart.

It is important to practice test administration. It may be helpful to administer each test to at least 2-3 times as a trial before you administer the test to the client. It may also be helpful to write notes IN PENCIL on the test form as reminders while you are administering the test. Remember, it is your ethical responsibility to be proficient in test administration prior to working with the client.
DAY OF EVALUATION

Plan on arriving at the clinic a minimum of 30 minutes before the scheduled evaluation appointment time. Each team is responsible for audiotaping the evaluation. The supervisor will set up the video recording and consult the diagnostic team regarding area being taped. The assigned team will be responsible for obtaining testing/reinforcement materials, organizing the testing area, and preparing the audio equipment for the evaluation.

Organize the testing room appropriately with tests, appropriate toys (where applicable) and clinical materials. To comply with Universal Precautions use disposable gloves during the oral-motor assessment and wash your hands thoroughly after the evaluation. Also wash any materials that may have been mouthed or drooled on with 10:1 water/bleach solution. Have a penlight and stopwatch and any other materials required for a specific test. It is suggested that you use a clipboard to hold test forms and organize your paperwork. Begin the diagnostic only when the Clinical Supervisor is ready.

All diagnostics will consist of formal testing and informal assessment procedures including receptive and expressive language. A communication/language sample, articulation/phonology assessment, oral peripheral examination, observations or assessment of voice, fluency, pragmatics, and an audiological screening/assessment will be obtained, as appropriate. A parent/caregiver/client interview will also be conducted.

Once your client has arrived, you escort them along with the clinical supervisor into the testing room from the reception area. Be sure that all of the following forms have been signed: authorization for exchange and use of clinical information, release of information forms, and consent to usage and disclosure form. All of these forms must be kept in the client’s file.

Your Clinical Supervisor will be in the testing room during the evaluation. The sequence of tests and component parts of the evaluation will be decided upon by the team members in conjunction with your Clinical Supervisor. It is suggested that the client’s primary area of concern be addressed first.

A Diagnostic Practicum Evaluation Form containing an evaluation performance rating scale follows. This will be used by the Clinical Supervisor to assess individual evaluation skills and clinical competencies. You will also receive a Diagnostic Practicum Report Critique Form (which follows) each time you conduct an evaluation. This form collectively scores both you and your partner for writing the report and completing all pertinent documentation. Please review these forms and address any questions with your Clinical Supervisor.
MARYWOOD UNIVERSITY
DEPARTMENT OF COMMUNICATION SCIENCES AND DISORDERS
Diagnostic Practicum Performance Evaluation
Revised 12/1/2016

Client’s Initials: ___________________________ Student Clinician: ___________________________

Age: ___________________________

Supervisor: ___________________________ ASHA #: ___________________________

Tests Administered: ___________________________ Date: ___________________________

Rating Criteria: Please use the following scale to rate each graduate student clinician.

5= Demonstrates independence with occasional collaboration with the supervisor. Makes changes when appropriate and is effective; excellent.
4= Needs minimal direction from supervisor to perform effectively/complete written assignments; above average.
3= Needs general direction with occasional specific direction from the supervisor to perform effectively/complete written assignments; average.
2= Needs specific direction /assistance from supervisor to perform effectively/complete written assignments; below average.
1= Specific direction from the supervisor is needed to perform effectively/complete written assignments with limited application; poor.
0= No points earned due to omission of forms and/or content areas.
N/A= Not applicable
Developing and Planning Evaluation
1. Reviews and demonstrates understanding of available relevant information (case history, prior reports, etc.)
2. Develops appropriate questions for client/family interview based on information obtained from case history or other reports
3. Selects age and disorder appropriate standardized measures
4. Selects specific and appropriate informal assessment procedures
5. Demonstrates ability to provide rationale for selected measures
6. Prompt and prepared for meeting with supervisor
7. Selects order of evaluation and clinician roles

Implementing Evaluation - Client/Family Interview
8. Explains evaluation procedures to the client/family member
9. Asks open-ended questions in a manner that elicits maximum information from the informant
10. Probes for clarification when informant provides unexpected information
11. Demonstrates sensitivity towards client/family (i.e. active listening, patience, adequate response time, awareness of cultural/linguistic diversity, etc.)
12. Asks questions in a clear, concise manner without using professional jargon/slang

Implementing Evaluation - Testing
13. Prepares for test administration by organizing materials and environment
14. Administers formal and informal tests in a timely and orderly manner

15. Formal Testing Procedures
   a. Presents materials according to test administration instructions
   b. Provides clear and concise directions
   c. Uses appropriate universal precautions
   d. Establishes correct start point, basal and ceiling levels
**Professional Interactions/Expectations**

- Uses appropriate speaking rate, pitch, volume
- Uses non-verbal communication effectively (i.e. proximity, facial expression, eye contact, etc.)
- Appears interested in client/family member’s success
- Demonstrates flexibility during the evaluation, as appropriate
- Complies with universal precautions during all clinical situations
- Dresses professionally
- Adheres to ASHA Code of Ethics
- Responds appropriately to supervisor’s feedback within the evaluation
- Contacts family prior to the evaluation
- Demonstrates the ability to work effectively on a team (i.e. peer interactions, sharing information/resources, etc.)

30. One yes equals 1/2 point on a five-point scale for a total of five points

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Total

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Supervisor’s Comments:

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Total Points          0    divided by number of items scored          1      {exclude N/A items} =  Total          0.0
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**Graduate Clinicians**

<table>
<thead>
<tr>
<th>Grade</th>
<th>Score Range</th>
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<tbody>
<tr>
<td>A</td>
<td>4.6 - 5.0</td>
</tr>
<tr>
<td>A-</td>
<td>4.0 - 4.5</td>
</tr>
<tr>
<td>B+</td>
<td>3.7 - 3.9</td>
</tr>
<tr>
<td>B</td>
<td>3.4 - 3.6</td>
</tr>
<tr>
<td>B-</td>
<td>3.0 - 3.3</td>
</tr>
<tr>
<td>C+</td>
<td>2.5 - 2.9</td>
</tr>
<tr>
<td>C</td>
<td>2.0 - 2.4</td>
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<tr>
<td>F</td>
<td>&lt; 2.0</td>
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</table>
I have read the evaluation of my clinical performance and I would/would not (circle one) like to make the following statement.

Student Clinician: __________________________ Date: ________________

Supervisor: __________________________ Date: ________________

ASHA #: __________________________
MARYWOOD UNIVERSITY  
DEPARTMENT OF COMMUNICATION SCIENCES AND DISORDERS  
Diagnostic Practicum Report Critique  
Revised 12/1/16

Student Clinician: ___________________________  
Client's Initials: __________________________

___________________________  
Age: _________________________

Supervisor: ___________________________  
ASHA #: ________________________

Date of Evaluation: _________________________  
Date: _________________________

Rating Criteria: Please use the following scale to rate each graduate student clinician.

5= Demonstrates independence with occasional collaboration with the supervisor to complete  
   written assignments. Makes changes when appropriate and is effective; excellent.
4= Needs minimal direction from supervisor to complete written assignments effectively; above average
3= Needs general direction with occasional specific direction from the supervisor  
   to complete written assignments; average.
2= Needs specific direction/assistance from supervisor to complete written assignments; below average
1= Specific direction from the supervisor is needed to complete written assignments  
   with limited application; poor.
0= No points earned due to omission of forms and/or content areas.
N/A= Not applicable

Identifying Information
1. Input Relevant Personal Information
2. Includes Appropriate Diagnosis

Background Information
3. Reason for Referral
4. Developmental Milestones
5. Medical History
6. Social/Educational/Occupational History
7. History of Services
8. Current Status

Comments

0 Items Scored
0.00
Evaluation Results
9. Behavioral Observations
   a. Situation Assessed
   b. Difficulties Noted
   c. Parent/Spouse/Caregiver/Clinician Interactions

10. Pragmatics
    a. Situation Assessed
    b. Content Areas Included
    c. Overall Statement

11. Language
    a. Tests Administered
    b. Charts Included with Appropriate Set-up and Content
    c. Subtests Identified and Explained
    d. Strengths and Weaknesses Identified
    e. Detail/Trends Noted
    f. Overall Subtest Statements with Severity
    g. Overall Test Diagnosis with Severity

12. Language/Narrative Sample
    a. How Obtained
    b. Content/Form/Use and/or Stages
    c. Strengths/Weaknesses Identified
    d. Normative Information Included
    e. Overall Statement with Severity

13. Articulation
    a. Tests Administered
    b. Charts Included with Appropriate Set-up and Content
    c. Detail/Trends Noted
    d. Developmental/Normative Information Included
    e. Overall Test Diagnosis with Severity

14. Phonology/Motor Speech/Cognitive-Linguistic (if tested formally)
    a. Tests Administered
    b. Charts Included with Appropriate Set-up and Content
    c. Detail/Trends Noted
    d. Developmental/Normative Information included
    e. Overall Test Diagnosis with severity
15. Voice/Fluency/Resonance (if tested formally)
   a. Test Administered/Informal Assessment
   b. Subjective/Objective Data
   c. Normative Information
   d. Subtest Descriptions
   e. Overall Testing Diagnosis with Severity

16. Oral Motor Assessment
   a. How Obtained/Arcaes Assessed
   b. Strengths/Weaknesses Identified
   c. Normative Information Included
   d. Overall Statement with Severity

17. Hearing Screening
   a. Audiometer Used
   b. Objective Data Included
   c. Overall Statement

   Items Scored
   0.00

Clinical Impressions
18. Overall Diagnosis
19. Tests Administered
20. Areas of Deficit
21. Results and Recommendations Reviewed
22. Prognostic Statement Included

Recommendation
23. Overall Recommendation
24. Appropriate Behavioral Objectives Established
25. Appropriate Short Term Goals
26. Appropriate Long Term Goals

   Items Scored
   0.00

Writing Mechanics
27. Organization of Report
28. Clarity and Conciseness
29. Coherency and Redundancy
30. Edit Drafts Before Submission
Cover Letters
31. All Components of Professional Letter Included
32. Writing Style Suitable to Recipient
33. Includes Pertinent/Accurate Information

Revisions and Timeliness:
Note: For each revision of the report beyond the first, 0.1 points will be deducted from the student's overall grade, 0.25 points will be deducted for late submission of the report, test forms and/or audio and video tapes.

Overall Grade determination:
Items 1 through 8 weighted at 5% of overall grade
Items 9 through 10 weighted at 10% of overall grade
Items 11 through 17 weighted at 40% of overall grade
Items 18 through 26 weighted at 30% of overall grade
Items 27 through 33 weighted at 15% of overall grade

Supervisor's Comments:
Initial Grade: 0.00

Deductions: 0

Final Grade: 0.0

Numerical Equivalency:
A  4.6 - 5.0
A- 4.0 - 4.5
B+ 3.7 - 3.9
B  3.4 - 3.6
B- 3.0 - 3.3
C+ 2.5 - 2.9
C  2.0 - 2.4
F  < 2.0

I have read the final evaluation of my clinical performance and I would/would not (circle one) like to make a statement.

Student Clinician: ___________________________ Date: ___________________________

Student Clinician: ___________________________ Date: ___________________________

Supervisor: ___________________________ Date: ___________________________

ASHA#: ___________________________________
Client's Initials: ______________________  Student Clinician: ______________________

Age: ______________________

Supervisor: ______________________  ASHA #: ______________________

Tests Administered: ______________________  Date: ______________________

Rating Criteria: Please use the following scale to rate each graduate student clinician.

5= Demonstrates independence with occasional collaboration with the supervisor. Makes changes when appropriate and is effective; excellent.
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1= Specific direction from the supervisor is needed to perform effectively/complete written assignments with limited application; poor.
0= No points earned due to omission of forms and/or content areas.
N/A= Not applicable
**Implementing Evaluation - Client/Family Interview**
1. Explains evaluation procedures to the client/family member
2. Asks open-ended questions in a manner that elicits maximum information from the informant
3. Probes for clarification when informant provides unexpected information
4. Demonstrates sensitivity towards client/family (i.e. active listening, patience, adequate response time, awareness of cultural/linguistic diversity, etc.)
5. Asks questions in a clear, concise manner without using professional jargon/slang

---

**Implementing Evaluation - Testing**
6. Prepares for test administration by organizing materials and environment
7. Administers formal and informal tests in a timely and orderly manner
8. Formal Testing Procedures
   a. Presents materials according to test administration instructions
   b. Provides clear and concise directions
   c. Uses appropriate universal precautions
   d. Establishes correct start point, basal and ceiling levels
9. Administers hearing screening appropriately
   a. Follows appropriate screening protocol
   b. Provides clear and concise directions
10. Uses language and clinical approach that is appropriate to the client's age and level of functioning
11. Provides appropriate feedback and reinforcement

---

**Scoring**
12. Demonstrates the ability to accurately transcribe or score protocols concurrently with test administration
13. Transcribes speech and language samples accurately after reviewing audio and videotapes
14. Scores tests accurately (standard scores, percentiles, etc.)
15. Prepared to discuss scoring/errors with supervisor at conclusion of evaluation
**Interpretation of Results**

16. Identifies and interprets informal evaluation data in order to formulate clinical impressions
17. Identifies and interprets formal evaluation data in order to formulate clinical impressions
18. Utilizes clinical impressions to formulate appropriate recommendations
19. Explains evaluation results and recommendations accurately to the client/family

**Total Points**  
0 divided by number of items score 0 (exclude N/A items) =  
Total: 0.0

**Supervisor's Comments:**

---

**WRITTEN PORTION OF MOCK EVALUATION**

**Background Information**
1. Reason for referral
2. Medical history
3. History of services
4. Current status

**Evaluation Results**
5. Behavioral Observations
   a. Situation assessed
   b. Difficulties noted
   c. Parent/spouse/caregiver/clinician interactions

---

0 Items Scored
0.00
6. Pragmatics
   a. Situation assessed
   b. Content areas included
   c. Overall statement

   **Formal Testing Procedures**
   7. (Test)
      a. Test administered/informal assessment
      b. Objective data
      c. Normative information
      d. Subtest descriptions
      e. Strengths/weaknesses/trends identified
      f. Subtest overall statements with severity
      g. Overall testing diagnosis with severity

   **Informal Testing Procedures**
   8. Oral Motor
      a. How obtained/areas assessed
      b. Subjective data/weaknesses identified
      c. Normative information included
      d. Overall statement with severity

   9. Hearing Screening
      a. Objective data included
      b. Subjective data included
      c. Overall statement

   **Clinical Impressions**
   10. Overall diagnosis
   11. Tests administered
   12. Areas of deficit
   13. Results and recommendations reviewed
   14. Prognostic statement included
Recommendation
15. Overall recommendation
16. Appropriate behavioral objectives established
17. Appropriate short term goals
18. Appropriate long term goals

Writing Mechanics
19. Organization of report
20. Clarity and conciseness
21. Coherence and redundancy
22. Edit drafts before submission

Cover Letters
23. All components of professional letter included
24. Writing style suitable to recipient
25. Includes pertinent/accurate information

Revisions and Timeliness:
Note: For each revision of the report beyond the first, 0.1 points will be deducted from the students overall grade, 0.25 points will be deducted for late submission of the report, test forms and/or audio and video tapes.

Overall Grade determination:
Items 1 through 4 weighted at 5% of overall grade
Items 5 through 6 weighted at 10% of overall grade
Items 7 through 9 weighted at 40% of overall grade
Items 10 through 18 weighted at 30% of overall grade
Items 19 through 25 weighted at 15% of overall grade

Deductions: ____________________________
Supervisor's Comments:

Written Report Evaluation Summary

Initial Grade: 0.00

Deductions: 0

Final Grade: 0.0

Numerical Equivalency:

<table>
<thead>
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<th>Grade</th>
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<td>C</td>
<td>2.0 - 2.4</td>
</tr>
<tr>
<td>F</td>
<td>&lt; 2.0</td>
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</tbody>
</table>
I have read the final evaluation of my clinical performance and I would/would not (circle one) like to make a statement.

Student Clinician: ___________________________ Date: ____________

Supervisor: ___________________________ Date: ____________

ASHA#: ___________________________
### Diagnostic Practicum Summary

**Marywood University**  
**Department of Communication Sciences and Disorders**  
**Speech-Language-Hearing Clinic**  
Revised 01/01/11

Graduate Student Clinician: ___________________________ Semester: ___________________________

<table>
<thead>
<tr>
<th>Client Initials and Date</th>
<th>Performance Grade</th>
<th>Report Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation 1</td>
<td></td>
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<td>Evaluation 2</td>
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<td>Evaluation 3</td>
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<td>Evaluation 4</td>
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<tr>
<td>Evaluation 5</td>
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</table>

Final Performance Grade: _____________

Final Report Grade: _____________

Final Overall Grade: _____________

Graduate Student Clinician: ___________________________ Date: _____________

Clinical Supervisor: ___________________________ Date: _____________

**ASHA #:** ___________________________

Clinical Supervisor: ___________________________ Date: _____________

**ASHA #:** ___________________________

Clinical Supervisor: ___________________________ Date: _____________

**ASHA #:** ___________________________
POST EVALUATION

Regardless if therapy is warranted, a review of the evaluation results will be completed with the client/family. If therapy is indicated, treatment will be discussed at the family conference following the evaluation. Indicate client’s preferences for days and times of therapy on the Clinical Services Referral form in the client’s folder, if the Clinic Director has not previously completed this. Inform the client that the Clinical Director or Clinical Supervisor will contact them to arrange treatment appointments, if needed. Make sure the correct phone number for the client is listed. The Clinical Supervisor will distribute the Attendance Policy and the Family Satisfaction Evaluation Survey (see next page for sample.)

The Clinical Supervisor is to escort the client/family to the front office at the completion of the evaluation for payment. If clients are paying privately, payment in full is required on the day of the evaluation. If the client is covered by insurance, the established copay (if required by insurance) will be paid on the day of evaluation. The Clinical Supervisor will then be responsible for forwarding the information of the evaluation to the billing clerk. If a complete hearing evaluation needs to be completed on another day payment will be taken for the speech/language evaluation and separate billing will be completed for the hearing evaluation once completed. The Clinical Supervisor should review any billing information with the client/family. Team members are to remain following the diagnostic for a complete “wrap-up” session (case discussion, clean-up, etc.)

All COPIES of test forms and the language sample must be placed in the client’s folder immediately following the diagnostic evaluation. The client’s file will then be placed in the REPORT PENDING FILE in the designated drawer of the locked file cabinet located in the Student Preparation Room until the report is completed. The tester(s) is (are) responsible for scoring all formal tests administered. Copies of test forms and the first draft of behavioral objectives for the client must be submitted to the Clinical Supervisor within 24 hours of the time of the evaluation’s starting time; the first draft of the report and cover letters within 48 hours of the evaluation completion. Subsequent returns of the test forms or evaluation reports should be handed in within 24 hours of supervisor’s corrections. Once approved, the ORIGINAL test forms must be completed in PEN and filed in the client’s chart. All drafts will be forwarded to your Clinical Supervisor.

Responses MUST be recorded at the time of test administration rather than relying on audio or video equipment, which can malfunction. Remember that all test materials used AT ANY TIME must be signed in and out. Daily diagnostics are continuing and you need to be mindful that others need to use the testing materials. Finally, be sure to make notes on the Communication Log Sheet, which is found inside the front cover of the client’s file, of any contacts with the client or client’s family. A note should be entered following the diagnostic evaluation indicating that the diagnostic evaluation was completed. The notes are made in ink, initialed, and dated.

A post assessment contact should be conducted (if warranted) with the client. Procedures may include:

1. Allow the family sufficient time to review and discuss the evaluation results and recommendations.
2. Contact the parents/caregivers to determine if they have additional questions or would like to further discuss the information contained in the diagnostic evaluation report.
3. Convey assessment results and recommendations, with permission of informant, to spouses and other family members who were not present at the time of the evaluation as appropriate and necessary.
4. Thank the family for their participation and contribution to the assessment process and leave the lines of communication open to the family to contact you in the future, as necessary.

If contact is complete or attempted, document on the Communication Log Sheet.
Thank you for your interest in the Marywood University Speech-Language-Hearing Clinic. We hope that you were pleased with the evaluation and/or therapeutic services at our clinic. It is at this time that we ask you for your help in evaluating the quality of the speech-language-hearing services that you received at our facility. Please take a few minutes to respond to the items on this survey that pertain to your visit, and then return it in the enclosed postage paid envelope to the Marywood University Speech-Language-Hearing Clinic.

To ensure anonymity we ask that you not write your names on the surveys; however please feel free to write comments or concerns that you may have regarding the services that you received. If you have any questions or would like to further discuss this questionnaire please feel free to contact me at 570-348-6299 ext. 2608.

Thank you again for your participation in this survey and for the opportunity to be of service to you.

Sincerely,

Renee Jourdanais, MS, CCC-SLP
Clinic Director
Read each item carefully and circle the one answer that is best for you. Please be sure to mark NA (Not Applicable) if an item does not pertain to you. We ask that you provide an explanation in the comment section for a score of 2 or below so that we can address any concerns and make appropriate changes. Any additional comments are also welcome.

**Strongly Agree - 4**  **Agree - 3**  **Disagree - 2**  **Strongly Disagree - 1**  **NA - 0**

**PROFESSIONAL STAFF**

1. The supervisor was courteous, pleasant, and professional.  
   
   4 3 2 1 0

2. The supervisor created a comfortable atmosphere for sharing information.  
   
   4 3 2 1 0

3. The supervisor was knowledgeable.  
   
   4 3 2 1 0

4. The student clinician was courteous, pleasant, and professional.  
   
   4 3 2 1 0

5. The student clinician created a comfortable atmosphere for sharing information.  
   
   4 3 2 1 0

6. The student clinician was knowledgeable.  
   
   4 3 2 1 0

7. The supervisor/student clinician explained schedules, treatment procedures, and therapies to my satisfaction.  
   
   4 3 2 1 0

**CLINIC SERVICES**

1. The treatment sessions were scheduled at a convenient time for my family and/or me.  
   
   4 3 2 1 0

2. The supervisor and student clinician clearly reviewed the results of the treatment sessions.  
   
   4 3 2 1 0

3. Opportunities were offered to me, my spouse, and/or other family members to observe the treatment sessions.  
   
   4 3 2 1 0

4. Opportunities were offered to me, my spouse, and/or other family members to contact the supervisor to discuss any further concerns and/or ask additional questions.  
   
   4 3 2 1 0

5. The supervisor and student clinician made me aware of payment information and insurance coverage.  
   
   4 3 2 1 0
6. The services provided were adequate and benefited my family member and/or me.  
   
7. I would recommend the Marywood University Speech-Language-Hearing Clinic to other individuals.  

**ASSESSMENT PROCESS (Please complete only if a Speech-Language Evaluation was completed.)**

1. The evaluation was scheduled and conducted in a timely manner.  
   
2. To prepare for the evaluation process, the supervisor and student clinician discussed the purpose of the evaluation.  
   
3. Sufficient time was allowed for me and/or family members to ask questions and provide information.  
   
4. The supervisor's responses to my questions were clear and helped me and/or members of my family understand the nature of the communication problem and the recommended course of treatment.  
   
5. If used, professional terminology throughout the evaluation and subsequent report was clearly explained.  
   
6. The supervisor or student clinician encouraged me and/or other family members to participate in the evaluation.  
   
7. The supervisor or student clinician encouraged me and/or other family members to participate in the decision-making process about treatment recommendations and goals.  
   
8. Evaluation results were discussed in detail and additional referrals to other professionals were made if necessary.  
   
9. In my opinion, the speech-language evaluation was conducted in a family-centered manner.  

**COMMENTS (Your comments are appreciated and will help us to enhance our clinical services. Please feel free to use the reverse side of this survey for additional space.)**
THE DIAGNOSTIC REPORT

The schedule for the submission of the rough draft report and cover letters is as follows:

- Tuesday evaluation- report due by 12pm on Thursday
- Thursday evaluation- report due by 10:30am on Tuesday
- Friday evaluation- report due by 12pm on Tuesday

** Any changes in diagnostic practicum times may result in a modified schedule. The supervisors will provide specific time frames if necessary.

An outline of a diagnostic evaluation report is provided. The report should be **double-spaced for the first submission only and back-to-back for all submissions.** Include copies of all test forms as well as any correspondence when reports are submitted. Failure to initially hand in all paperwork will result in a loss of points based on the missing information (e.g., .25pts deducted from the report, and subsequent 0 scores for any/or all missing sections). All revisions *MUST* include all previous drafts. Subsequent rewritten reports are submitted to the Clinical Supervisor within 24 hours. After that time, 0.1 points will be deducted per day from your grade until the report is re-submitted.

A cover letter should be written to each individual/agency receiving the evaluation report, and is to be included with the first draft of the evaluation report. Until approved, these letters should be on plain white paper.

The following information pertains to typing requirements for diagnostic reports for *FINAL copies ONLY.*

1. Cover letters will be typed on clinic letterhead stationary; one plain paper copy for chart.
2. Reports will be typed single spaced and back-to-back on plain white paper.
3. See example report form for appropriate format and style of report.
4. Spacing: Follow the spacing indicated in the report outline (i.e., double spacing between the name and paragraphs, single spacing within paragraphs.)
5. Signature lines: These should appear as indicated on the outline. Be sure you include the name, degree, and certification of the Clinical Supervisor.
6. Computer printed reports must be letter perfect using the font Times New Roman with font size 12.
A. IDENTIFYING INFORMATION

Name: Date of Birth:
Address: Date of Evaluation:
Telephone Number: Physician:
Parents (if applicable): Diagnosis:

B. BACKGROUND INFORMATION

1. Reason for Referral
Medical diagnosis, communication difficulties, etc.

2. Pertinent History
Age, handedness, previous medical history (risk factors), hemiplegia, hemianopsia

   Localizing information: CT scan, EEG, etc.

   Social history, marital status, living situation

   Education/occupational history

   Previous history of speech, language, hearing or learning problems

C. EVALUATION RESULTS

1. Behavioral Observations: orientation, affect, lability, motivation, insight

2. Pragmatics: include information on turn taking, topic maintenance, eye contact, etc.

3. Language: results of formal and informal language assessment to include all four-language modalities
   a. Auditory Comprehension
   b. Reading Comprehension
   c. Verbal Expression
   d. Graphic Expression
   e. Gestural Expression (if applicable)
   f. Alternative and Augmentative Communication (if applicable)

4. Speech:
   a. Oral Peripheral Speech Mechanism: comment on structure and function.
b. **Speech intelligibility/Speech production**: results of informal/formal testing which could include word, sentence, or conversational levels.

c. **Voice/Fluency/Resonance**: (if tested formally) comment on pitch, loudness, quality, resonance (as appropriate) as well as rate and stress patterns (as appropriate) if not reported on in the oral peripheral speech mechanism section.

5. **Audiological Status**: include results from hearing screening or audiological evaluation (e.g., hearing acuity, auditory discrimination)

6. **Additional Considerations**: if applicable (e.g., swallowing ability)

**D. CLINICAL IMPRESSIONS**

a. diagnosis with severity level
b. test(s) given with significant aspects of the communication disorder
c. results and recommendations reviewed with client/family
d. prognosis

**E. RECOMMENDATIONS**

Statements regarding the following should be included:

a. the need for intervention (i.e., comment whether or not therapy is warranted at this time or if a re-evaluation should be scheduled and when)
b. if therapy is recommended, comment on the type (individual, group) frequency and length of treatment sessions
c. list specific long and short term goals that will be addressed in therapy
d. recommendations for services to other professionals, if applicable

__________________________
<table>
<thead>
<tr>
<th>Supervisor’s Name, Degree, CCC/SLP</th>
<th>Graduate Clinician’s Name, Degree</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Title) Clinical Supervisor</td>
<td>Graduate Student Clinician</td>
</tr>
</tbody>
</table>
A. IDENTIFYING INFORMATION

Name: Date of Birth:
Address: Date of Evaluation:
Telephone Number: Physician:
Parent Name: Diagnosis:

B. BACKGROUND INFORMATION

1. Reason for Referral: Medical diagnosis, communication difficulties, etc.
2. Pertinent History: Pregnancy, birth, and developmental milestones

Medical
Speech-language development
Social/Educational

Familial history of communication, speech-language, hearing, learning problems

C. EVALUATION RESULTS

1. Behavioral Observations: (e.g., cognitive and social play skills, level of cooperation/motivation, parent/caregiver-child interaction, and noteworthy physical characteristics)

2. Pragmatics: include information on turn-taking, topic maintenance, eye contact, etc.

3. Language:
   a. Results of formal and informal receptive language assessment (e.g., comment on comprehension of vocabulary and syntax, ability to follow directions, response to question forms; knowledge of linguistic concepts)
b. **Results of formal and informal expressive language assessment** (e.g., language sample-comment of content-form-use interactions, MLU, Brown’s Stage of Syntactic Development; narrative sample—comment on level of narration, chaining, cohesive devices, story grammar components; discourse style, writing sample—comment on organization and mechanics)

4. **Speech**

   a. **Oral Peripheral Speech Mechanism:** comment on structure and function

   b. **Oral-Motor/Feeding** (if applicable): comment on food preferences, chewing and cup-drinking patterns of development

   c. **Articulation/Phonology** (formal and informal results): include a statement estimating intelligibility of speech and stimulability potential

   d. **Voice/ Fluency/Resonance:** (if tested formally) comment on pitch, loudness, quality, and resonance (as appropriate) as well as rate and stress patterns (as appropriate) if not reported on in the oral peripheral speech mechanism section.

5. **Audiological Status:** include results from hearing screening or audiological evaluation (e.g., hearing acuity, auditory discrimination)

D. **CLINICAL IMPRESSIONS**

   a. diagnosis with severity level

   b. test (s) given with significant aspects of the communication disorder

   c. results and recommendations reviewed with client/family

   d. prognosis

E. **RECOMMENDATIONS**

Statements regarding the following should be included:

   a. the need for intervention (i.e., comment whether or not therapy is warranted at this time or if a re-evaluation should be scheduled and when)

   b. if therapy is recommended, comment on the type (individual, group) frequency, and length of treatment sessions

   c. list specific the long and short term goals that will be addressed in therapy

   d. recommendations for services to other professionals, if applicable

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Supervisor’s Name, Degree, CCC/SLP  
(Title) Clinical Supervisor

Graduate Student Clinician’s Name, Degree  
Graduate Student Clinician

60
All students must attend each scheduled preparation meeting with your Clinical Supervisor, diagnostic evaluation, and/or other scheduled times with your diagnostic partner(s). Each individual student will receive a 0.3 deduction (one letter grade) for any missed preparation session. If a diagnostic evaluation is missed, a 0 grade will be earned for both the performance and report writing grades. This will be calculated as part of your final grade. There are no make-ups based upon the established departmental protocol. In cases of family/medical emergencies, contact your Clinical Supervisor, prior to the time of the meeting/evaluation and a decision regarding the absence will be dealt with on a case by case basis. Documentation will be required for any excused absence. In the case of a prospective client cancelling the evaluation, all attempts will be made to find another client to fill the evaluation spot, however, there are no guarantees provided.

Client confidentiality is critical. Discussion of any client in the hallways or in any public area is prohibited. Violation of client confidentiality will result in notification of the Department Chairperson and Program Director. Breech of confidentiality or failure to comply with other clinic/diagnostics policies and procedures may result in Academic Probation or dismissal from the graduate program.

Audiotapes of all diagnostic sessions are the property of the CSD Speech-Language-Hearing Clinic and should be erased upon completion of the evaluation and/or report.

Client files and test forms as well as tape recorders MUST remain in the Clinic area at all times. Testing materials may be checked out according to the attached regulations.

Students must follow the dress code for the Clinic. Student clinicians are meeting the public in a professional capacity and are to dress accordingly. Women should wear skirts, dresses, or nice slacks. It is inappropriate to wear tank tops, low-cut tops, leggings, shorts, jeans, jean-like pants/jackets, or sneakers. Men should wear a dress shirt with nice slacks. In the summertime, sandals are allowed, however, they must be worn with stockings or socks at all times when you have direct client contact. Lip and tongue piercings should be removed as they may interfere with intelligible speech, a skill that is expected of all student clinicians. Nose rings should also be removed, and visible tattoos covered prior to working with your clients. These types of accessories, although used to show individuality and diversity, are not considered to be acceptable when working with clients at the Marywood University Speech-Language-Hearing Clinic. In addition, students need to be neat and clean in appearance/hygiene when working with clients in the clinic area. If a CSD faculty or clinical staff member deems a student’s attire to be inappropriate or the student to be lacking in appearance/hygiene, the student will be asked to leave and return with the appropriate attire/appearance/hygiene. If the student is not able to return in a timely manner, he/she will not be able to participate in the evaluation and will earn the 0 grade for both the performance and report writing grades.

Additional clinic policies and procedures can be found in the Clinic Handbook that was distributed during the first semester of the graduate program.

As a reminder, a performance grade of B-(3.0) or better must be earned for each diagnostic evaluation in order to accrue clinical hours for that evaluation. In addition, an overall grade of B- (3.0) for the entire practicum must be earned in order to advance to 519I, 520E; EDUC 597.
MARYWOOD UNIVERSITY  
DEPARTMENT OF COMMUNICATION SCIENCES AND DISORDERS  
SPEECH-ANNUALGE-HEARING CLINIC  
Regulations for Checking Out Testing Equipment

1. Only one test of any type may be checked out at one time.

2. All test checked out during the day (8:30 am to 4:00 pm) must be returned by 4:00 pm! Any test to be checked out over night or for a weekend must be checked out between 4:00 pm and 4:30 pm and returned by 8:30 am the following morning (in case of weekend, by 8:30 am on Monday morning).

3. If you have a test checked out during the day and returned by 4:00 pm you may not check out the same test overnight or for the weekend if someone else requests the test.

4. Students taking CSD 521 Diagnostic Practicum in Speech-Language Pathology have first options on all tests

5. No one can check out a test for anyone else

6. ALL RULES WILL BE FOLLOWED- NO SPECIAL FAVORS!!!!!!!!!!! The first infraction of these rules means you will not be able to check out any test for one week. The second infraction means you will have your grade lowered one letter grade (C+ to a C, C to a D+ etc.)

I am cognizant of the fact that if I lose a test, damage a test, or lose or damage any part thereof, I will replace it, assuming full financial responsibility. Without my signature of responsibility, I will not be allowed to use CSD tests and equipment outside of the Clinic Building.

______________________________  
Signature/Date
Diagnostic Remediation:
To remediate unmet Formative Assessment (FA) learning outcomes as related to the Knowledge and Skills Acquisition (KASA) form, an Academic/Clinical Support Plan (ACSP) will be developed that outlines the following:

1. Learning outcomes to be remediated, course number/instructor, plan for remediation, date remediation due, and results of remediation with date of completion. All ACSP will be initiated after all other diagnostic responsibilities for the course have been finished. The limit to any ACSP is three submissions/demonstration of designated skills (eg. 3 drafts of a report; first draft and 2 revisions). If the ACSP exceeds the end of the semester an “X” grade (temporary delay in reporting grade) will be given until the ACSP is completed to ensure that the ACSP is finished in a timely manner. (As a reminder, in order to successfully transition to off-campus placement sites, CSD 521 and all learning outcomes related to diagnostic practicum that are included in the FA manual must be passed.)

2. At the completion of the ACSP, the instructor will assign one of two competency levels: satisfactorily completed or not satisfactorily completed. Earning a “not satisfactorily completed” would indicate that a Beginning Competency (BC) level of competency could not be given for a learning outcome. If the instructor judges that the ACSP was “not satisfactorily completed” further opportunities for diagnostic remediation would be necessary.

3. Further diagnostic opportunities will require the student clinician to register for an additional diagnostic practicum (1 credit). This practicum will need to be completed during the first 5 weeks of the fall semester (note; this will affect the start date of the off-campus externship and potential end date in order to meet minimum timeframes). It should also be noted that any off-campus placement site has the right to deny the student clinician a late start date. If this is the case, the graduation date would be delayed by one semester in the next year.

4. Student clinicians would need to complete the additional 1-credit diagnostic practicum passing both the course as well as meeting all FA manual learning outcomes. If this does not occur, the student clinician would forfeit their externship in the fall semester and the plan of study would need to be modified.