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2. CLINICAL POLICIES AND PROCEDURES

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9. APPENDIX A-E
CLINICAL EDUCATION PROGRAM

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- Clinical Roles and Responsibilities
- Conflict Resolution
- Clock Hour Description
- Sample Student Schedules
University of Maryland
Clinical Education Program in Speech-Language Pathology

Mission
The clinical training component of the Department of Hearing and Speech Sciences provides education which integrates professional practice, scholarship, research, and community service. It operates the Hearing and Speech Clinic on the College Park campus as the primary mechanism to support this mission during students’ first year of training. The clinic provides diagnostic, therapeutic, educational, and consultative services to individuals from the local community who present with a wide variety of communicative disorders. Throughout their participation in the delivery of these comprehensive services, students are supervised and mentored closely by members of the clinical faculty. During the second (final) year of clinical training, students are assigned to externships with experienced speech-language pathologists at schools and hospitals in the Baltimore-Washington area. Upon completion of the program, students are proficient in provision of evidenced-based practice and highly qualified for certification from the American Speech-Language-Hearing Association (ASHA).

The clinical education program is an integral component of the Department of Hearing and Speech Sciences, yet operates with a clear organizational structure of its own.

Clinical Education Program Organizational Chart
Clinical directors ensure that the Hearing and Speech Clinic draws a client population that is sufficiently large and diverse to meet the training needs of graduate students in the department and operates on a fiscally responsible basis. Clinical faculty members participate fully in scheduling and operational decisions and carefully monitor the quality of client care. Caseload assignments are determined after thoughtful consideration of many factors including expertise, learning styles, communicative effectiveness, interpersonal skills, and availability. Student clinicians receive new caseload assignments each semester in order to maximize the scope of clinical training.

Goals of the Clinical Education Program
The clinical education program is designed to facilitate students’ knowledge and skills in four main areas. These goals include:

Application of academic/clinical knowledge and technical skills
- Administer screening and assessment tools to collect, interpret, and summarize information to make appropriate diagnoses, recommendations, and referrals.
- Collect, document, and interpret data to monitor treatment efficacy and client progress.
- Select, handle, and modify session materials/activities which are sensitive to each client’s developmental/chronological age, disorder, and culture.
- Design sessions to promote maximum client performance with regard to proxemics, pace, dynamics, and other environmental supports in individual and group sessions.
- Gather information from various sources (e.g., research articles, coursework, conferences) to formulate long and short term behavioral objectives based on task hierarchies appropriate to the client’s chronological/developmental age, disorder, and culture.
- Use effective teaching strategies (e.g. modeling, guided practice, prompting, delivery of task instructions) to maximize client performance.
- Provide appropriate response reinforcement/feedback and performance summaries based on observation and data.
- Identify and evaluate client behavior to formulate effective plans to address problem behaviors and enhance attention and learning.
- Use culturally appropriate counseling strategies to meet assessment and therapy goals (e.g. interview techniques, client/family education, overcoming barriers to progress, appropriate referrals).
- Design therapy plans, activities, and home assignments to promote generalization and maintenance of client’s communication skills.
- Apply clinical knowledge to promote effective communication skills in the local community through
  - Training and education in normal speech and language development, and recognition of risk factors for communication disorders.
  - Monitoring and screening activities.

Oral and written communication
- Communicate effectively and positively with clients, families, supervisors, colleagues, and professionals.
- Present clinical cases information with clarity and professional demeanor (e.g. maturity, technical vocabulary, adjusts for context and setting).
- Write and edit clinical reports including treatment plans, progress reports, and diagnostic reports with attention to appropriate content, style, and mechanics.
Problem solving/critical thinking

- Adjust treatment parameters (e.g., task and stimulus demands, teaching strategies, pace, interaction style, environmental supports) to maximize client performance.
- Engage in clinical problem solving based on knowledge of communication disorders and client needs, and provides rationales for clinical decisions.
- Engage in thoughtful self-evaluation and develop plans for improving clinical effectiveness.

Professional and personal characteristics

- Demonstrate positive and supportive interactions with clients, families and colleagues.
- Demonstrate “ownership” of all immediate and long-term aspects of case management with an increasing level of independence.
- Communicate consistently with supervisors for effective collaboration regarding case management and personal growth.
- Develop/demonstrate personal characteristics that support successful performance in the clinical training program (e.g., consistently positive attitude toward learning, flexibility, initiative, responsibility).
- Follow clinic procedures and abides by professional standards of conduct (e.g., timely reports/logs, client confidentiality, maintenance of files, completing required paperwork).
- Demonstrate knowledge of current professional issues including ethics, business practices, licensure, specialization, scope of practice, legislation, etc.

Clinical Roles and Responsibilities

Student clinicians function as the primary therapist for each individual in their assigned caseload. Responsibilities typically include the following: programming goals and objectives, preparing for sessions, implementing diagnostic and therapeutic activities, collecting and analyzing data, communicating progress, and writing reports. Case supervisors are responsible for ensuring that all aspects of service delivery are carried out in the most appropriate and effective manner. They work closely with student clinicians to develop, implement, and evaluate the diagnostic and therapeutic services provided to clients, and supervise all aspects of communication with families and other interested parties. Generally speaking, student clinicians should receive supervisor approval and verify that appropriate releases of information have been signed prior to engaging in any substantive communication with family members or other professionals regarding their clients. Ultimately, clinical instructors are responsible for all clinical services delivered to specific clients by graduate student clinicians in the department.

Conflict Resolution

Occasionally, a student or clinical instructor may perceive that a problem exists in the supervisory relationship. Within the context of clinical practicum, early problem-solving is crucial for two major reasons:

a) lack of resolution may interfere with student learning and/or affect the quality of client care
b) students need to master the interpersonal and communicative strategies necessary for resolving problematic situations as part of their professional development

If either a student or clinical instructor perceives that a problem exists, the following procedures should be implemented:

1. Discuss the problem together. Simple misunderstandings are often rooted in lack of clear communication and frequently can be cleared up through discussion.
2. If either party feels that discussion has not resolved the situation, the Clinic Director should be contacted immediately. The director will work with both parties to ensure a quick and effective solution to the problem.

3. In the unlikely event that the problem persists, the student may wish to bring the matter to the department chair/ombudsman for discussion.

**Clock Hour Documentation**

All clinical training is documented in a computerized tracking program. Each clinical hour (50 minutes) of direct contact with clients is identified as fitting within one of nine categories described by ASHA (articulation, fluency, voice, language, dysphagia, cognitive, social, modalities, hearing). ASHA no longer specifies minimum numbers of clock hours in any category. However, the Department of Hearing and Speech Sciences does follow an established rubric in order to ensure that all students graduating from the program have been exposed to the widest possible variety of communication disorders. There are nine major categories which represent the various aspects of the profession:

- Articulation
- Fluency
- Voice
- Language
- Dysphagia
- Cognitive (attention, memory, sequencing, executive function)
- Social (challenging behavior, ineffective social skills, lack of communication opportunities)
- Modalities (oral, manual, augmentative, alternative)
- Hearing

To meet ASHA requirements, each student must acquire a **minimum** of 375 contact hours plus 25 observation hours by the end of their degree program. Most students graduate from the University of Maryland program with significantly more than the minimum requirements (e.g., average of 450-500 hours). Hours from the on-campus clinic as well as outside placements count toward the total accumulation. At least 325 clock hours must be earned at the graduate level of study.

The Department of Hearing and Speech Sciences imposes a further requirement that students must acquire a **minimum** of at least 5 clock hours in each of the nine categories listed above. These hours can be earned across the categories of observation, evaluation, or treatment for each of the nine specified categories. Please see the sample clock hour form posted on the HESP 648B practicum course website.

All graduate clinicians record their completion of client contact hours on a regular basis in a binder kept in the student lounge. The clinic assistant enters this data into a spreadsheet tracking program and provides interim summaries on a biweekly basis. Students’ clock hour distributions are used to make caseload assignment decisions in subsequent semesters, so accurate and timely recording of client contact is crucial to the clinical training process.
# Sample Graduate Student Clock Hours

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**Total Hours Per Placement** (diagnostic and treatment only)
- **University of Maryland**: 166.75
- **Mercy Medical Center**: 86.75
- **Bollman Bridge ES**: 165.25

**Date Run**: 8/19/2011 19:41

**Signature**: Colleen Worthington, M.S., CCC-SLP

**ASHA #**: 00862730
**UNIVERSITY OF MARYLAND**  
**SPEECH AND HEARING CLINIC**  
**REPORT OF OBSERVATION HOURS**

Name: _______________________________  

**KEY:**  

Age:  
C = Children  
A = Adult

Semester: _______________________________  

Category: Select from list below  

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**Total Observation Hours**

Number of Speech Hours: ________________  
Number of Audiology Hours: _____________

Supervisor’s Signature: ________________  
Supervisor’s Signature: ________________

Date: ________________________________  
Date: ________________________________
**Clinical Portfolio**

The Department recommends that all students develop a portfolio that provides documentation of their practicum training and clinical growth across the semesters. At the end of your degree program, you will be using ASHA’s KASA form to summarize your mastery of the knowledge and skills required by the program. However, a well-developed portfolio provides exemplars that better illustrate the scope and depth of mastery achieved through the clinical education program.

Students should try to collect at least four portfolio items each semester that convey information on major accomplishments during that term. Items can include a wide variety of materials including (but not limited to):

-- copies of therapy session feedback forms
-- lesson plans
-- report drafts
-- list of disorders treated in semester caseloads
-- list of standardized tests mastered
-- competency exam forms
-- learning outcome forms
-- copies of handouts generated from team projects assigned in classes
-- research papers

The portfolio should be organized in a cumulative fashion across the duration of the graduate training program. Each item should be accompanied by a cover sheet that includes the following information:

-- definition of the item
-- description of how the item demonstrates growth in clinical/academic/research skills
-- rationale for why the specific item was selected

Students are free to use either hard copy or electronic formats and are encouraged to determine their own organization system. A comprehensive portfolio becomes an excellent tool to share with future employers when students have graduated and are interviewing for jobs. Faculty may request to view student portfolios on a random basis throughout the school year.

**NOTE: Be sure to follow appropriate HIPAA guidelines for protecting client information when developing your portfolio**
CLINICAL PRACTICUM OVERVIEW

The clinical training program is designed to be an integral part of the master’s degree program in speech-language pathology. The department operates an on-campus clinic which provides speech-language pathology services to the surrounding community.

Enrollment in clinical practicum requires a fulltime commitment. Students register for practicum during each of the five semesters. A general description of the clinical training program by semester includes the following:

**First semester**
- Register for two credits of HESP 648B and one credit of HESP 648A
- Therapy caseload assignment of 2-3 clients/week generates approximately 6 hrs/week client contact time plus approximately 8-12 hours devoted to planning and paperwork.
- Diagnostic caseload generally entails 3 hrs/week of observation. Primary and secondary clinicians engage in an additional 2-5 hrs/week in planning and report-writing.
- A variety of meetings is held throughout the semester and includes weekly cores, group staffings, individual supervisory conferences, and materials room duty. These meetings generally represent a time commitment of approximately 4 hrs/week.

**Second semester**
- Register for two credits of HESP 648B
- Therapy caseload assignment of 3 clients/week generates client contact time of approximately 6 hrs/week. Planning and paperwork time averages 5-8 hrs/week.
- Diagnostic caseload assignment remains unchanged (see description above)
- Meetings and materials room duty remain unchanged (see description above)

**Third semester (6 week summer session)**
- Register for two credits of HESP 648B
- Therapy caseload assignment of 3-4 clients/week generates approximately 8 hrs/week of client contact time. Planning and paperwork time averages 4-5 hrs/week.
- Diagnostic caseload assignment remains unchanged (see description above)
- Meetings and materials room remain unchanged (see description above)

**Fourth semester**
- Register for two credits of HESP 728
- Outside placement assignment averages 3-4 days/week
- Occasional screenings coordinated by core clinic assigned 1-2 days per semester

**Fifth semester**
- Register for two credits of HESP 728
- Outside placement assignment averages 3-4 days/week
- Occasional screenings coordinated by core clinic assigned 1-2 days per semester
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* SAMPLE STUDENT SCHEDULE

* REPRESENTS A TYPICAL STUDENT SCHEDULE. YOUR INDIVIDUAL SCHEDULE MAY VARY.
**SAMPLE STUDENT SCHEDULE**

**STUDENT 2**

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* REPRESENTS A TYPICAL STUDENT SCHEDULE. YOUR INDIVIDUAL SCHEDULE MAY VARY.
### *SAMPLE STUDENT SCHEDULE*

**STUDENT 3**

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* REPRESENTS A TYPICAL STUDENT SCHEDULE. YOUR INDIVIDUAL SCHEDULE MAY VARY.
CLINICAL POLICIES AND PROCEDURES

- Clinic Office
- Session Procedures
- HIPAA
- Observation Room
- Safety and Emergency Procedures
CLINIC OFFICE PROCEDURES

Getting Client Files:
Client files are located in the gray file cabinet in the Clinic Office (Room 0110). Current therapy client files are in the section labeled “Active Speech”. Clients scheduled for diagnostic sessions are in the section labeled “Speech Diagnostics”. To check out a client’s file, ask the clinic secretary or office assistant to give you the orange “OUT” card assigned to your client. Fill in the date and your name, and return it to the secretary. She will give the file to you and place the “out” card in the file drawer to mark the correct spot. All files must be returned to the clinic office by the end of each day. If you finish with a file before 5:30, it must be returned to the clinic secretary. She will replace the “out” card with the client file and cross out your name. If it is after 5:30 p.m., put the file in the student room mailbox labeled “clinic office”. Please do not leave the file in your personal mailbox at the end of the day. If the file is too large, find a clinical supervisor to unlock the clinic office door and place the folder on the secretary’s desk or chair.

*** No client file can leave the building. If a standardized test form has responses recorded on it (regardless of whether identifying information is present), it should not leave the building. Files can only be used in the clinic spaces or student room. They may not be taken to the computer lab and information in a file cannot be photocopied. This means that scoring and analysis of test data must be conducted within the department (not at home).***

Canceled Sessions:
When a client calls to cancel a therapy or evaluation session, the office secretary will send an email message to both the supervisor and the student clinician within 15 minutes of receiving the call. She will also create a hard copy of the cancellation notice. As each student prepares to start their assigned duty slot in the materials room, they should check with the secretary for cancellation notices and distribute them into the appropriate clinician’s mailbox. If a client calls the clinician at home to cancel an appointment, it is the clinician’s responsibility to notify the clinic office and the supervisor.

If you need to cancel a session for any reason (e.g., illness, emergency, etc.), please obtain supervisor approval prior to contacting your client. If you cannot reach the case supervisor, get in touch with another of the clinical instructors.

If you have an evening client who may try to cancel a session after the office closes at 5:30 p.m., please give them your supervisor’s office phone number and ask them to leave messages on the supervisor’s voice mail.

Cancellation Log:
When a therapy session is canceled, the clinician should document it on the “contact sheet” in the front of the client folder and in the white “Cancellation Log”. This log is located in the cabinet above the clinic secretary’s desk. Request it from the clinic office staff or your supervisor, just as you would request a client file. Fill in your name, client’s name, date of the canceled session, and circle who canceled the session. This is very important for billing reasons. Do not fill in the “Make-Up Date” until the extra session actually occurs.
When a make-up date is held, please document it in the Cancellation Log and indicate the date of the originally cancelled session. For billing purposes, the clinic needs to have the ability to track which make-up sessions are associated with specific cancellations. When a diagnostic session is canceled, only the contact sheet notation in the client’s folder is required.

**Tidbits to Know:**

Please get in the habit of turning out the lights as you leave your therapy room.

Do not use push pins or tape to attach anything to the acoustic wall panels or painted doors in the therapy rooms. Picture stimuli should be mounted with magnets on the chalkboard or affixed to an easel, feltboard, etc.

“Scavenger hunts” that require stimulus pictures should not be conducted in departmental corridors. No materials should be taped to any surface in the buildings hallways.

Each therapy room contains a cabinet, table, and chairs (two chairs in kiddie rooms and four chairs in adult rooms). On occasion, you may need to rearrange furniture in the therapy rooms to accommodate your client’s needs. Do not place furniture in a manner that causes scratches in the door paint. **Please return all furniture to the original configuration immediately after your session.**

You may want to give your home number to your client so they can call you directly to cancel a session. This may save you a trip to campus, particularly if the client is scheduled toward the beginning or end of the day. Remember, it is still your responsibility to notify both the clinic office and your supervisor. The contact sheet/cancellation log procedures should be completed as soon as you return to campus.

Clients are billed for the entire semester at the beginning of treatment and may elect to pay in installments. Student clinicians are not responsible for handling any financial transactions. Clients should contact the clinic office staff to make payments or ask questions about their account. If your evening client wants to make a payment after the secretary has left for the day, please direct them to your supervisor who will document the transaction.

Each client is issued one parking permit at the beginning of each semester. They are allowed a second one at no charge. If additional ones are requested, the charge is $10.00 per permit. Clients should use the assigned parking tag only during the days/times when they are coming into the clinic for services.

Each student will be assigned a storage bin in which to keep privately-owned therapy materials. These bins should be kept on the shelves in the student room or in the cabinets in the kiddie hallway. Lids on these bins should be used to preserve a neat appearance in the student room and kiddie hallway. Please register to use the lockers located in the department to hold any materials that don’t fit in your assigned bin. See the secretary in the clinic office for assignment and bring your own lock. **Please do not store/hoard tests or therapy materials borrowed from the clinic in your bin – they’re for everyone’s use!**

When you meet your client in the waiting room, check to make sure that they have signed in at the clinic office. From a safety standpoint, it is important for us to know what clients are being seen in the clinic at any given moment if an emergency situation arises (e.g., fire drill, power outage, etc.).
**Guidelines for Student Access to Printing and Copying Services**

Limited use of HESP departmental printers and copiers is appropriate for preparing some clinical materials. The materials room holdings are designed to provide clinicians with a wealth of readily available therapy resources. However, there may be some occasions when therapists deem it necessary to create their own session materials or copy an existing set. Please be judicious in your use of departmental printing and copying resources.

Departmental printers and copiers should not be used for personal documents. Please see the list below for guidance on what is considered personal use. If a clinician is unclear about the appropriateness of a specific printing/copying task, please feel free to ask your clinical supervisor. Printers and copiers are available for students’ personal use in the OACS computer lab and in McKeldin Library. If it is necessary, for logistical reasons, to print/copy personal materials using HESP equipment, the department should be reimbursed as posted above the Xerox machine in the front office. If a student has an overwhelming financial or logistical problem that requires use of departmental resources for printing or copying personal documents, please see the department chair to arrange a solution.

**EXAMPLES**

**OK to print or copy**
- drafts of clinical reports (ITPs, progress reports, diagnostics)
- individualized materials for client homework/carry-over
- limited amounts of therapy workbook pages or stimulus materials

**Not OK to print/copy**
- class powerpoint notes
- journal articles
- chapter readings for class
- documents for class projects
- drafts of term papers or candidacy papers
# Speech Therapy Session Cancellation Log

<table>
<thead>
<tr>
<th>Clinician</th>
<th>Patient</th>
<th>Date of Cancelled Session</th>
<th>Make-up Date</th>
<th>Who Canceled? (Circle)</th>
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</thead>
<tbody>
<tr>
<td>Liz Smith</td>
<td>Joe Schmo</td>
<td>9/24/03</td>
<td></td>
<td>PATIENT/CLINICIAN</td>
</tr>
<tr>
<td>John Brown</td>
<td>Bill Jones</td>
<td>9/24/03</td>
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<td>PATIENT/CLINICIAN</td>
</tr>
<tr>
<td>Betty Boop</td>
<td>Mr. Magoo</td>
<td>9/24/03</td>
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Note: In the column labeled "Who Canceled? (Circle)", patients or clinicians can circle "PATIENT," "CLINICIAN," or "Illness" to indicate the reason for the cancellation.
HIPAA
Health Insurance Portability and Accountability Act

HIPAA, the Health Insurance Portability and Accountability Act, offers protections that ensure continuity of health care coverage for all citizens. For example, it limits exclusions for preexisting medical conditions and prohibits discrimination in health insurance enrollment based on health status-related factors.

In addition to these guarantees, HIPAA’s Privacy Rule provides patient privacy protections. This rule requires organizations and health care providers to reasonably safeguard all health care information that they have access to.

The University of Maryland has determined that the University Health Center is currently the only unit that qualifies as a “Health Care Provider” and must, therefore, comply with HIPAA privacy regulations. Compliance also includes units that may have access to health care information because of their activities in support of the University Health Center. Other units within the university community who perform health care related functions may voluntarily choose to comply with some or all of HIPAA’s requirements.

The Hearing and Speech Clinic has elected to comply with the privacy rules outlined in HIPAA. The Clinic feels that it is important for clinic faculty, staff, and graduate clinicians to be knowledgeable about client rights, understand their responsibilities as health care providers, and ensure that client information is handled confidentially at all times (see below for examples). The department has developed an online HIPAA training course for this purpose. All graduate students in the department are required to complete this course and pass a competency test demonstrating knowledge and understanding of HIPAA privacy regulations. *The course and test form can be accessed on the department website.*

Examples of clinic regulations related to client privacy:

- **Old reports and early drafts of reports:** These should always be shredded - they should never be placed intact into a wastebasket.
- **Electronic transmissions:** All identifying information must be deleted from reports that are electronically transmitted or stored.
- **Case file review:** Files must be reviewed in the department – they may not be taken out of the building or to any other location within the building. Individuals may take notes on information from a client’s file, but no portion of the file may be photocopied.
- **Discussion of cases:** Clinicians can discuss cases with one another when necessary to facilitate programming and intervention, but all communication of this nature should take place in private areas of the clinic – not in the hallway or in the student room.
- **Substantive discussions and consultations:** Before engaging in any substantive communication about your client with family members or other professionals, you must seek supervisor approval and verify that all appropriate releases have been signed.
- **Phone messages and email correspondence:** When leaving a phone message or communicating with a client via email, any discussion of private matters should be kept to a minimum – take the client’s lead with regard to the type and amount of information to be shared through these media.
UNIVERSITY OF MARYLAND
HEARING AND SPEECH CLINIC
NOTICE OF PRIVACY PRACTICES
As Defined by the Privacy Regulations of the
Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA)

PLEASE REVIEW THIS NOTICE CAREFULLY

I. OUR COMMITMENT TO YOUR PRIVACY
The University of Maryland is dedicated to maintaining the privacy of your protected health information (PHI). PHI is individually identifiable health information about you that relates to your past, present or future physical or mental health or other condition, as well as any related health care services. This Notice of Privacy Practices provides you with the following important information: our obligations concerning your PHI; how we may use and disclose your PHI; and your rights with regard to your PHI.

II. UNIVERSITY STUDENTS
Although federal privacy requirements for protected health information generally exclude student health information, the confidentiality of such information is protected under the federal Family Education Rights and Privacy Act (FERPA), Maryland state law and/or University Policy, as applicable. The Hearing and Speech Clinic recognizes the need for confidentiality and privacy with respect to student health information, and we will use, disclose and otherwise treat your health information accordingly, following the requirements of applicable law and University policy (see Section IV below).

III. NON-STUDENTS

A. OUR OBLIGATION
The Hearing and Speech Clinic has chosen to abide by federal and state laws requiring that the privacy of your PHI be maintained. By complying with these laws, we are required to provide you with this notice regarding our privacy practices, our legal duties and your rights concerning your PHI. Except for student records and certain records the University creates or receives in its role as an employer, this Notice of Privacy Practices applies to all records containing your PHI that are created or retained by the Hearing and Speech Clinic. A copy of the Notice of Privacy Practices will be posted in a visible location in the Hearing and Speech Clinic waiting room at all times, and you may request a copy of the Notice at any time.

B. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS (NOT ALL POSSIBLE SITUATIONS ARE COVERED):

- For treatment, payment, and health care operations, to third-party business associates (e.g., billing services), for health related services, to individuals involved in your care, under some circumstances for research purposes, when required or allowed by law, with your written authorization

IV. YOUR RIGHTS REGARDING YOUR PHI

A. NON-STUDENTS
You have the following rights regarding the your PHI, and you may request any of the following:

- Confidential communications, restriction of communication to individuals otherwise permitted by law to inspect your PHI, Inspection and Copies of personal records, amendments to your PHI if you believe the information is incorrect or incomplete, a list of disclosures we have made of your PHI, and a Copy of this Notice

B. UNIVERSITY STUDENTS
We generally provide University students with similar rights regarding their health information, including the rights to request confidential communications, restrictions on use or disclosure, inspection and copies, amendments, accounting of disclosures, and copies of this Notice. Those rights may, however, be implemented in different ways under FERPA, Maryland law and/or University policy, as applicable. If you have questions about your rights regarding your health information, please contact the Hearing and Speech Clinic Directors (see below).

V. IMPLEMENTATION, QUESTIONS AND COMPLAINTS

A. IMPLEMENTATION
This Notice provides a general overview of our privacy practices. This Notice and our privacy practices are implemented in accordance with applicable University policies and procedures and the requirements of HIPAA and other federal and Maryland laws, as applicable.

B. COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with the Hearing and Speech Clinic. All complaints must be submitted in writing. We will not retaliate against you in any way if you file a complaint with us.

VI. CONTACT INFORMATION
If you have any questions regarding this Notice or our health information privacy practices, please contact:

Margaret McCabe, Au.D., CCC-A
Instructor, Department of Hearing and Speech Sciences
Director of Audiology Services
Hearing and Speech Clinic
mmccabe@hesp.umd.edu
(301) 405 – 4221
0111Q Lefrak Hall

Colleen Worthington, M.S., CCC-SLP
Instructor, Department of Hearing and Speech Sciences
Director of Speech-Language Services
Hearing and Speech Clinic
cworth@hesp.umd.edu
(301) 405 – 4238
0141H Lefrak Hall
SPEECH-LANGUAGE OBSERVATION POLICY

The observation room is used to view therapy sessions in progress, enabling the clinical instructors to supervise students’ delivery of services to clients. In addition, students in practicum courses are encouraged to make observations as they relate to specific academic classes.

We encourage family members to observe therapy sessions. However, there are specific guidelines that must be followed to ensure that the teaching of students in not interrupted, and that therapy and diagnostic evaluations of individual clients are not compromised.

1. In order to respect the privacy of all clients, please only watch your own family member. Only family members and those who are specified on a release form may watch a session.

2. Observations are made through a one-way mirror. Clients in the therapy rooms will not be able to see observers as long as observers do not get too close to the glass. Please do not adjust the lights in the observation room.

3. Please use headphones when there are others present in the observation room.

4. In order to provide a quiet listening environment for others and to keep noise from traveling into the therapy room, please do not speak above a whisper and keep conversations to a minimum in the observation room.

5. Excessive noise in the hallway travels into the therapy rooms, as well as into classrooms and offices. Accompanying children must be supervised at all times in the hallways and in the waiting room.

6. Food and drink are not permitted in the observation room.

8. Please do not touch the video-recording system components in the observation rooms. Clinical faculty are the only individuals who have been trained to use this system.
Safety and Emergency Procedures

Universal precautions are procedures designed to protect both the student and the client from transmission of communicable diseases. To minimize health risks, always assume that bodily fluids are potentially infected. Each fall, new student clinicians will attend an in-service training session on bloodborne pathogens conducted by the university’s Department of Environmental Safety.

To minimize the risk of communicable diseases, the Department requires that students participating in clinical practicum training be vaccinated against hepatitis B. This vaccine consists of a series of 3 shots administered over a six-month period and should be initiated prior to entering the program.

Routine Hand Washing: Before and after each client session  
After sneezing, coughing, or wiping a nose  
After using the toilet  
After handling soiled items such as a diaper or dirty toys  
Before preparing or eating food  
Use alcohol-based hand cleaner as an alternative

Use of Disposable Gloves: Gloves should be worn whenever the clinician will come into contact with bodily fluids or place their hands near the client’s face (e.g., oral mechanism exam). Put gloves on immediately prior to touching the client. If you put them on too early and then touch other objects (e.g., clipboard, pencil, own hair, etc), your gloves may become contaminated. Remove gloves by peeling them off from the wrist and turn them inside out as you go.

Cleaning Clinic Materials: Any potentially contaminated surface should be disinfected. Toys/objects that have been mouthed by a child and therapy table tops should be cleaned with a disinfectant wipe immediately after each session. Ear tips used for immittance screenings should be placed in the designated container and will be cleaned on a periodic basis by the clinic assistant.

In case of emergencies, student clinicians should follow established procedures for orderly evacuation of the building. In case of power outage and loss of electrical lighting, each therapy room is equipped with a battery-powered flashlight stored at the top of the blackboard. **These flashlights are intended for emergencies only and should not be moved or used for any other purpose.**

Upon loss of electrical power or activation of the fire alarm, student clinicians should move their clients quickly and quietly outside the building and gather in front of the South Campus Dining Hall. Therapy room and hallway doors should be closed as each client is evacuated. The clinic secretary will bring the client sign-in sheet to the designated gathering spot in order to allow a member of the clinical faculty to ensure that all students and clients are accounted for. **Student clinicians should not re-enter the building until given instructions by a member of the clinical faculty.**
CLIENT FILES

- Organization
- Contact Sheet
- Consent/Authorization Forms
- Disposition Form
- Case History Forms
Client’s records are to be maintained in a neat and orderly manner. The client’s folder is the most crucial piece of information in our clinical operations. The files are not only a direct reflection of the caliber of work and professionalism of speech and hearing clinic, but are also a record of clinic-client contacts (i.e. evaluation reports, progress reports) and a record of phone calls, histories, correspondence, etc. all interactions should be kept in a logical chronology. By quickly reviewing a client’s file, a complete history of his/her interactions with the clinic should be apparent. Client files and the papers they contain are considered confidential medical records. Nothing from the file may be removed from the department’s clinical spaces or photocopied.

1. A contact sheet is stapled to the inside left half of the client’s file. (A sample sheet is included in this packet). The contact sheet serves as a quick reference for phone calls, communications, information sent from the clinic or any other pertinent data requiring a brief notation. It also should include a brief statement concerning further recommendations (i.e. re-evaluate in January 2012)

   A. On the top quarter of the contact sheet, the identifying information should be completed including the client’s name, birth date, parent’s name (if client is a child), address, home and work phone.

   B. On the remainder of the sheet is space for brief notes relating to the following contacts:

      1) Phone calls- Each call concerning the client should be briefly summarized (3-5 line) and include the date, name of individual communicated with, their phone number (if not indicated elsewhere), your comments concerning the call and your initials, if it is a long or complicated communication, the information should be typed on a full sheet of paper and placed in the file with a note on the contact sheet (Example: 7/1/10 phone call from Ms. Maryland. See note. Recommend – terminating therapy. RS).

      2) Communications – any report, letter, note, etc. sent from the clinic should be indicated. (Example 2/2/10 – Audio-logical evaluation sent to Dr. Quack. UR). Clinic secretary will make this note.

      3) Evaluation dates – a note stating when an evaluation was performed should be indicated. (Example: 3/2/10 – Speech and language re-evaluation in December 2011 BS).


2. On the inside right half of the clients file, all papers, forms, reports, etc. should be clamped. The information should be divided into two sections (see below). Each section should be placed in order with the oldest information in the back and the most recent information on the top. All papers in the file must include the following: Client’s name, date, signature of the graduate student and supervisor.

   Beginning at the back of the file, the information should be placed in the following order:
Consent to participate in speech and hearing clinic activities
Case history forms
Reports from outside agencies
Release forms

Audiological Evaluation
   A. Typed letters and reports on top
   
   B. Audiogram, hearing aid evaluation, impedance results, electro-acoustic analysis, hearing aid orientation, etc. below report pertaining to these results.

Speech and Language Diagnostic Reports
   A. Typed evaluation on top
   
   B. Audiometric screening, diagnostic test forms below report pertaining to these results.

Speech and language initial therapy plan
Speech and Language semester progress report

Remember, each item appearing in the file should be dated and properly signed by the appropriate clinician and supervisor. Throw away all loose pieces of paper, forms with no date, hand written pages in which the information is included in an existing report.
Name: Susie Q
Birthdate: 6-10-80
Parents Name: John and Mary Q
Referral: Phonebook
Address: 906 Lynch Drive
Our Town, MD
Home Phone: 301-405-4287
Work Phone: 301-405-4218
Disorder: Apraxia
Health Insurance: _______________________
I.D. #: ________________________

University Affiliated? Y/N How? UMD Professor
S.S. #: ________________________

Date:                       
9/22/03 Began therapy for Fall Semester—Kate Skinker RS
9/24/03 Client called and cancelled session due to illness. RS
9/25/03 Mrs. Q called to say that Susie’s teacher thinks we should work on her “s”. Will discuss RS
With supervisor and return call. RS
9/26/03 Returned call to Mrs. Q. Will discuss target sound choices with her at Monday’s (9/29) session. RS
12/9/03 Final session of Fall semester. Parent conference held. Copy of report given to Mrs. Q. RS
2/1/04 Spring semester therapy started. Liz Smith LS
2/3/04 Client did not show for therapy session. LS
2/4/04 Called client to ask about absence. Susie’s mom forgot about session. Will schedule make-up session t next session. LS
Consen Form

The Department of Hearing and Speech Sciences at the University of Maryland has three purposes: to train speech-language pathologists and audiologists, to render services to clients, and to conduct research in hearing, speech, and language. In order to meet these purposes, any of the following diagnostic, therapeutic, teaching, and/or research procedures may be used by authorized personnel within the department: direct observation, audio taping, video taping, photography, and review of client records. For research purposes, clients may be asked to participate in research projects conducted by authorized personnel. Client participation in any research project is strictly voluntary, and refusal to participate will in no way affect services rendered to the client.

I consent to the participation of _______________________________ in the programs of the Department of Hearing and Speech Sciences at the University of Maryland.

I grant this consent with the understanding that any use of privileged information, other than to meet the department’s stated purposes, will not be undertaken without further written consent.

Signature: ___________________________________________ Date: ____________

Print Name: ____________________________________________________________________________

Address: ____________________________________________________________

Relationship to Patient: ___________________________________________________________
Authorization for Release of Records from the University of Maryland

Patient Name: ____________________________________________  DOB: __________

I hereby consent to the release of any and all hearing, language, and speech records for the individual named above to:

Name / Agency: ___________________________________________
Address: ____________________________________________________________________

Name / Agency: ___________________________________________
Address: ____________________________________________________________________

This information pertains to assessment and treatment by the Speech and Hearing Clinic, University of Maryland, College Park.

Signature: ____________________________________________  Date: __________
Name: ________________________________________________
Relationship To Patient __________________________________
Witness: ___________________________________________________________________

FOR CLINIC USE ONLY – REPORTS TO BE MAILED

Report(s)  Reports(s) Date  Supv. Sig.  Sent  Sec
Authorization for Release of Information from Agency or Physician to the University of Maryland

Patient Name: _______________________________________________ DOB: _____________
Agency or Physician: ___________________________________________________________
Address of Agency or Physician: ___________________________________________
_____________________________________________________________________________

The above named person has requested the services of the University of Maryland Speech and Hearing Clinic. We understand that this individual was seen at your facility. Kindly forward any hearing, language, speech, medical, psychological, educational, or social information regarding the above named individual.

Please send your reply to the attention of Beth Coon, Office Manager, University of Maryland Speech and Hearing Clinic, College Park, MD 20742.

Thank you for your prompt cooperation.

Date: __________

This will certify that you have my permission to release information concerning the individual named above to the University of Maryland Speech and Hearing Clinic.

Signature: ________________________________
Name: ________________________________
Address: ________________________________

Relationship: ________________________________
To Patient: ________________________________
## UNIVERSITY OF MARYLAND
HEARING and SPEECH CLINIC

## CLIENT DISPOSITION FORM

**Client Name:** ___________________________  **Date Completed:** __________

**Birthdate:** __________   **Age:** _____   **Disorder:** ______________________

### NEW CLIENTS:

**Diagnostic needed?** Yes   No

- [ ] If completed previously, specify date: __________
- [ ] Place on diagnostic wait list
- [ ] Place on treatment wait list

### REPORTS:

- [ ] File in client folder
- [ ] Mail to client/parent

### DIAGNOSTIC CLIENTS:

- [ ] **Therapy recommended.** Change patient type to “Waitlist-Therapy” in Practice Explorer.
  - Place on treatment wait list according to file’s original stamped date. Place file in Speech Waitlist drawer.

- [ ] **Therapy recommended.** Change patient type to “Active” in Practice Explorer.
  - Place file in Speech Active drawer.

- [ ] **Re-evaluation recommended.** Place client on re-evaluation reminder list in Practice Explorer for __________ (month/year).

- [ ] **Will not be receiving services at UMCP.** Change patient type to “Inactive” in Practice Explorer.
  - File report and place folder in inactive drawer.

**Comments:** ____________________________________________________________

### THERAPY CLIENTS:

- [ ] **Continue therapy** in fall / spring / summer ______(year)

- [ ] **Schedule for follow-up** (monitoring session, phone update) on ________ (month/year).

- [ ] **Discharge from therapy.** Change patient type to “Inactive” in Practice Explorer.
  - Place folder in inactive drawer.

- [ ] **Temporarily discontinue from therapy.** Change patient type to “Waitlist-Therapy” in Practice Explorer effective __________ (date). Place file in Speech Waitlist drawer.

**Comments:** ____________________________________________________________

### OTHER:

- ____________________________________________________________
- ____________________________________________________________

**SUPERVISOR INITIALS:** ________________  **OFFICE INITIALS:** ____________
Please answer the following questions as best you can and mail the form to the address given at the top of this page. If there are some questions which you cannot answer, leave them blank. Your answers will help us save time in understanding your child’s problem.

I. ROUTINE INFORMATION

Name of your child___________________________ DOB: ______________ Age____ Gender____

Name of parents_______________________________________________________________________

Address__________________________________________________________

Home phone__________ Parent’s work phone, Mom’s # ___________ Dad’s #______________

E-mail address___________________________________________________________

Name of person giving information___________________________________________

Relationship_______________________ Phone number if different from above_____________________

Health Insurance_____________________________________________________________

Name of Policy Holder________________________________ Policy #_____________________________

Race of the child*____________
0 = Not reported 3 = Asian/ Pacific Islander
1 = American Indian/ Alaska Native 4 = Hispanic
2 = Black/ African American 5 = White/ Caucasian

* This information is requested because the University is a public teaching institution and will be used solely for the purpose of describing caseload diversity. Your response will not affect consideration of your child’s application.

Why has a speech evaluation been requested?
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
II. PRESENT SPEECH AND LANGUAGE STATUS

Does your child understand what you say to her/him?_______ If not describe her/his reactions:______________________

Does your child have trouble understanding other people’s speech?_______ Give examples:______________________

Do you know why your child does not understand?_______ Please explain:________________________________________

Does your child respond consistently to sounds in the home (doorbell, phone, etc.)?______________________
Explain:____________________________________________________________________________________

Do you suspect a hearing loss?_______ Why?____________________________________________________________

Does your child attempt to talk?_______ Is the child’s speech understood by parents?______________________
Siblings?_______ strangers?________

What is your child’s reactions when his/her speech is not understood?____________________________________

What does your child do to express himself when his/her speech is not understood by others?__________________

Does your child say as much as most children of the same age?________
Give an example of a sentence your child might say:____________________________________________________

Does your child pronounce words well?________
List sounds or words that your child pronounces incorrectly:______________________________________________

Select one skill in each column that best describes your child:

| __responds to only loud sounds | __makes no vocal sounds |
| _____________________________ | ______________________ |
| __responds only to sounds in the home | __babbles only |
| _____________________________ | ______________________ |
| __understands single words | __says single words |
| _____________________________ | ______________________ |
| __understands simple sentences | __speaks in simple sentences |
| _____________________________ | ______________________ |
| __understands complex directions and sentences | __uses complex sentences |
| _____________________________ | ______________________ |
| __uses only gestures | ______________________ |

Does your child hesitate and/or repeat sounds or words?_______ How often does it happen?______________
When did you first notice this behavior?__________________
Describe any struggle behaviors that accompany the hesitations/repetitions:______________________________

What, if anything, have you done about it?_____________________________________________________________

Is your child’s voice too high-pitched?_______ too low-pitched?________ too weak or quiet?________
Is your child’s voice quality unusual?_______ If so, describe:__________________________________________

Is your child’s speech too fast?_______ too slow?________
Are there any physical causes for any of the above answers?_______ If yes. Please explain:________________
III. DEVELOPMENTAL HISTORY

A. Birth History
Mother’s condition during pregnancy?__________________________________________
Full term?_________If premature, how many weeks gestation?______________________
Birth weight?________Any evidence of injury at birth?___________________________
If so, please describe:_________________________________________________________
Indications of weakness or poor health at birth?
Explain:_____________________________________________________________________
____________________________________________________________________________
Any difficulty in initiating breathing?_________________________________________

B. Growth
During infancy, did your child demonstrate any feeding or swallowing problems? Please describe:_____________________________________________________________________
Has your child increased in height and weight normally?________
If not, please describe:_____________________________________________________

C. Motor
Age of sitting up_____________Age of crawling_____________Age of walking_________
Does your child seem to have normal coordination for his/her age?________
If not, please describe:_____________________________________________________
Which hand does your child use?_____________________________________________

D. Speech Development
Did your child babble and coo during the first ten months?_______________At what age did your child use single words meaningfully?_______Age for short phrases/sentences?_________

E. General Development
Does your child have opportunities to play with other children?_________What ages?_______
How many?________
Does your child like to play with other children or would your child prefer to play alone?_______
At what age did your child start feeding himself/herself?__________________________
Dressing himself/herself?______________Become toilet-trained?__________________

Does your child present any special behavior problems?________
If so, please describe:__________________________________________________________
___________________________________________________________________________

Check all of the following which describe your child:

___Friendly ___Unresponsive ___Temper Outbursts
___Happy ___Quiet ___Shy
___Stubborn ___Aggressive ___Tense
___Sensitive ___Cooperative ___Talkative
IV. MEDICAL HISTORY

A. List diseases/conditions and their effects and severity:

<table>
<thead>
<tr>
<th>Disease/Condition</th>
<th>Age</th>
<th>Severity and Effects</th>
</tr>
</thead>
</table>

B. List significant injuries, ages and effects:

<table>
<thead>
<tr>
<th>Injury</th>
<th>Age</th>
<th>Severity and Effects</th>
</tr>
</thead>
</table>

C. List operations and ages for each operation:

<table>
<thead>
<tr>
<th>Operation</th>
<th>Age</th>
<th>Severity and Effects</th>
</tr>
</thead>
</table>

D. Name of child’s current pediatrician_________________________________________________

E. Address__________________________________________________________

F. Please list any conditions for which child is currently taking medication

____________________________________________________________________________

Name and dosage of each medication___________________________________________

Does your child have any allergies or dietary restrictions?_____________________

____________________________________________________________________________

V. SCHOOL HISTORY

A. Please complete all of the following that apply to your child:

<table>
<thead>
<tr>
<th>Name and Location</th>
<th>Age Entered</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attended Nursery School:______________________________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elementary School:____________________________________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Junior High:__________________________________________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Senior High:_________________________________________________________</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

B. Status

List subjects that are especially difficult for your child_________________________________________________

____________________________________________________________________________

Describe any serious behavior problems at school________________________________________

____________________________________________________________________________

Has your child ever repeated a grade?____Which one and why?___________________________

____________________________________________________________________________

Has your child’s school attendance been regular?_______________________________________

Describe your child’s participation in after-school activities?___________________________

____________________________________________________________________________
VI. SPEECH-LANGUAGE HISTORY

A. Describe any special work in speech and/or language in school

________________________________________________________________________
________________________________________________________________________

Dates Group or individual sessions Frequency

Name of therapist and school

________________________________________________________________________

B. Has your child received any speech/language services at any other clinic or agency?

________________________________________________________________________

Please list the names of other clinics or agencies where your child has been evaluated or treated for speech-language or hearing difficulties. Please attach copies of any reports to this form.

<table>
<thead>
<tr>
<th>Name</th>
<th>Location</th>
<th>Dates</th>
<th>Evaluated</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
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<tr>
<td>2.</td>
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<tr>
<td>3.</td>
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</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

C. Describe any help given to your child by his family, friends, physicians, which has not been reported previously, in attempts to help your child correct his present speaking difficulties.

________________________________________________________________________
________________________________________________________________________

VII. FAMILY and SOCIAL HISTORY

A. Family

Father’s name Age

Place of birth Occupation

Education completed: _____8th grade _____High school _____College _____Other _____

Mother’s name Age

Place of birth Occupation

Education completed: _____8th grade _____High school _____College _____Other _____
Names and age of brothers and sisters________________________________________________
______________________________________________________________________________

Others in household______________________________________________________________
______________________________________________________________________________

Describe any family history of speech/language or hearing difficulties (e.g. learning disabilities, stuttering, articulation impairment, deafness, etc.)
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

List any languages other than English that are spoken in your child’s home or everyday environment________________________

Please attach a recent photograph of your child. Since this photograph will not be returned to you, you need not send an expensive one. A snapshot will serve the purpose.
Speech and Hearing Clinic  
Department of Hearing and Speech Sciences  
University of Maryland  
College Park, Maryland 20742  
(301) 405-4218

Adult Case History Form

Please answer the following questions as best you can and mail the form to the address at the top of this page. If there are some questions you cannot answer, leave them blank. Your answers will help us provide you with the best and most efficient evaluation and/or treatment.

General Information

Name_________________________________ DOB: ________ Age ________

Address: __________________________________________________________ Sex ________

City __________________________ State __________ Zip __________

Home Phone__________ Business Phone__________ Cell Phone ____________

Email Address____________________ May we contact you at work? Yes No

Are you affiliated with the University of Maryland Yes No ID # _________________

Occupation __________________________ Employer __________________________

Name of person completing form __________________________ Relationship__________

Referred by ______________ Marital Status __________ Spouse’s name __________

Who lives in the home? _________________________________________________

Race of Client* __________________

0 = Not Reported 3 = Asian/Pacific Islander
1 = American Indian/Alaska Native 4 = Hispanic
2 = Black/African American 5 = White/Caucasian

* This information is requested because the University is a public teaching institution and will be used solely for the purpose of describing caseload diversity. Your response will not affect consideration of your application.

Educational History

Highest level of education achieved ________________ Primary Language______________

Other languages spoken __________________________ Language spoken in the home ______________

Do you have any reading and/or learning difficulties? Yes No

If yes, please describe ________________________________________________________________
Present Speech, Language or Voice History

As completely as possible, describe your speech and or language problem ______________________
____________________________________________________________________________________
____________________________________________________________________________________
How long have you had this problem? ______________________________________________________
What do you think caused this problem? ____________________________________________________
How has the problem changed since it was first noticed? _____________________________________
____________________________________________________________________________________
How does this problem affect you? _________________________________________________________
In your family? ________________________________________________________________________
Socially? ____________________________________________________________________________
Vocationally? _________________________________________________________________________
Have you sought help for this problem elsewhere? Yes No

Please list the names of other clinics or agencies where you have been seen for evaluation or treatment of your
communication problem.

<table>
<thead>
<tr>
<th>Name</th>
<th>Location</th>
<th>Dates</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
1.    |          |       |         |
2.    |          |       |         |
3.    |          |       |         |

Medical History

Is there a medical reason for your present communication problem? Yes No

When did it occur? ___________ Describe ______________________________________________________
____________________________________________________________________________________

If hospitalized, please give location and dates of hospitalization.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Location</th>
<th>Date Admitted</th>
<th>Date Discharged</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Name of Physician treating this medical problem ________________________________

Location ___________________________ Phone ___________________________

Do you have any other significant medical problems?    Yes    No
Describe __________________________________________________________________

Do you have any eating or swallowing problems?       Yes    No
Describe __________________________________________________________________

Please provide any additional information that might be helpful in our evaluation or treatment planning.
POLICY STATEMENT

The purposes of the University of Maryland Speech and Hearing Clinic are:

1. To provide a training facility for those students seeking to become certified speech pathologists and audiologists.
2. To provide an environment for research.
3. To provide speech and hearing services to the public.

Because the clinic is a training facility for students, services are provided to the public at a reduced cost. All students conducting clinical sessions are supervised by Speech-Language Pathologist and Audiologists licensed by the State of Maryland and certified by the American Speech and Hearing Association. The clinic operates by appointment only, and follows the academic calendar of the University of Maryland. Services of this clinic may occasionally be cancelled for professional meetings.

Since we have a commitment to provide varied experiences for students, acceptance into the clinical program is of a selective nature and cannot be guaranteed from semester to semester. In addition, we cannot assure you of immediate placement in our program following the initial examination. We make every effort to provide the needed rehabilitative services, but it is sometimes necessary for us to place prospective clients on a waiting list. If accepted into the program, clients are expected to maintain regular and punctual attendance. If frequent absence or tardiness occurs, we reserve the right to dismiss the client from our program. If a session is missed due to clinic emergencies, the session will be make up another time or the fee for that session refunded. Clients are responsible for payment of sessions they cancel.

We trust that the above policy statements will contribute toward a smooth running, pleasant experience for all those who participate in the program at the University of Maryland Speech and Hearing Clinic.

BILLING POLICY

**Diagnostic evaluations** are scheduled for three-hour time slots and billed at a flat rate (call for Fee Schedule). Full payment is due at the time service is rendered. Cancellations must be made more than 24 hours in advance of the scheduled testing date. Clients who cancel diagnostic appointments with less than 24 hours notice will be billed a $75.00 fee.

**Speech therapy** fees are billed on a semester basis and are calculated based on the number of sessions per week multiplied by the weeks of service. Full payment is due on or before the first day of therapy unless specific alternate arrangements are made with the clinic office manager or clinic director.

**Cancellations**: Clients are responsible for paying for every scheduled session. Any sessions cancelled by clients (whether for vacation or illness) are not subtracted from the semester bill. Attempts will be made to arrange make-up sessions at times mutually convenient to both the client and clinician. However, if a make-up session cannot be scheduled, the client will be billed for the cancelled session.

If your clinician cancels a session for any reason or the University of Maryland in College Park closed for severe weather conditions, it is the clinician’s responsibility to provide a make-up session. If a mutually convenient date is not available, then the clinic will cancel the charge for that therapy session.

**Insurance**: We encourage clients to investigate the possibility of insurance coverage for speech-language services. However, please note that clients are responsible for paying their bill in full on the first day of therapy and then requesting reimbursement from their insurance provider. The clinic cannot validate claim forms before semester bills have been settled. Clients should request that their insurance company reimburse them directly. If the insurance company sends a direct payment to the clinic, we will return it to the insurance company to be re-issued, to refund the client.
SESSION IMPLEMENTATION AND DOCUMENTATION

- Decision Making charts
- Daily Logs
- SOAP Notes
Getting Started

Review Client folder

- Gather additional information
  - Do you need additional information?
    - YES: Collect additional information
    - NO: Is the information complete?
      - YES: Identify areas of need
      - NO: Collect additional information
        - Do you need additional evaluation information?
          - YES: Collect additional evaluation information
          - NO: Baseline targets
            - Write goals and behavioral objectives
              - Implement treatment
Treatment Sessions

Post Log
Prepare Data Sheets
Assemble Materials
Set-up Room

Do you need any special accommodation for the client?

YES

IDENTIFY NEED AND ACCOMMODATION

NO

BEGIN WITH OVERVIEW OF SESSION

INTRODUCE OBJECTIVE. BEGIN TREATMENT.

Branch Down
Offer more support

Branch Up

Is the client successful?

YES

Is target too easy?

NO

Complete activity.
Summarize performance.

Give target specific feedback & continue until criterion is met.

NO
EVIDENCE-BASED APPROACH TO TREATMENT

All graduate clinicians are encouraged to incorporate an evidence-based practice (EBP) approach to intervention. EBP is best conceptualized as the integration of three main components: (1) current best scientific evidence; (2) clinician expertise; and (3) client values, beliefs, and preferences including cultural/linguistic factors. Information in the professional literature can be categorized according to levels of scientific design and quality. The table below provides an evidence rating hierarchy that ranges from most to least scientifically robust.

Evidence Rating Hierarchy*

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>IA</td>
<td>Well designed meta-analysis of more than one randomized controlled study</td>
</tr>
<tr>
<td>IB</td>
<td>One well designed randomized controlled study</td>
</tr>
<tr>
<td>IIA</td>
<td>One well designed controlled study without randomization</td>
</tr>
<tr>
<td>IIB</td>
<td>One well designed quasi-experimental study</td>
</tr>
<tr>
<td>III</td>
<td>Well designed non-experimental studies (i.e., correlational and case studies, including multiple baseline designs)</td>
</tr>
<tr>
<td>IV</td>
<td>Expert committee report, consensus conference, clinical experience of respected authorities</td>
</tr>
</tbody>
</table>

* Adapted from ASHA 2008 website

From a practical perspective, clinicians should realize that “gold-standard” evidence (Levels I and II) is frequently unavailable in the research literature for our profession. Clinicians should evaluate existing information from the other levels of the hierarchy to guide their decision-making, to the extent possible. Implementation of an EBP approach may take many forms depending on the disorder and the needs of the client. As students receive caseload assignments during graduate clinical training, they should use these key steps to implement and EBP approach to treatment:

1. Ask an answerable and intelligent clinical question
2. Search for the best available evidence
3. Critically evaluate the evidence
4. Consider individual client characteristics and needs
5. Make a clinical decision with client input
6. Implement treatment plan and document progress/outcome(s)
Accent: a manner of pronunciation of a language
Dialect: variations of language differing in pronunciation, vocabulary, grammar, and prosody

Speech and Language Differences:
- Articulation/pronunciation
- Vocabulary/lexicon
- Syntax and morphology
- Prosody/intonation and stress
- Social language customs
- Knowledge and understanding of figurative language

Potential Clients:
- Speakers of regional American dialects
- Speakers of English as a second language

Goal Areas:
- Articulation
- Grammar
- Stress and intonation
- Co-articulation as it affects the “rhythm” of the language
- Social language, including figurative language and social cues

Focus of Therapy:
- Pronunciation only [similar to articulation therapy]
- Pronunciation and articulation
- Pronunciation, intonation, grammar, and social language

Resources:


**Disorder: Aphasia**

**Clinical Symptoms:**
- Agrammatism
- Paraphasias
- Perseverations
- Impaired word finding
- Non-fluent speech
- Impaired auditory comprehension
- Agraphia
- Alexia
- Excessive speech
- Jargon

**Associated Conditions:** Stroke, Traumatic Brain Injury, Neurosurgery, Agnosia, Cognitive Impairments, verbal apraxia, dysarthria

**Goal Areas:**
1. Automatic speech
2. Word finding
3. Phrase and sentence production
4. Auditory comprehension
5. Reading comprehension
6. Functional oral or written communication
7. Augmentative/alternative communication

**Therapy Approaches**
- Psychosocial Approach
- Life Participation Approach to Aphasia
- Functional Communication Approach
- Cognitive Approach
- Group Therapy

**Resources:**


Articulation and Phonology Disorders in Children

Clinical Symptoms:
- Slow acquisition of speech sounds
- Substitution or omission of speech sounds
- Difficulty identifying/using appropriate phonological rules
- Poor intelligibility of speech

Associated Conditions:
- Language impairment
- Hearing loss
- Childhood apraxia of speech
- Cerebral palsy
- Cleft palate
- Intellectual Impairment

Goals Areas:
- Increasing repertoire of consonants and vowels
- Increasing accurate production of speech sounds
- Improving mastery of phonological rules
- Improving intelligibility of speech

Therapy Approaches:
- Traditional (sensory-perceptual)
- Motokinesthetic
- Paired oppositions (minimal-maximal)
- Phonological processes

Resources:
**Disorder: Autism Spectrum Disorders**

**Clinical Symptoms:**
- Impairment in social interaction
- Impairment in communication
- Restricted, repetitive patterns of behavior. Narrow interests and activities.

**Receptive Language Profile:**
- Difficulty processing social meanings
- Deficits in processing nonsymbolic behavior
- Difficulty with rule extraction
- Dependence on context cues
- Limited understanding of a variety of semantic categories
- Lack of attention to listener needs
- Concrete/literal interpretation of language

**Expressive Language Profile:**
- Limited repertoire of communicative functions
- Limited/unconventional repertoire of communicative means
- Rote quality of expression
- Unconventional verbal behavior
- Deficits in oral motor programming
- Reduced rate of communication
- Prosodic features

**Goal Areas**

**Preverbal Stage**
- Establish reliable system of communication (PCS, sign, verbal)
- Expand conventional means and functions for communication
- Increase joint attention and social reciprocity

**Emerging Language Stage**
- Acquisition and expansion of vocabulary
- Increase ability to produce intelligible communicative acts (word, sign, picture)
- Ability to combine words, signs, pictures creatively to express relational concepts
- Build literacy skills

**Advanced Language Stage**
- Ability to convey information about past and future
- Increased conversation skills
- Use of nonverbal behavior to support social interaction
- Use of language as a tool for emotional regulation

**Therapy approaches (communication training):**
- Behavioral approaches
- Developmental/pragmatic approaches

**Essential Treatment Strategies:**
- Visual teaching
- Environmental supports
- Consistency, predictability and structure
- Clear, effective reinforcement

**Resources:**


### Disorder: Child Language

#### Clinical Symptoms:
- Failure to acquire language
- Delayed language
- Qualitatively different language acquisition
- Acquired language disabilities

#### Associated Conditions
- Intellectual Disability
- Hearing Impairment
- Minimal Brain Damage
- Emotional Disturbances
- Learning Disabilities
- Linguistic Differences
- Cerebral Palsy & Other Motor Disorders
- Environmental Deprivation
- Autism Spectrum Disorders

#### Goal Areas:
<table>
<thead>
<tr>
<th>Form</th>
<th>Receptive and/or Expressive Morphology and Syntax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Content</td>
<td>Receptive and/or Expressive Semantics</td>
</tr>
<tr>
<td>Use</td>
<td>Receptive and/or Expressive Pragmatics</td>
</tr>
</tbody>
</table>

#### Therapy Approaches:

<table>
<thead>
<tr>
<th>Developmental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive</td>
</tr>
<tr>
<td>Psycholinguistic</td>
</tr>
<tr>
<td>Integrative</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Non-Developmental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Content not from normal acquisition</td>
</tr>
<tr>
<td>Stress functional skills</td>
</tr>
</tbody>
</table>

#### Resources:


**Disorder: Stuttering**

**Clinical Symptoms:**
- Stuttering-like disfluencies including part-word repetitions, whole-word repetitions, prolongations, and silent blocks.
- Other “normal” disfluencies including interjections, phrase repetitions, multi-syllable word repetitions, and revisions.
- Physical concomitant behaviors including loss of eye contact, facial grimacing, head or limb movements
- Feelings associate with fluency breakdown or inability to effectively communicate including shame, embarrassment, frustration, inferiority, helplessness, and fear of speaking and stuttering
- Escape and avoidance behaviors including those that lead to struggle (tension, concomitant behaviors listed above), concealment of stuttering symptoms (linguistic coping strategies, attitudinal postures, role playing, etc)

Onset generally in early childhood, most often during the preschool years. The disorder progresses and changes over with increased awareness and desire to hide one’s identity as a person who stutters.

**Goal Areas:**
- Increased understanding about the nature of stuttering and the factors that lead to recovery and persistence
- Reduction of struggle and tension in communication
- Reduced fear of speaking/stuttering, as well as feelings of shame associated with stuttering
- Increased speech fluency and/or comfortable, forward-moving speech that includes some easy disfluency
- Reduced situational avoidance and increased comfort in public speaking
- Increase positive attitudes about oneself as a person who stutters and about speech and communication

**Therapy Approaches:**

Direct Therapy
- Changes in speech pattern: fluency modification; stuttering modification
- Changes in attitudes and emotions: desensitization; cognitive restructuring

Indirect Therapy (young children)
- Input and output strategies in the communicative environment

Operant Approaches
- Lidcome (young children)

Adjuncts to Therapy
- Electronic devices
- Psychopharmacology

**Resources:**


The Stuttering Homepage: [http://www.mankato.msus.edu/dept/comdis/kuster/stutter.html](http://www.mankato.msus.edu/dept/comdis/kuster/stutter.html)
Disorder: Voice

Clinical Symptoms: Clients usually present with a vocal quality that is hoarse and/or breathy or are unable to produce voice at all. Clients may experience pain or discomfort during phonation and may lose their voice frequently. The quality of the voice often affects their communication in social, academic, and professional settings. The etiology of the altered vocal quality may vary. It is important to establish the etiology so that treatment approaches are congruent with the disorder underlying the vocal symptoms.

Associated Conditions: Vocal nodules, vocal abuse/misuse, vocal fold paralysis/paresis, dysphonia, vocal hyperfunction/hypofunction, Parkinson’s Disease, surgery, head and neck cancer, neuromotor diseases, craniofacial anomalies, resonance disorders.

Goal Areas:
- Vocal volume
- Decreasing hoarseness and breathiness
- Improving breath support
- Use of compensatory strategies (frontal focus and easy onsets)
- Principles of vocal hygiene

Therapy Approaches:
1. Vocal function exercises
2. Vocal hygiene and facilitation of lifestyle changes
3. Teaching appropriate compensatory phonation strategies
4. Counseling regarding quality of life
5. Resonant voice therapy
6. Lee Silverman Voice Treatment program

Resources:


Clinician Responsibilities

**Daily:**
- Planning/preparation for therapy sessions
- Daily log (Fall, Spring)
- Home assignments for clients, as appropriate
- Record clinic hours
- Record client/clinician cancellations
- Maintain client files (contact notes)

**Weekly:**
- Communication/meetings with supervisor
- SOAP notes (summer)
- Meeting with co-clinicians, as appropriate
- Attend Core meeting (Thursdays at noon)
- Diagnostic Team
- Materials room assignment

**Semester:**
- Initial Treatment Plan (ITP)
- Progress Report
- Maintenance/carry-over activity for breaks in therapy
- Summer treatment plan (end of Spring semester only)
- Therapy application completed by client/family at end of each semester
- Midterm and final evaluation (grading) meetings with supervisor
DAILY LOGS
Instructions For Completion

Complete a daily log for each therapy session. Logs consist of 6 actions:

1. Behavioral Objectives
2. Rationales
3. Reinforcement
4. Client Performance
5. Self-evaluation of Clinical Skills
6. Problem-Solving, Insights and Planning

Sections 1, 2 and 3 are completed prior to session. The log is then posted on the therapy room window so that it may be viewed by the supervisor during the session. After the session, complete sections 4, 5, and 6. Place the completed log in the supervisor’s box within 24 hours of the therapy session.

1. Behavioral Objectives
   All planned objectives for a session should be listed, preferably in the order in which they will occur. There may be more than one objective for a target. List the terminal goal for the session first, and then list the sub-goals leading toward the objective.
   Note: In some cases, one activity is used to teach several targets (for example, a play dough activity might target verbal requests as well as joint eye gaze). Conversely, more than one activity may be used to elicit one target (for example, production of /r/ may be practiced with word reading, games, and in answering questions). Speak with your supervisor to agree on a system for listing activities as well as objectives, as appropriate

2. Rationales
   Write a rationale for why you chose a particular objective, why the client needs this skill, or why you are focusing on this skill during your session.

3. Reinforcement
   Write the type and schedule of reinforcement that you plan to implement during the session

4. Client Performance
   Report the client’s performance on the stated objectives. All data collection should be reported and interpreted here. Any branching that was necessary should be recorded and explained. You can describe the impact of the use of teaching strategies such as prompts, as well. Include subjective comments in reference to factors which you believe have affected client performance.

5. Evaluation of Clinical Skills
   Use this section to analyze your own performance. What went well today and why? What did not go well, and why? What changes in your performance would you make? What areas of your performance should be continued? Consider some of the skills listed in the Self-Evaluation of Clinical Skills in your clinic packet.

   Look beyond comments provided by your supervisor. What are your own perceptions of your performance during the session? What are your needs for long term change and growth?
6. **Problem-Solving, Insights, and Planning**

   Use this section for solving problems or for generating ideas for continued client improvement. Choose your own topics or consider one or more of the following questions to stimulate your thinking:

   Did I observe something that helped me understand my clients learning style or processing strengths and weaknesses?

   Was my client performing optimally? If so, what were the factors contributing to the clinical process? Where will I get from here?
   If not, what is impeding optimal performance? What variable can I change?

   Were my materials and activities motivating to my client? Did they provide optimum practice of target behaviors? Are they functional and relevant? Do they foster generalization to daily life?

   Am I challenging my client enough, yet keeping frustration to a minimum?

   Did the clinical environment, session structure, and visual displays aid my client’s learning?

   Is my client making steady progress? What are some of the factors that contribute to this?

   How am I relating to my client and client’s family? Is there a positive learning environment? Have I made the client and family an active part of the treatment team?

   I could improve my sessions if I learned a little more about ________. Explain.
<table>
<thead>
<tr>
<th>Behavioral Objective/Task</th>
<th>Rationale</th>
<th>Reinf.</th>
<th>Client Performance</th>
</tr>
</thead>
</table>


EVALUATION OF CLINICAL SKILLS:

PROBLEM SOLVING- INSIGHTS- PLANNING
### Behavioral Objective/Task

<table>
<thead>
<tr>
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<th>Reinforcement</th>
<th>Client Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>CE will produce /ɚ/ “er” (in a variety of vowel contexts) at the word level at a rating of 3 (on a scale of 1 to 3), with 90% accuracy. [special emphasis on plain /ɚ/ “er”, which has been much less accurate alone than in post-vocalic context at the word level]</td>
<td>To practice correct production at the word level.</td>
<td>1:1 verbal praise and corrective reinforcement</td>
<td>Initial informal assessment found all on target productions of /ɑɚ/, /ɛɚ/, /ɔɚ/, /ɑɪɚ/, but off target production of /ɔɚ/ and /ɚ/. Initial /ɚ/: 3/4 Medial /ɚ/: 15/28 Final /ɚ/: 5/8 Overall: 23/40 (58%)</td>
</tr>
<tr>
<td>CE will segment and decode written 2-syllable real and nonsense words with consonant clusters and digraphs but only simple vowels (no vowel digraphs) with 90% accuracy.</td>
<td>'To increase decoding knowledge.'</td>
<td>1:1 verbal praise and corrective reinforcement</td>
<td>[ ] “checklist” correctly segmented and decoded except for /ɛ/ produced as /ɪ/.</td>
</tr>
<tr>
<td>CE will segment and decode written 2-syllable real and nonsense words with consonant clusters and digraphs that include the vowel digraphs &lt;oo&gt;, &lt;ow&gt;, and &lt;ea&gt; with 90% accuracy.</td>
<td>'To increase decoding knowledge.'</td>
<td>1:1 verbal praise and corrective reinforcement</td>
<td>5 real words and 1 nonsense word all correctly segmented. Decoding correct in real words except for vowel errors. Decoding of digraphs 6/6 on possible sounds of digraphs in question (though not always the correct sound target). Sequencing trouble with “kealip”; persistent anticipatory insertion of /l/ right after /k/.</td>
</tr>
<tr>
<td>CE will segment and decode written 3-syllable words with consonant clusters and digraphs but only simple vowels (no vowel digraphs) with 90% accuracy.</td>
<td>'To increase decoding knowledge.'</td>
<td>1:1 verbal praise and corrective reinforcement</td>
<td>[not attempted]</td>
</tr>
</tbody>
</table>
Evaluation of Clinical Skills

- I was aware that Go Fish is traditionally for carrier phrase level work and that CE was not ready for this level. I wanted to do something different than Memory. I did instruct her to stick to single word production, but she often provided a carrier phrase (which is certainly more natural given the task) which would tend to decrease the speech planning resources she could devote to target production. So, not such a great task.

- Needed to provide her with more decoding support. Phyllis’ instruction to sound out each segment in isolation prior to blending accomplished this.

- Provided her mother with homework sentences for decoding involving the letter combinations we have been working on. (Provided her with a separate solution page with segments separated by / symbols.)

Problem Solving—Insights—Planning

- The problem is determining what the most efficient path is to improve her production. I have noticed that some sound contexts facilitate /ə/: after a velar and after /ɾ/ and /ɾ/. More specifically, she produces on target /sə/ and /oə/ very consistently and /kə/ and /ɡə/ lead to pretty good /ə/ production (though I wouldn’t say consistent yet). I think I went too far in implicitly concluding that plain /ə/ is the main problem and that the other vowel contexts have been “acquired” (/ɔə/ clearly is not).

- From this session’s data, she has a higher success rate with initial and final /ə/ than with medial (as could be expected due to coarticulation demands). Given the paucity of real words fitting this shape, our targets will have to be mainly nonsense syllables like /tə/ and /ɡə/. I could also try alterations with more successfully productions (as we did at the sound level), such as practice with /ɑəm/ to get /ɾm/.

- The original reading goal has two objectives, both based solely on vowel digraphs. The first objective is matching these digraphs to vowel sounds and the second involves decoding real and nonsense words that incorporate the target digraphs. My original intention had been to implement these objectives y gradually introducing more and more digraphs to the mix. I strayed away from these objectives by introducing multiple syllable words after noticing her speech planning difficulties with “acrobat” and “ornament”. The idea was that by segmenting and sounding out simple multisyllabic words (i.e., without vowel digraphs), she could practice motor planning on longer words. I now see this direction as somewhat of a distraction. I think we can productively work on /ə/ and vowel digraphs with single syllable words, and save multiple syllables for /ɾ/, since both CE and AF seem consistently ready to branch up with this latter target.
<table>
<thead>
<tr>
<th>Behavioral Objective/Task</th>
<th>Rationale</th>
<th>Reinforcement</th>
<th>Client Performance</th>
</tr>
</thead>
</table>
| 1. Given written stimuli containing target digraphs, E will accurately segment and blend non-words and real words with varying single syllable structures with no more than 1 prompt per word 90% of the time over 2 consecutive sessions. | --Increase automaticity of code knowledge ability to facilitate reading  
--Focus on 2 previously practiced sounds: “ai” and “ea”  
--Practice 2 new sounds: “oa” and ”oy” | Continuous verbal praise/fixed ration activity reward | Quick review of “ai” and “ea”: 8/8=100%  
“oa”: 11/12 = 92% (see back for details)  
“oy”: 12/12=100% |
| 2. Given orally presented words and a selection of graphemes to choose from, E will provide the correct spelling of the word with no more than 2 verbal prompts per word with 90% accuracy over 2 consecutive sessions. | To make use of practiced code knowledge to strengthen spelling skills | | 18/20=90% (see back for details) |
| 3. Given visual and/or verbal prompts, E will orally read 3-5 sentences consisting of target sounds with no more than 2 errors in 2 consecutive attempts over 2 consecutive sessions. | To reinforce practiced code knowledge and improve reading fluency | | 1st paragraph: 4 errors  
• 2 mispronunciations  
• 2 substitutions  
2nd paragraph: 3 errors  
• 2 mispronunciations  
• 1 omission (slowly→slow) |
**Evaluation of Clinical Skills:**

Good use of another fun board game that keeps E interested yet not so focused on the game that he doesn’t put effort into actually practicing the target sounds. Reviews of previously practiced sounds continue to be helpful, it’s pretty apparent that the “ai” and “ae” sounds have been maintained so far. E had extra incentive to work hard since his reward for reaching his money goal was to finish therapy at the diner. While filling up our water at the triple-filtered water spout, I had E read the sign describing what kind of water it was and that was fun and functional! E stayed on task and got through the planned readings without much frustration. It was some good clinician/client bonding time!

**Problem Solving—Insights--Planning:**

Although E was consistently producing the “oa” sound correctly, he still required 1 prompt for 2 words where he inserted as sound (foach→froach) or mispronounced a different sound (roas→roash). These are things he does when he doesn’t pay enough attention to the graphemes, because he knows that the grapheme “s” does not make the /ʃ/ sound. So I have to continuously remind him to pay closer attention to the graphemes. During spelling, he spelled “paint” as “peant”, in which case I can see the confusion (since “ea” can also make that sound) so I’m not always sure what to say or do during these instances since hi is using the skill he learned. I just said I can see why he would spell it that way, but English is a silly language and sometimes uses different letter combinations to make the same sound.
<table>
<thead>
<tr>
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<th>Rationale</th>
<th>Reinforcement</th>
<th>Client Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Client will speak without scripts in 90% of opportunities given clinician prompt.</td>
<td>1. To improve intelligibility of speech.</td>
<td>1. Verbal praise; tokens or icons as needed.</td>
<td>1. Client produced jargon-free speech in 20% (2 of 10) of opportunities with maximum clinician prompting (“Just say the real words. Say ____”).</td>
</tr>
<tr>
<td>2. Client will produce complete sentences in 90% of opportunities given clinician prompt.</td>
<td>2. To improve effectiveness of communication by speaking in complete sentences.</td>
<td>2. Verbal praise; tokens or icons as needed.</td>
<td>2. Client produced complete sentences in 50% (5 out of 10) opportunities with maximum clinician prompting (“Say the whole thing. Say ________”).</td>
</tr>
<tr>
<td>3. Client will shift eye gaze to conversational partner while speaking and listening in 80% of opportunities given clinician prompt.</td>
<td>3. To improve effectiveness of conversational skills by indicating attention with eye gaze.</td>
<td>3. Verbal praise; tokens or icons as needed.</td>
<td>3. Client shifted eye gaze to the clinician during a structured game in 67% (2 of 3) of opportunities with maximum clinician prompting (“Look at me. Look at my eyes when you talk”). Although client was able to shift eye gaze on some opportunities, eye contact was quickly abandoned while client spoke.</td>
</tr>
<tr>
<td>4. Client will take turns during a structured game format in 90% of opportunities given clinician prompt (“Whose turn is it?”).</td>
<td>4. To establish the foundations of conversational turn taking.</td>
<td>4. Verbal praise; tokens or icons as needed.</td>
<td>4. Client took turns during a structured game activity in 91% of opportunities with moderate clinician prompting (“Whose turn is it?”). Prompting occurred in about half of the turns.</td>
</tr>
</tbody>
</table>
Evaluation of Clinical Skills:

I was at a loss for how to engage S at the beginning of the session. He didn’t respond to the usual enticements at all. I felt patient with him, though, because I know how hard it is for kids like S to have a change in routine. Also, I’m sure it was a lot more enjoyable to be home with Dad than to be in therapy. When he finally did engage with me, it was when I brought the different things over to him. I had remembered that his mom showed him the real objects that were his choices when she was in the session with us one day. She said his teacher at school talks way too much, and I realized I had been yakking away about his choices. After that, I just went on instinct. I had no idea what to do about his insistent scripting. It was as if he wanted me to join him in that little world rather than joining me in the therapy word. I didn’t want to go along with his scripting but I felt conflicted too, because his attempts to have me say it were attempts at connection. But I opted for retreat because I felt like it was the “healthier” choice.

The “shopping for snack” activity was successful. I didn’t think S would talk to a stranger but he did, and was able to ask “May I have some Cheetos please?” or something close to that, with prompting. He had eye contact most of the time too. I think it’s good for him to be challenged a little bit outside his comfort zone, and food may be the way to do it.

Problem Solving—Insights—Planning:

I’m not sure it would have helped, but I could have acknowledged S’s feelings about being at therapy (“You might be feeling angry about coming here today” or “You seem sad to be here”).

I will try bringing objects over to him next time this happens. I wonder what would happen if I just laid down next to him when he shuts down. If it a situation where it was my classroom, I would probably try it. Or if next time I sit on the floor where he can look at me if he wants to, and I start to eat Goldfish crackers one at a time. That might snap him out of it.

I’m still trying to figure out how to extend the snack activity to get new things out of it. He can follow steps for making the “trail mix” pretty independently with visual cues. He doesn’t want any other “recipe” (I tried that). I can continue to have him tell me what to do next (like I do with painting) or have him say what he needs to do next when he makes the snack. I can continue to have him “shop” for the snack. I think it went very well this time because he asked Anne for each item (I was surprised he did it) with a list and prompting. I might see if he’ll shop for snack with one designated person in the student lounge. I could also do something like remove the spoon that he uses to stir the trail mix and ask him what we should do, and give him choices (“We could go get a spoon in the student lounge or you could stir it with this fork”). I’m really seeing how much autistic kids rely on routine and sameness. I think it’s part of the disorder, and changes are best made in tiny increments. I can just imagine how thrown off S was today because of huge changes in his routine.
S.O.A.P Notes

This is the standard format for writing daily or weekly progress notes in medical charts. We have modified our format a little from the typical hospital format. The parts that we have modified are in **BOLD** print.

The idea of a SOAP not in the real world is to be brief, be informative, focus on what the other members of the team (doctors, nurses, OT, PT, dietician, social worker… etc.) need to know, and include whatever information an insurance company would need to see to justify your continued involvement with the patient.

SOAP notes should be turned into your supervisor 24 hours after your session. Every attempt will be made to return them in a timely manner, however, you should keep a copy to help you plan for your next session.

**S: (SUBJECTIVE)** your impressions about the patient’s level of awareness, motivation, mood, willingness to participate. Could also be anything that the patient and/or family may say to you during a session?

**O: (OBJECTIVE):** Your data goes here. Any test scores, percentages for any goals; objectives worked on, any quantitative information clinical observation. NO INTERPRETATION!!!

**A: (ASSESSMENT):** So what? What does all the data mean? This is the interpretation section. **And CRITIQUE** what impact does the objective data have on the patient’s communication. **THIS IS ALSO WHERE YOU CRITIQUE YOURSELF AND THE SESSION.**

**P: (PLAN):** As the result of this session, what is your plan for the next session/week? Any changes to objectives, activities, reinforcement schedules that you want to implement go here.
SAMPLES

Typical Hospital SOAP note:

S: Patient alert for first 10 minutes then became lethargic and complained of pain in abdomen.

O: Patient seen at bedside for meal observation following swallowing study. Diet of pureed foods with honey thick liquids. Patient ate 50% of meal, required moderate cueing follow aspiration precautions. Family present and educated, handout given.

A: Significant improvement in oral stage dysphasia. Patient how able to tolerate mechanical soft diet without difficulty.

P: Consult with physician to upgrade diet to mechanical soft with thin liquids. Continue swallowing precautions. Will see daily for meal observation.

Typical Adult Aphasic Client

S: Patients wife: “He seems to be speaking much more clearly today, and seems to understand me better.

O: 1. Client completed word retrieval activities with 70% accuracy (7/10) Patient needed phonemic cues on 4 items.

2. He followed complex 2 step commands with 60% accuracy (6/10). Visual cueing needed for 2 items, and repetition needed on 4 items.

3. He wrote single words with 70% accuracy with no grammatical or spelling errors. Written homework assignment completed with only 2 errors.

* Criteria 80% for all objectives

A: Improvement observed in word retrieval activities and writing. Auditory comprehension remains at low level. Commands may be too hard or my presentation too fast. Pace of session was good.

P: Continue with all current objectives. Review auditory commands before next session. If auditory comprehension of commands continues to be low, could consider other types of comprehension activities. Remember to slow down presentation of commands by noting on data sheet.
**Typical Child Artic/ Lang Client**

**S:** Family arrived 15 minutes late for session. Client seemed tired and needed frequent cues to redirect attention.

**O:** 1. Client will produce /k, g/ with 80% accuracy in single CVC words given the clinicians model 10/20 trials correct = 50% accuracy

2. Client will differentially produce indefinite articles “a/am” at the carrier phrase level while describing pictures with 90% accuracy 20/20 trials correct = 100%

**A:** Client continues to demonstrate difficulty with velar consonants even though this is the 5th session to target them. Use of indefinite articles has been mastered at the carrier phrase level. Session pace was slow and may have affected client’s attention. Handled client’s off-task comments effectively.

**P:** Modify Objective #1 listed above by branching down to CV syllable level. Modify objective #2 by moving to spontaneous sentence level. Available time in session will allow for incorporation of new target: to produce personal pronouns (he/she) with 80% accuracy given clinician’s model at carrier phrase level.
**Typical Fluency Client**

S: Client reported reduction in overall fear level and tension in neck area during oral presentation in group meetings at work this week. Client is concerned about a telephone conference call scheduled for next Tuesday at work.

O: 1. Client will monitor retrial during a two-minute monologue with clinician with 90% accuracy over 2 sessions. 12/30 +40%

2. Client will make 2 phone call per week in a bystander situation at work as reported in 3 homework lag. 6/6/00, 6/8/00 = met this week

3. Client will use pull-outs in 50% of opportunities during a two-minute conversation with the clinician. 4 pull-outs/6 opportunities =66%

A: Client continues to demonstrate difficulty distinguishing between core repetition and retrials. **Also, he may be observing retrials but not signaling consistently.** Pull-outs on fixations met target criteria, pull-outs on laryngeal closures did not.

P: Use gestural prompt to aid signaling during monitoring, then fade. Add direct modeling for pull-outs on laryngeal closures.
S: EG had a good 3rd week. He was happy, cooperative and willing to participate in all planned therapy activities. He particularly enjoyed building a puzzle and water play with boats.

O:

Goal I. To spontaneously produce pronouns (I, me, my).

Objective B. Given verbal prompts, EG will produce the pronoun “I” in sentences with 90% accuracy over two consecutive sessions.

- “I”
  - 6-15 29/43=67%
  - 6-17 20/32=62%
  - 6-19 19/25=76%

Objective C. EG will spontaneously produce the pronouns “me” and “my” in sentences with 90% accuracy over two consecutive sessions.

- “me”
  - 6-15 12/12=100% [criterion met first time]
  - 6-17 11/11=100% [criterion met second time]

- “my”
  - 6-17 10/10=100% [criterion met first time]
  - 6-19 14/14=100% [criterion met second time]

Goal II. To spontaneously produce four word utterances

Objective D. EG will spontaneously produce 4 word utterances with 90% accuracy over two consecutive sessions.

- 6-15 14/20=70%
- 6-17 15/18=83%
- 6-19 14/19=74%

Goal III. To spontaneously use the articles “a” and “the”.

Objective B. Given visual and verbal prompts, EG will produce the articles “a” and “the” in their obligatory position in a carrier phrase with 90% accuracy over 2 consecutive sessions.

- “the”
  - 6-15 5/11=45%
  - 6-17 9/13=69%
  - 6-19 14/19=74%

- “a”
  - 6-15 [did not address]
  - 6-17 8/11=73%
  - 6-19 9/12=75%

A: EG met some objectives this week, including producing “me” and “my” at the spontaneous level. He continues to use “I” inconsistently; his four word utterances are rather inconsistent as well. He has clearly made progress with the use of articles as compared to last week. I need to make sure I leave enough time for the last activity of each session so that I can elicit a higher number of targets.

P: Continue emphasizing “I” instead of “me,” and giving immediate feedback after an incorrect production. Continue providing proper models for EG to produce 4 word utterances and give him a lot of praise for using long sentences. Work on “a” and “the” within carrier phrases and try to elicit more trials for both “a” and “the”.
DIAGNOSTIC PROCEDURES

- Before the Diagnostic Session
- During the Diagnostic Session
- After the Diagnostic Session
- Session Assignment Sheet
- Diagnostic Protocol Form
- Preliminary Results Form
- Diagnostic Evaluative Feedback Form
- Hearing and Immitance Screening Procedures
You will be part of a diagnostic team and assigned to a particular day & time. Each week two members of the team will do an evaluation and the other members of the team will observe. This opportunity to observe diagnostics that are being performed by other members of your team is an important part of your diagnostic clinical training. As an observer, you will be expected to arrive on time, watch carefully, score standardized tests, and may be included in the student/supervisor conference.

**When you are assigned an evaluation:** Two clinicians will be identified for each diagnostic session. Both will receive an assignment slip at least one week prior to the scheduled session. The slip will identify one student as the **primary clinician** and the other will assume the role of **secondary clinician**. The primary clinician will receive a grade and clock hours for the evaluation. The secondary clinician will not receive a grade, but can accrue clock hours as long as all assigned responsibilities are carried out in a satisfactory manner. A basic description of the responsibilities for each role is listed below. *Please be aware that a case supervisor may suggest modifications in how these responsibilities are carried out based on the specific needs of an individual client.*

**PRE-DIAGNOSTIC PREPARATION:** Both students will be responsible for planning the evaluation session. Sign out the client folder from the clinic office and review pertinent case history information. *(Please remember that client folders are confidential medical records. They never leave the building and photocopying information from them is prohibited.)*

Collaborate to decide what clinical questions need to be answered and what information/data should be collected during the session. Form tentative interview questions and identify a list of measures that will enable you to assess the relevant areas of communication (this could include standardized tests, clinician-designed tools, etc). Be prepared to give rationales for your choice of measures/tools.

The **primary and secondary clinician** should meet together with the case supervisor to discuss the plan for the session. Generally, the supervisor will not agree to a meeting to discuss the case unless both clinicians are in attendance. The **secondary clinician** should post the Diagnostic Protocol Form in the student room at least 2 school days prior to the session to let the “observer” team members become familiar with the plan. Make enough copies of all test answer forms for the observers and put them in their mailboxes so they will be able to follow along during administration of the measures in the session.

The **secondary clinician** should make sure that the hearing screening equipment (otoscope, audiometer, tympanometer) is functioning properly immediately prior to the start of the diagnostic session and that consumable supplies are available (screening forms, eartips, etc).

The **primary clinician** should contact the client 1-2 days prior to the session to confirm the appointment. Make sure they’ve received the necessary directions/parking information. Inquire about preferred activities/topics/reinforcers, but try not to ask substantial questions about significant background or history. Generally, those questions are better handled in the personal interview. If the client indicates that they will not be keeping the appointment, be sure to ask if they would like to be re-scheduled. Convey this information to the supervisor and other team members. Document this and any other contacts with the client on the contact sheet located at the front of the client’s folder.
**DURING THE DIAGNOSTIC:** Both **primary and secondary clinicians** should arrive at least 20-30 minutes prior to the session in order to set-up. Members of the observation team should arrive at least 10 minutes before the evaluation begins. Post the session protocol in the therapy room window. The **secondary clinician** generally ensures that any video and/or audio equipment is set up and ready for use.

**Primary clinician** should take the lead to introduce herself and then the secondary clinician as well as the supervisor to the client. Be sure to determine preferred forms of address in advance. Escort the client to the room accompanied by secondary clinician. Review the agenda for the 3 hr. session and then conduct case history interview. If the client is an adult, the **secondary clinician** generally remains in the room and takes detailed notes that will support the information recorded by the primary. If the client is a young child, the **secondary clinician** may take the child to another room to record a language sample while the primary clinician conducts the parental interview.

The **primary clinician** is generally responsible for administration of standardized tests and any other informal measures. This includes presentation of test stimuli, recording client responses, and providing encouraging feedback. The **secondary clinician** is generally present in the room and will act as the double-scorer of the client’s responses to test items and should make notes regarding clinical observations of the client’s communicative behaviors.

The **secondary clinician** may assume responsibility for the parts of the session that consist of hearing screening and oral peripheral examinations. When the testing portion of the session has been completed, the secondary clinician may escort the patient back to the waiting room and suggest that this may be a good time to talk to the clinic secretary about billing.

**Both clinicians** should meet with the supervisor (and possibly the observer team members) to brainstorm and talk about their impressions of the case. Discussion may include issues such as: whether a disorder exists, the severity of the impairment, prognosis, and treatment recommendations. This preliminary information should be recorded on the Preliminary Results of Evaluation form. The **primary clinician**, in conjunction with the supervisor, generally presents the wrap-up info to the client. The secondary clinician may be present in the room or watch from behind the window.

**AFTER THE DIAGNOSTIC:** Documentation that the session occurred should be entered by the **primary clinician** on the contact sheet in the client’s folder. **Once the data has been recorded on a standardized test form (regardless of whether identifying information is included), these are confidential medical records and should be treated as such.** All standardized test forms should be placed into the client’s folder **IMMEDIATELY following the session. All subsequent access to these test forms will require that the client file be signed out.** If an application for therapy has been filled out by the client, the **secondary clinician** should ensure that it is submitted to the Clinic Director’s mailbox. Be sure to fill out the top half of the back of the form.

The **primary clinician** is responsible for writing the diagnostic report. The **secondary clinician** must double-score all tests by reviewing scoring accuracy, recalculating raw scores, percentile ranks, and standard scores. This double-scoring should be recorded on the standardized test forms in a different color ink and include the secondary clinician’s initials and date. This is valuable information that the primary clinician will need to incorporate into the first draft of the diagnostic report. **Remember that this analysis will need to be done within the department (either in the student room or an empty therapy room) since none of the test forms may leave the building.**
A draft of the report should be submitted to the case supervisor by the primary clinician within one week. This first draft should represent your best work. Your ability to clearly present data and effectively analyze it in writing represents an important factor in the determination of your grade for diagnostic practicum. Supervisors will not accept submission of a first draft unless the test forms indicate that the double-scoring process has already been completed. The supervisor will return the first draft with written comments/modifications and will generally specify a due date for the revision. Submit the first draft along with your revised copy so the supervisor can easily see what changes should have been made. This process continues for all subsequent drafts. All rough drafts should be double spaced – the supervisor will specify when a final draft is ready for single-spacing and signatures.

Some supervisors may prefer to receive initial and subsequent drafts in electronic form. If this is the case, please submit your report as an email attachment (use client’s initials and do not include any other confidential information in your document). Comments/modifications will be made by the supervisor using Track Changes, and the document will be returned to you via email. Submit each subsequent draft in the same manner (supervisor will most likely maintain electronic copies of earlier drafts), until your supervisor indicates that the report is ready for single-spacing and signatures.

When the final drafts are signed by the supervisor and the primary clinician, then the supervisor will fill out a disposition form and forward the report to the clinic office for mailing/filing.
# Diagnostic Policies and Procedures

<table>
<thead>
<tr>
<th><strong>Primary Clinician</strong></th>
<th><strong>Secondary Clinician</strong></th>
<th><strong>Both Clinicians</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-Diagnostic Preparation</strong></td>
<td><strong>Post the Diagnostic Protocol Form</strong> in the student room at least 2 school days prior to the session</td>
<td><em>review pertinent case history information</em></td>
</tr>
<tr>
<td><em>Call client 1-2 days prior to the appointment to confirm</em></td>
<td><em>make enough copies of all test answer forms and give to diagnostic team members</em></td>
<td><em>develop the clinical questions and decide on what information/data should be collected during the session</em></td>
</tr>
<tr>
<td><em>document all contact with the client on the contact sheet located at the front of the client’s folder</em></td>
<td><em>check that the hearing screening equipment (otoscope, audiometer, tympanometer) is functioning properly and that consumable supplies are available (screening forms, eartips, etc).</em></td>
<td><em>form tentative interview questions</em></td>
</tr>
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<td><em>post the Diagnostic Protocol Form in the student room at least 2 school days prior to the session</em></td>
<td><em>reserve test materials</em></td>
<td><em>generate a list of assessment measures</em></td>
</tr>
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<td><em>document all contact with the client on the contact sheet located at the front of the client’s folder</em></td>
<td><em>ensure that video/audio recordings are ready to begin operation</em></td>
<td><em>have rationales for your choice of measures/tools</em></td>
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<td><em>make enough copies of all test answer forms and give to diagnostic team members</em></td>
<td><em>check that the hearing screening equipment (otoscope, audiometer, tympanometer) is functioning properly and that consumable supplies are available (screening forms, eartips, etc).</em></td>
<td><em>meet together with the case supervisor to discuss the session plan</em></td>
</tr>
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<td><em>check that the hearing screening equipment (otoscope, audiometer, tympanometer) is functioning properly and that consumable supplies are available (screening forms, eartips, etc).</em></td>
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<td><em>review pertinent case history information</em></td>
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<td><em>form tentative interview questions</em></td>
<td><em>generate a list of assessment measures</em></td>
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<tr>
<td><em>post the session protocol in the therapy room window</em></td>
<td><em>take detailed notes that will support the information recorded by the primary</em></td>
<td><em>arrive at least 20-30 minutes prior to the session in order to set-up</em></td>
</tr>
<tr>
<td><em>conduct case history interview</em></td>
<td><em>with young children, may elicit language sample while the primary clinician conducts the parental interview</em></td>
<td><em>meet with the supervisor (and possibly the observer team members) to brainstorm and talk about their impressions of the case</em></td>
</tr>
<tr>
<td><em>administer standardized tests and any other informal measures</em></td>
<td><em>act as the double-scorer</em></td>
<td><em>arrive at least 20-30 minutes prior to the session in order to set-up</em></td>
</tr>
<tr>
<td><em>present results and summarize information to the client with the supervisor</em></td>
<td><em>hearing screening and oral peripheral examinations</em></td>
<td><em>meet with the supervisor (and possibly the observer team members) to brainstorm and talk about their impressions of the case</em></td>
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<tbody>
<tr>
<td><em>document that the session occurred on the contact sheet in the client’s folder</em></td>
<td><em>ensure that the application for therapy has been submitted to the Clinic Director’s mailbox and make sure to fill out the top half of the back of the form</em></td>
<td><em>arrive at least 20-30 minutes prior to the session in order to set-up</em></td>
</tr>
<tr>
<td><em>write the diagnostic report</em></td>
<td><em>check raw scores and standard scores/percentile ranks. Place initials and date of double-scoring on all test forms</em></td>
<td><em>meet with the supervisor (and possibly the observer team members) to brainstorm and talk about their impressions of the case</em></td>
</tr>
<tr>
<td><em>submit a double-spaced draft of the report to the case supervisor within one week</em></td>
<td><em>make revisions as appropriate</em></td>
<td><em>arrive at least 20-30 minutes prior to the session in order to set-up</em></td>
</tr>
<tr>
<td><em>include the first draft along with your revised copy so the supervisor can easily see what changes should have been made (this process continues for all subsequent drafts)</em></td>
<td><em>ensure that the application for therapy has been submitted to the Clinic Director’s mailbox and make sure to fill out the top half of the back of the form</em></td>
<td><em>meet with the supervisor (and possibly the observer team members) to brainstorm and talk about their impressions of the case</em></td>
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DIAGNOSTIC SESSION ASSIGNMENT

FROM: ___________________________, CLINICAL SUPERVISOR

DATE ASSIGNED: __________________________

CLIENT: ___________    AGE: ______________

DISORDER: ______________________________________________________________

PRIMARY CLINICIAN: ________________________________

SECONDARY CLINICIAN: ________________________________

SUPERVISOR: __________________________________

DATE: _______________    TIME: _______________

ROOM: _______________

PLEASE MAKE APPOINTMENT TO MEET WITH YOUR SUPERVISOR AS SOON AS POSSIBLE

ADDITIONAL NOTES:
DIAGNOSTIC PROTOCOL FORM

CLIENT INITIALS: ______________________ AGE: __________

DISORDER: ____________________________________________

PRIMARY CLINICIAN: ________________________________

SECONDARY CLINICIAN: ________________________________

DATE: ________  TIME: ________  ROOM: ________

PLAN FOR EVALUATION

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________
PRELIMINARY RESULTS OF SPEECH AND LANGUAGE EVALUATION

NAME:  
DATE OF EVALUATION:

STUDENT CLINICIAN:  
LICENSED SPEECH-LANGUAGE PATHOLOGIST:

This is a preliminary report summarizing the results of the speech-language evaluation. A comprehensive report including test results and implications will be sent to you in approximately three weeks. Please contact us if you have any questions or concerns.

__________________________________________________________

SUMMARY OF SPEECH-LANGUAGE EVALUATION:

HEARING SCREENING:

RECOMMENDATIONS:
Criteria for Hearing Screening

Audiometric Screening

Pure-tones should screen monaurally with earphones. ASHA standards for audiometric screening recommend:

- 1000 Hz, 2000 Hz, 4000 Hz – at 20 dB HL for children (to 18 years)
- T000 Hz, 2000 Hz, 4000 Hz – at 25 dB HL for adults

The Screening is failed if any one stimulus presentation is missed at the screening level. The examiner must be sure that these recommended screening levels can be heard in the test environment by a person with normal hearing. Check yourself if you have normal hearing. Many test environments are inadequate because of ambient noise levels that are too loud.

Immittance-Screening

Tympanometry should be completed on both ears whenever possible.

This screening is failed if:

- Maximum compliance (the pressure peak) occurs at less than -150daPa
- Static compliance is less than .2ml
- Tymanometric configuration is flat
- Ear canal volume is inappropriate

Any failure should be reported or verification of recommendations.

Recommendations

1. With failure of both pure-tone and immittance screenings, a medical consultation and follow-up audio-logic evaluation or re-screening is recommended.
2. With failed pure-tone screening and normal immittance, refer for a complete audio-logic evaluation.
3. With normal pure-tone screening and a flat tympanogram, recommend medical consultation.
4. With normal pure-tone screening and significant negative pressure, schedule for an immittance check only 1-2 weeks later.
5. With failed pure-tone screening and negative pressure, a medical consultation and follow-up audio-logic evaluation or re-screening is recommended.
6. If earphones could not be used for pure-tone screening, refer for an audiologic evaluation.
7. If the pure-tone screening is normal, but immittance could not be completed (i.e., child was uncooperative, adult had excessive wax accumulation), attempt to re-screen 1-2 weeks later, if possible but no return visit is required.
8. If pure-tone screening takes longer than 20 minutes, try immittance screening. May need to reschedule for audiologic evaluation.
Sample Reporting of Screening Results

1. Normal results:
   John passed both pure-tone audio-metric and immittance screenings bilaterally. His hearing appears to be adequate for communication.

2. Normal audiometric results, abnormal immittance:
   A) Flat tympanograms

   John passed a pure-tone audiometric screening bilaterally but immittance test results indicated flat tympanograms in each ear. Although his hearing appears to be adequate for communication, immittance screening results suggest the possible presence of middle ear dysfunction bilaterally. It is recommended that John receive an otolaryngological consultation as soon as possible to assess the significance of these screening results.

   B) Significant negative pressure

   John passed a pure-tone audiometric screening bilaterally but immittance test results indicated significant negative middle ear pressure reflective of Eustachian tube dysfunction bilaterally. His hearing appears to be adequate for communication. However, it is recommended that John return in 1-2 weeks for a check of immittance data to ensure that his negative pressure has resolved.

3. Failed audiometric screening, normal immittance:
   John failed a pure-tone audiometric screening bilaterally. However, immittance test results indicated normal middle ear function in both ears. The possibility that John posses a communicatively significant hearing loss should be ruled out. Therefore, it is recommended that John receive a complete audiologic evaluation as soon as possible.

4. Failed audiometric screening, abnormal immittance:
   John failed both the pure-tone audiometric and immittance screenings. Typanometric results indicated flat tympanograms bilaterally. These findings suggest the possibility of a communicatively significant hearing impairment and the presence of bilateral middle ear dysfunction. It is recommended that John receive an immediate otolaryngological consultation and a complete audiological evaluation following any indicated medical treatment.

5. Could not test:
   John was seen for a pure-tone audio-metric screening on 9/9/00. Attempts to do audio-metric testing under headphones were unsuccessful. It is recommended that John be seen for a complete audiological evaluation.
General Guide to Tympanometry

Compliance (ml): Measures mobility of ear system. NORMAL RANGE: 0.2 to 1.75
Comments: may be higher than 1.75 and still be OK, especially if hearing is OK.
Action: If less than 0.25, call to attention to Doctor, unless you are sure there is a patent P.E. tube in place.

COMPLIANCE (daPa): Measures middle ear pressure. NORMAL RANGE: +25 to -175
Comments: Positive values of +50 or greater are probably artifact. Retest.
Action: if compliance (ml) is within normal limits but pressure is below -175, retest should be scheduled to follow progress. If tympanogram is flat or rounded (with no distinct peak), call to the Doctor’s attention.

Volume (ml): Measures size of ear canal. Normal Range: infants – Preschoolers: 0.2 to 0.6 ml; Preschool – school age: 0.5 to 1.2 ml; school age – adult: 1.0 to 2.0 ml
Comments: If smaller than 0.2 ml, test is probably not valid or ear is blocked with wax. Retest immediately.
Action: If larger than two time’s normal size, may be a perforation or a patent P.E. tube.

Reflex (dB SPL): NORMAL RANGE: 95 to 105 Db
Comments: Reflex may be absent due to fluid or hearing loss, however, obtaining accurate reflex data can be difficult, especially with young children.
Action: If reflex is absent and all other measures are normal, retest immediately. If reflex is consistently absent, test hearing acuity. If reflex is absent and other tympanometric findings are abnormal, call to Doctor’s attention.

General Comments: All values are nominal. Always retest immediately if you get a result that “doesn’t make sense.”

Make sure you are at eye level with the ear when testing. Pull the ear up and back firmly and point the probe down the canal.

Hold your hand steady and don’t move while the test is in progress.

Unusual spikes or irregularities in the tympanogram are usually caused by hand movement, talking, swallowing, etc.

Do not test draining ears; do not test with wet probe tips.

Keep probe and probe tips clean.
SAMPLE TYMPANOGRAMS

GSI 27
GRASON-STADLER, INC.

NAME

LEFT/RIGHT

DATE

EAR

EAR CANAL ml 0.8

TYMP PEAK ml 0.5
dPa -30

REFLEX dB HL

mi 1.5

Normal

PRESURE daPa

0 - 200 0 + 200

GSI 27
GRASON-STADLER, INC.

NAME

LEFT/RIGHT

DATE

EAR

EAR CANAL ml 0.7

TYMP PEAK ml 1.1
dPa -1.0

REFLEX dB HL

mi 1.5

Flat Normal Vol.

PRESURE daPa

0 - 200 0 + 200

GSI 27
GRASON-STADLER, INC.

NAME

LEFT/RIGHT

DATE

EAR

EAR CANAL ml 3.0

TYMP PEAK ml 1.1
dPa -1.0

REFLEX dB HL

mi 1.5

Flat Large Vol.

PRESURE daPa

0 - 200 0 + 200

GSI 27
GRASON-STADLER, INC.

NAME

LEFT/RIGHT

DATE

EAR

EAR CANAL ml 0.7

TYMP PEAK ml 1.1
dPa -1.0

REFLEX dB HL

mi 1.5

Flat Small Vol.

PRESURE daPa

0 - 200 0 + 200
PROFESSIONAL WRITING

- Philosophy
- Rules to Live By
- Technical Style
- Proofreading
- Report Headings
- Diagnostic Report Format
- Initial Therapy Plan Format
- Semester Progress Report Format
- Summer Semester Report Format
PROFESSIONAL WRITING

As a speech-language pathologist, you will typically write diagnostic reports, therapy plans, case notes, progress reports, and discharge reports. These various report formats allow you to present and interpret test scores, make recommendations, summarize performance and progress in therapy, and provide documentation of various issues related to your client.

Although case notes can be brief and less formal, all other reports and documentation must be written in an appropriate professional and technical style. Remember…your report might be the first contact that another professional has with you. Your competence and professionalism can and will be judged by how well you communicate in writing. Poorly written reports can compromise your professional credibility.

Philosophy

- Report your findings objectively; conclusions must be supported by the data. Be careful not to state your opinion as if it is fact. You are not expected to be omnipotent. If you cannot fully explain test findings, behaviors, etc., say so in your report. Always acknowledge discrepancies in test results and/or observations and attempt to explain them.
- Assume that your client and/or family members are going to read your report. Take this into consideration when deciding what information to include and how to present it. This is particularly important when summarizing reports from other professionals. Be sure to indicate where you got your information and be careful not to change this information in any way.
- Know your scope of practice and do not overstep these bounds. For example, as a speech-language pathologist, you cannot diagnose ADHD, autism, or learning disabilities.
- Be particularly careful when stating prognoses and making recommendations. Be realistic. Base your prognosis on available all available evidence, and never promise a certain level of success within a specific time period.

General Rules to Live By

- Use professional terminology but provide explanations and examples so that nonprofessionals will understand
- Avoid needless words
- State the full name of tests, diagnostic labels, institutions, facilities, etc. the first time you use them in a report. Thereafter, you can use abbreviations or acronyms.
- If you are speculating, make that clear to the reader. Use phrases such as, “It appears that,” “It seemed as though,” “the data suggest that,” and “It is possible that.”
- Avoid misusing words (e.g., affect / effect, among/between, accept/except, principle/principal, ensure/assure).
- Beware of unusual singulars and plurals (e.g., datum/data, criterion/criteria, phenomenon/phenomena, locus/loci, parenthesis/parentheses)
- Use commas, hyphens, colons, and semi-colons correctly. Remember….”Punctuation marks are the traffic signals of language. They tell us to slow down, notice this, take a detour, and stop.” (Lynne Truss in Eats, Shoots, and Leaves)
- Know your Latin abbreviations and use them correctly (e.g. means “for example” ….i.e. means “that is”)
Technical Writing Style
(Adapted from Roth & Worthington, 2011)

• Avoid writing clinical reports in a conversational style (e.g., “He just didn’t get the point” versus “He did not appear to understand the task”).

• Use correct spelling, grammar, and punctuation and write in complete sentences.

• Write in the third person (e.g., “The Token Test was administered” rather than “I administered the Token Test”).

• Avoid use of contracted verb forms (e.g., isn’t, can’t, I’ve).

• Give the full names of tests when first mentioned before sing acronyms and other abbreviations in the remainder of the report.

• Express information in behavioral terms (e.g., “followed two-step command” versus “is able to follow two-step commands”).

• Present information (particularly case history) in chronological sequence.

• Differentiate clearly between information reported by others versus information obtained directly though clinician observation.

• List all data such as test scores or baseline measures before providing any interpretative statements; this approach facilitates interpretation of a client’s overall profile rather than presenting unrelated descriptions of isolated communication skills.

• Include information about a client’s strengths as well as weaknesses in the body of the report.

• Avoid presenting information in the summary section of any report that was not introduced previously in the body of the report.

• Write reports to communicate with colleagues using professional terminology, but include simple explanations and clear examples to make reports meaningful to family members and other non-professionals.

• Use language that is specific and unambiguous (e.g., “He demonstrated language skills characteristic of 4-year-old children” versus “He demonstrated poor language skills”).

• Avoid exaggeration and overstatement (e.g., “completely uncooperative,” “absolutely intelligible,” “never produces /s/,” “extremely motivated”).
Proofreading

• A first draft is your finished report
  o It should be neat, complete and proofed. All drafts must be word processed and printed double spaced
  o Completed tests forms/data sheets should be turned in with your first draft
  o All previous drafts must be given to the supervisor with each subsequent draft, revision or final copy
  o Final copies should be single spaced

• Before you hand in your first draft and all subsequent drafts…
  o Make sure that you have used the required report format
  o Read the report over… aloud! You are more likely to catch errors that way
  o Check for typos, spelling errors, and grammar errors

• When you get your report back from the supervisor
  o Read over the comments and ask for clarification when needed
  o As you make each suggested change, check it off in a different color ink to make certain that you have addressed all edits

ADDITIONAL TIPS FOR PROOFREADING CLINICAL REPORTS

Student clinicians can use the following set of proofreading questions to edit and monitor the quality of clinical reports.

• Are spelling, grammar, and punctuation correct?
• Are professional terms used accurately?
• Is there redundancy of word usage or sentence type?
• Are any sentences too lengthy, rambling, or unfocused?
• Is all the important client information included in the report?
• Is information presented only in the germane sections of the report (e.g., recommendation statements should not be included in the background information section)?
• Does the report follow a logical sequence from one section to the next (i.e., from background, to data and interpretation, to summary and recommendations)?
• Are raw data interpreted and not merely reported?
• Are all conclusions and assumptions supported by sufficient data?
• Are speculative statements explicitly identified as such?
• Does the report contain seemingly contradictory statements without adequate explanation?
• Is the working clear or are some statements vague and ambiguous?
• Is content presented with appropriate emphasis (e.g., has any critical information been overlook? Has any minor point been overemphasized)?
• Is the report written with ethical/legal considerations in mind?

Content and Organization

As a student clinician, you will be writing Diagnostic Reports, Individual Therapy Plans, and Semester Progress Reports. The next several sections outline the required content and organization for each of these reports.

Report Heading Formats

UNIVERSITY OF MARYLAND
HEARING AND SPEECH CLINIC
College Park, MD  20742
(301) 405-4218

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Speech-Language Evaluation
Semester, Year

<table>
<thead>
<tr>
<th>Name:</th>
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</thead>
<tbody>
<tr>
<td>Parents/Spouse:</td>
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Initial Therapy Plan
Semester, Year

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Semester Progress Report
Semester, Year

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Summer Semester Report

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<td>Therapy Dates:</td>
<td>Graduate Clinician:</td>
</tr>
<tr>
<td>Number of Sessions:</td>
<td>Supervisor:</td>
</tr>
</tbody>
</table>
Instructions for Diagnostic Reports

Headings and Identifying Information
These should be positioned and listed as shown on the “Report Heading Format” section.

REASON FOR REFERRAL: This section should include when the client was referred, by whom, and for what reason.

PERTINENT HISTORY: Include pertinent birth, medical, developmental, educational, speech-language, and social history. Identify with whom the client lives, occupation (if an adult), and the presence of family history of disability, if appropriate.

ASSESSMENT RESULTS:

Test Behavior: An objective description of the client’s behavior including attention, distractibility, motivation, cooperativeness, and/or physical condition.

Test Data: List all tests administered and report the following information (as applicable) in table format: raw scores, standard scores, composite scores/quotients, and percentile ranks.

Skill Areas: This area provides an analysis of the client’s performance, including interpretation of the test scores listed previously. The headings/organization of skill area discussion will vary according to disorder and salient client characteristics. As a general rule, this section should not be organized solely on a list of the subtests as presented in the previous table.

Other Pertinent Data: This section should include information about relevant areas of assessment such as oral-motor examination or hearing screening. Information should be as detailed as necessary based on client characteristics.

SUMMARY AND IMPRESSIONS: This section should pull together the assessment results discussed in the body of the report. Summary should include mention of both strengths and weaknesses in client profile. Provide clear statements of diagnosis, severity rating, and prognosis (as appropriate).

RECOMMENDATIONS: State whether or not intervention is recommended. IF so, give an indication of the type and frequency of therapy needed. If appropriate, specific recommendations for goals and objectives to be addressed during intervention can be provided. Include recommendations for additional testing or referrals as appropriate.

The content of diagnostic reports may vary considerably based on disorder and client profile. See following pages for examples. Additional sample reports will be provided to students as needed.
A, a seventeen-year-old male, was evaluated at the University of Maryland Hearing and Speech Clinic on October 6, 2008 and October 20, 2008 because of concerns about his speech and language skills and their effect on his academic performance and social interactions. A has received speech and language services in school, and his parents would like updated testing to clarify his current speech and language abilities.

PERTINENT HISTORY:

Information relating to A’s developmental, medical, and speech and language history was obtained from a written case history, past reports, and personal interviews with A and his mother, Mrs. L, at the time of the evaluation.

According to Mrs. L, she took medication during her pregnancy to control contractions. Her pregnancy was otherwise unremarkable, and she carried A to term. Mrs. L reported that A met developmental milestones according to age-appropriate norms, although she noted that he had weak muscle tone.

A’s medical history is significant for recurrent middle ear infections. At one year of age, he had pressure-equalizing tubes placed in his ears. In subsequent years, he experienced perforations in both eardrums and had bilateral tympanoplasties to repair the perforations. This past summer, a small perforation in the right eardrum was discovered when A was examined by a physician for possible swimmer’s ear. A hearing test on July 15, 2008 at Kaiser Permanente indicated normal hearing, except for a mild loss of 40 dB at 250 Hz in his right ear. Middle ear tests indicated large ear canal volumes, suggesting ear drum perforations. He is scheduled for a follow up evaluation with his ENT.
A was diagnosed with Tourette Syndrome, Attention Deficit Hyperactivity Disorder (ADHD), and Obsessive Compulsive Disorder (OCD) when he was ten-and-a-half years old. Mrs. L reported that A’s father also has a history of OCD, as well as possible learning difficulties.

With regard to his speech and language abilities, Mrs. L reported that A understands what is said to him if it is simplified and usually responds to questions and statements with short answers. She said that A has difficulty participating in “the give and take” of conversation and does not know how to “repair” communication breakdowns. Mrs. L stated that A does not tend to engage in conversations as often as other youngsters his age and “does not seem like part of a group.” Although he has opportunities to interact with his peers from school, he is more likely to socialize with younger children in his neighborhood. In addition to these social issues, A’s parents are also concerned about the impact of receptive and expressive language weaknesses on his academic performance and his ability to self-advocate in the classroom. Areas that are reportedly difficult for him include written expression, math and reading. A said that he would like to strengthen his vocabulary, be able to ask questions and participate more in class, and become more confident in his ability to speak.

**Educational Background**

A attended Thomas Pullen School in Prince George’s County from September, 1996 to June, 2005. In 1996, when he was in kindergarten, A was identified as having receptive-expressive language deficits and delayed speech. He received speech and language services until he was in the fourth grade. When A was in the seventh grade, his speech and language skills were re-evaluated. The evaluation report, dated March 21, 2005, indicated overall oral language skills in the low-average to average range of functioning. Skills were described as “not significantly discrepant from that expected for his chronological age.”

In September, 2005, A transferred to the Harbour School in Annapolis. In July, 2007, he participated in a speech and language evaluation through the Prince George’s County Public Schools. The evaluation report did not include test scores, but a narrative summary of results reported overall performance in the moderately-low to well-below-average range on selected subtests of the *Clinical Evaluation of Language Fundamentals* – Fourth Edition (CELF-4). Auditory processing, pragmatic-language rule difficulties, memory weakness, and word retrieval problems were noted. Speech-language therapy was recommended, along with specific strategies and approaches to facilitate learning and to compensate for memory, linguistic, and processing difficulties. A subsequently received therapy at the Harbour School; a progress report dated March, 18, 2008 indicated that he received approximately one hour per week of direct and indirect speech and language services. Therapy goals focused on conversational skills and self-advocacy, answering inferential questions, vocabulary understanding, sequencing, and using comprehension strategies.

In September, 2008, A transferred to High Road School in Prince George’s County, which specializes in serving students with learning, language, and social challenges. His current IEP goals focus on pragmatic language skills, including conversational exchange, conversational repair, and self-advocacy, as well as receptive language skills, including comprehension, answering inferential questions, and vocabulary development.
Other Pertinent Information
In October, 2007, A participated in a neuropsychological evaluation at Children’s National Medical Center in Washington, D.C. The evaluation report described overall cognitive skills in the borderline range. Reported areas of weakness included: verbal and nonverbal information processing; attention and executive functioning; self-awareness; working memory; retrieval of information; and social interactions. Strengths included: A’s ability to retain information once it is encoded; his likeable interpersonal style and positive relationships; his steady growth in self-awareness and motivation; and his increasing openness to intervention. Academic and reading skills were also assessed. Letter-word identification and spelling scores were within the average range; calculation, applied problems, writing, reading fluency and reading comprehension scores were in the low-average to below-average range. Recommendations included speech and language supports through school and, possibly, outside of school.

ASSESSMENT RESULTS:

Test Behavior:
A was cooperative, friendly, and polite throughout each assessment session. He cooperated during all testing and gave each task his best effort. Therefore, test results and observations are felt to be an accurate reflection of A’s language abilities.

Test Results:

Clinical Evaluation of Language Fundamentals 4TH Edition (CELF-4)

<table>
<thead>
<tr>
<th>Subtest</th>
<th>Raw Score</th>
<th>Scaled Score</th>
<th>Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recalling Sentences</td>
<td>90</td>
<td>12</td>
<td>75</td>
</tr>
<tr>
<td>Formulated Sentences</td>
<td>52</td>
<td>11</td>
<td>63</td>
</tr>
<tr>
<td>Word Classes- Receptive</td>
<td>18</td>
<td>8</td>
<td>25</td>
</tr>
<tr>
<td>Word Classes- Expressive</td>
<td>11</td>
<td>7</td>
<td>16</td>
</tr>
<tr>
<td>Word classes- Total</td>
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<td>16</td>
<td></td>
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<tr>
<td>Word Definitions</td>
<td>27</td>
<td>10</td>
<td>50</td>
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<tr>
<td>Sentence Assembly</td>
<td>12</td>
<td>7</td>
<td>16</td>
</tr>
<tr>
<td>Semantic Relationships</td>
<td>14</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Understanding Spoken Paragraphs</td>
<td>8</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>
**Test of Language Competence-Expanded Edition (TLC-Expanded)**

### Subtest Scores
Mean=10; Standard Deviation=3

<table>
<thead>
<tr>
<th>Subtest</th>
<th>Raw Score</th>
<th>Standard Score</th>
<th>Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Ambiguous Sentences</td>
<td>30</td>
<td>9</td>
<td>37</td>
</tr>
<tr>
<td>2 Listening Comprehension: Making Inferences</td>
<td>24</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>4 Figurative Languages</td>
<td>18</td>
<td>4</td>
<td>2</td>
</tr>
</tbody>
</table>

### Composite Scores
Mean=100; Standard Deviation=15

<table>
<thead>
<tr>
<th>Composite</th>
<th>Sum: Subtest Standard Scores</th>
<th>Composite Standard Score</th>
<th>Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpreting Intents (Subtests 2 + 4)</td>
<td>7</td>
<td>65</td>
<td>1</td>
</tr>
</tbody>
</table>

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**Expressive Vocabulary Test - 2nd Edition (EVT-2)**
**Peabody Picture Vocabulary Test - 4th Edition (PPVT-4)**

Mean=100; Standard Deviation=15

<table>
<thead>
<tr>
<th>Test</th>
<th>Raw Score</th>
<th>Standard Score</th>
<th>Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>EVT-2</td>
<td>113</td>
<td>78</td>
<td>7</td>
</tr>
<tr>
<td>PPVT-4</td>
<td>182</td>
<td>91</td>
<td>27</td>
</tr>
</tbody>
</table>

(PPVT-4) – (EVT-2)
Standard Score Difference = 13
Significance Level = .05

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**Oral and Written Language Scales (OWLS)**
Mean = 100; Standard Deviation = 15

<table>
<thead>
<tr>
<th>Scale</th>
<th>Raw Score</th>
<th>Standard Score</th>
<th>Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Written Expression</td>
<td>35</td>
<td>92</td>
<td>30</td>
</tr>
</tbody>
</table>
**Skill Areas:**

**Semantics**
Semantics refers to the study of meaning in language and includes meaning at the word, sentence and discourse levels.

A’s receptive and expressive vocabulary skills were assessed at the single-word level using the PPVT-4 and the EVT-2. The PPVT-4 is a receptive test that required him to point to the correct picture from a field of four, given an orally presented word. His standard score of 91 falls within the low-average range for his age. The EVT-2 is an expressive test that required A to provide a synonym, given a picture prompt and an orally presented word. Performance on this test depends on both vocabulary knowledge and word retrieval. A’s standard score of 78 falls within the below-average range for his age. The 13-point discrepancy between his receptive and expressive vocabulary scores is statistically significant and suggests weak word retrieval skills, despite adequate vocabulary knowledge. Word retrieval difficulties can affect the ease with which an individual formulates language at the discourse level and can result in speech that seems disfluent and lacks specificity (e.g., using words like “thing” and “stuff,” when the desired word cannot be retrieved). Weaknesses in this area can have a negative impact in the classroom, such as when a student is required to answer curriculum-related questions or engage in classroom discussions.

The *Word Definitions* subtest of the CELF-4 evaluates the ability to define a target word, given that word in the context of a sentence. A’s scaled score of 10 falls in the average range for his age and suggests that he is able to derive and verbalize meaning from context. This skill is important in understanding curriculum-related word meaning across academic disciplines.

The *Word Classes* subtest of the CELF-4 evaluated A’s ability to comprehend relationships between words that share similar features (*Word Classes – Receptive*) and to verbally express the relationship between the two words (*Word Classes – Expressive*). For this subtest, A was given a list of four words and was asked to select the two that go together best. Once he made the selection, he was required to explain how the two words go together. A’s ability to identify the related words and to explain how they are related falls within the low-average range for his age (SS=8 and SS=7, respectively). In the classroom, these skills are essential for oral and written tasks that require classifying words by category, comparing and contrasting, and using antonyms and synonyms.

The *Semantic Relationships* subtest of the CELF-4 evaluated A’s ability to interpret sentences that make comparisons, identify location or direction, specify time relationships, include serial order, or express information in passive voice. On this subtest, A listened to a sentence or sentences, and then selected two correct responses, given a question related to the information presented. A’s scaled score of 6 falls in the below-average range for his age. He appeared to have the most difficulty with tasks that required him to understand time relationships and serial order. The ability to interpret semantic relationships is important in the classroom for interpreting relationships presented verbally and in text materials and for following verbal and written directions.
The *Understanding Spoken Paragraphs* subtest of the CELF-4 evaluated A’s ability to understand the main idea of orally-presented, paragraphs-length material, understand and remember details and sequence of events, and make inferences and predictions from the information presented. A’s scaled score of 5 falls in the below-average range for his age. These skills relate to classroom requirements for understanding narratives, events and opinions, applying critical thinking skills, and understanding instructional materials across academic subjects.

The Test of Language Competence (TLC) was designed to evaluate metalinguistic competence (higher-level language skills that allow one to reflect on and manipulate various aspects of language). Three subtests from the TLC were administered to assess metalinguistic competence in semantics: *Ambiguous Sentences; Listening Comprehension: Making Inferences; and Figurative Language*. *Ambiguous Sentences* evaluates the ability to recognize and interpret alternate meanings of word and sentence-structure ambiguities. Given an orally presented ambiguous sentence, A was asked to provide two alternative interpretations. His standard score of 9 falls in the average range for his age. It should be noted that A benefited from repetition and paraphrasing of instructions for this subtest, including encouragement to “visualize” the sentence. The *Listening Comprehension: Making Inferences* subtest evaluates the ability to make inferences, based on causal relationships or chains in orally-presented paragraphs. A was asked to provide two permissible inferences for each paragraph. His standard score of 3 falls in the below-average range for his age. The *Figurative Language* subtest evaluates the ability to interpret metaphors. Given a situation and a metaphoric expression, A was asked to select an equivalent metaphorical expression from among four written choices and then interpret the expression in his own words. Maximum points are earned when the correct expression is selected and the interpretation is adequate. A’s standard score of 4 falls in the below-average range for his age. His scores on the *Figurative Language* and *Listening Comprehension: Making Inferences* subtests were combined to provide the *Interpreting Intents* composite score, which fell in the below-average range. Weaknesses in this area can negatively affect A’s ability to interpret classroom directions or text materials, when information or intervening events are implied. In social situations, an inability to interpret intent can lead to misunderstandings or difficulty “following” conversations when the speaker implies information, uses unfamiliar figures of speech, or omits background information.

**Syntax and Morphology**

Syntax refers to the rules that dictate the acceptable sequence, combination, and function of words in a sentence. Morphology refers to the rules that regulate how words are formed (e.g., adding an “s” onto a noun indicates plurality; adding an “ed” onto a verb indicates past tense).

The *Formulated Sentences* subtest from the CELF-4 evaluates the ability to formulate complete, meaningful, and grammatically correct spoken sentences of increasing length and complexity, using target words and picture prompts. A’s scaled score of 11 on this subtest falls in the average range for his age.

The *Sentence Assembly* subtest from the CELF-4 evaluates the ability to formulate grammatically correct, meaningful sentences by rearranging words and groups of words. For
each test item, A was required to provide two correct sentences. His scaled score of 7 on this subtest falls at the low end of the average range for his age. With the exception of one test item, A provided at least one correct sentence for all items. The following are examples of incorrect sentences: “It was hot even though she ate it” and “The boy was clever who won the contest.” This task imposes more semantic and syntactic constraints on sentence formulation than the Formulated Sentences task, which might account for the discrepancy in A’s performance on these two subtests.

The Recalling Sentences subtest from the CELF-4 assesses the ability to listen to sentences of increasing length and complexity and repeat the sentences without changing word meaning, word form, or sentence structure. A’s scaled score of 12 falls in the high-average range for his age.

The OWLS Written Expression Scale was used to assess A’s ability to write meaningful and grammatically correct sentences and to use appropriate spelling, capitalization and punctuation. A’s standard score of 92 placed him in the average range for his age. Although he made some capitalization and punctuation errors, sentence complexity, grammar, spelling, and meaningful content were generally good. He had some difficulty when constraints were imposed, such as when he was required to combine several sentences into one or formulate a single sentence, given a specific set of target words. Results suggest that A’s written language skills at the sentence and short paragraph level are good in terms of mechanics, grammar and meaning. Skills such as organization and integration of information that are required for lengthier writing tasks were not assessed.

Overall, A’s understanding and use of the morpho-syntactic rules of grammar in oral and written expression are within the average range. These skills are important in the classroom for writing and note taking, formulating responses, asking questions, and engaging in classroom discussions.

**Pragmatics**

Pragmatics is the social use of language and involves the ability to use language for a variety of purposes, to change language based on the listener or the environment, and to follow social conventions in conversations.

The Test of Pragmatic Language (TOPL) assesses social language skills. Since A does not fall within the age range of the norm population, this test was used as an informal, descriptive measure. It required him to answer questions about various scenarios, taking into consideration the setting, audience, topic and purpose of the social interaction. A provided appropriate answers to 36 out of 44 questions (82%). He had difficulty on several items requiring him to take the perspective of another person.

In order to identify specific areas of concern that A and his mother might have regarding A’s pragmatic skills, they were each asked to complete the Social Communication Skills Rating Scale. A’s ratings indicated a number of strengths including: using appropriate body language and facial expressions; respecting “personal space;” accepting compliments; being aware of others’ feelings; getting along with people; and apologizing. Weaknesses including:
maintaining the topic of conversation; initiating and ending conversations; asking for help; and asking for clarification. This pattern of strengths and weaknesses was generally consistent with Mrs. L’s ratings; however, she included the following additional concerns: introducing himself and introducing others; expressing himself clearly; giving and receiving constructive criticism; stating his opinion in an appropriate way; and repairing conversational breakdowns.

Taking all the data into consideration, A’s pragmatic profile reveals both strengths and weaknesses. Based on observations during testing, his interactions with adult clinicians were always appropriate. He engaged in social routines, responded to greetings, took turns during conversation, maintained the topic of conversation, provided information when responding to questions, made appropriate eye contact, and used facial expression to help convey emotion. His performance on the TOPL suggests that he “says the right thing” in many day-to-day social situations, although he has some difficulty taking perspective. Test results also indicate that he has difficulty interpreting intent. These deficits can have an impact on A’s ability to see another person’s point of view and understand innuendo or implied meaning. As a result he might feel “lost” in conversation and elect to pass up opportunities to initiate conversation or enter ongoing conversations with peers. In fact, A recognizes some of these difficulties; he said that he sometimes has a hard time understanding what someone is trying to say, and that, while he gets along with everyone at school, he rarely initiates conversation and finds it hard to join in. A said that he is more comfortable interacting with neighborhood friends, because he knows them better.

Other Pertinent Data:

Hearing Status

A hearing screening was administered as part of the evaluation. A passed the audiological screening at 25 dB, bilaterally. Dr. Kerry Chmielenski, a clinical instructor in the Audiology Department at the University of Maryland, conducted immittance testing to assess A’s middle ear functioning, including the integrity and movement of his eardrums. Results suggested perforations in both eardrums (see attached summary of results).

SUMMARY AND IMPRESSIONS:

A number of formal and informal measures were used to evaluate A’s speech and language abilities. Results suggest overall language skills in the low-average to average range, with some isolated skills falling in the below-average range.

In terms of his semantic skills, strengths include: his vocabulary knowledge; his ability to understand and define words, given a context; his ability to recognize and interpret ambiguities; and his ability to convey meaning effectively in oral and written expression. A’s expressive vocabulary skills are below-average for his age and are significantly weaker than his receptive vocabulary skills. This suggests word retrieval deficits that can negatively affect language
formulation. A also has difficulty interpreting and expressing semantic relationships at the word and sentence levels, interpreting intent (e.g., inferences and non-literal language), and understanding orally presented paragraph-length information. These deficits can make it difficult for him to: understand classroom instruction and curriculum materials that require inferences or interpretation of relationships; make logical predictions; and answer questions that require comparison and contrast. In social situations, an inability to understand the intent of the speaker’s message can lead to misunderstandings and communication breakdowns.

With regard to grammar skills (syntax and morphology), A demonstrated age-appropriate understanding and use of grammar rules in spontaneous oral and written expression, although he had some difficulty formulating sentences with word or word-order constraints. Written expression at the narrative level was not evaluated; therefore, it is not possible to comment on A’s ability to organize and integrate information in lengthier text. This area should be further evaluated; if deficits exist, they could have a negative impact on A’s academic performance as writing demands increase.

A’s pragmatic profile reveals both strengths and weaknesses. During both evaluation sessions, his social interactions were always appropriate. He engaged appropriately in social routines, took turns in conversation, responded to questions, and commented appropriately. Test results indicated that he has some difficulty taking perspective and interpreting intent, especially when it is conveyed in a non-literal fashion. These deficits can make it difficult for him to see things from another person’s point of view and to understand innuendo or implied meaning in conversations and classroom discussions.

RECOMMENDATIONS:

It is recommended that A continue to receive speech-language therapy to address language weaknesses that can have a negative impact on his academic success. Goals should include the following:

- Improving conversational skills, including the ability to engage in extended conversation, repair communication breakdowns, and self-advocate
- Improving the ability to interpret non-literal language, including understanding figures of speech and making inferences
- Using word-retrieval strategies to facilitate language formulation and oral communication
- Improving the ability to interpret and express semantic relationships, especially as these skills relate to understanding curriculum materials

Additional testing is recommended to assess for possible deficits in A’s ability to organize and integrate information in lengthier writing tasks.

The following is a list of accommodations that could be provided in the classroom environment to facilitate A’s academic success:
• Clearly state verbal directions (straightforward and concrete)
• Ask A to summarize directions / instructions to ensure that he has understood them
• Repeat and/or paraphrase instructions if they have been misunderstood
• Encourage A to write down assignments
• Provide written instructions for more complex homework / project assignments
• Use multiple modalities when presenting new information (written, verbal, visual, demonstration)
• Provide models or examples of desired responses, behaviors, assignments
• Provide verbal prompts to aid with correct responding
• To increase self confidence with peers, ask A to lead a small group activity if he has some expertise or interest in that area
• Consider preferential seating for possible impact of mild hearing loss

B.A. Graduate Clinician

M.A., CCC-SLP Licensed Speech-Language Pathologist
Speech-Language Evaluation  
Fall, 2010

Name: A.M.  Date of Birth: 
Parents: Age: 9 years, 4 months  
Address: Gender: Male  
Phone: Graduate Clinician: B.A.  
Primary Language: English  Clinical Supervisor: M.A., CCC-SLP  
Date of Evaluation: 10/18/10 and 11/08/10

Statement of Problem:

AM, a 9-year, 4-month-old boy, was evaluated at the University of Maryland Hearing and Speech Clinic on October 18, 2010 and November 8, 2010 due to parental concerns regarding his articulation, language, and reading skills. He participated in a speech and language evaluation at the Hearing and Speech Clinic in the spring of 2008, when he was in the first grade. At that time, his reading comprehension fell in the below-average range, and he showed weaknesses in auditory comprehension and auditory reasoning. A speech and language screening in March 2010 resulted in a “borderline pass” for language understanding and language expression. Reading and language weaknesses were found, but articulation was within normal limits. It was noted that AM frequently asked for repetition and clarification of directions during the screening, and that he had difficulty expressing how words are related. He also demonstrated difficulty formulating grammatically correct sentences, given a set of target words. A complete speech and language evaluation was recommended following this screening. With regard to concerns about AM’s, articulation, Mrs. M noted that he runs words together and does not enunciate clearly much of the time. In terms of reading comprehension, she is concerned that AM is not retaining or understanding information that he has read. She stated that when he reads aloud, he substitutes words that do not make sense, given the context, and continues reading without apparently noticing his mistake. The main areas of concern for AM are reading comprehension, auditory comprehension, auditory reasoning, and articulation.

Pertinent History:

Information about AMs development was obtained from a case history report and an interview with his mother at the time of the first evaluation session. AMs birth history was unremarkable, and developmental milestones, including development of language skills, were met according to
appropriate timeframes. AM had frequent ear infections when he was younger. No hearing loss is suspected.

When AM was a toddler, he was diagnosed with dyspraxia and received private services for articulation and speech delay. He was enrolled in speech-language therapy at The Language Experience, LLC, to address his articulation. Goals included production of /n/ and /l/ and increasing oral motor strength, range of motion, and endurance. Therapy was discontinued in 2005, after approximately a year and a half of treatment, although not all goals had been met. Currently, his mother reports that his speech is understandable but that he tends to run his words together. In first grade he received a speech and language evaluation at the University of Maryland Hearing and Speech Clinic (HESP Clinic). Articulation skills were found to be within normal limits, but therapy was recommended for language-related issues. Although he did not receive speech-language therapy following the evaluation, he received reading resource services at his school in a small group setting until last year. This current school year, AM does not qualify for this service. His parents anticipate that the university’s evaluation will help determine if continued special services are needed. According to his mother, AM receives grades of “D” on assignments that involve reading; this affects his overall academic performance.

In addition to speech and language testing, AMs parents are also in the process scheduling neuropsychological testing to determine if he has attention deficit disorder (ADD). His parents and reading resource teacher notice that AM lacks focus when working on homework and school-related activities, especially those that involve reading. They want to rule out ADD as a contributing factor in language and reading difficulties. Although he did not have a definitive diagnosis, his doctor prescribed medication for ADD last year to determine if this would be helpful. His mother stated that she noticed a difference in his behavior and his ability to focus, when he was on the medication. Although his classroom teacher did not notice any difference, his reading resource teacher found that his processing was excellent and noted that he could write a focused paragraph that was clear and concise. She also found his thoughts to be more precise. His resource teacher noticed the greatest improvement in written expression, but also found improvements in comprehension.

**ASSESSMENT RESULTS:**

**Test Behavior:**

AM presented as a pleasant, energetic and receptive child during the evaluation. He particularly enjoyed earning tokens for completion of tasks. During the first day of testing, AM became restless and demonstrated decreased attention after about an hour of testing. He continued to work, but voiced his desire to finish multiple times. Occasionally, he became distracted or responded impulsively. With encouragement, he was able to refocus and continue testing for a time; however, a decision was made to continue the evaluation another day in order to ensure that test results were an accurate depiction of AMs skills. During his second day of testing, AM was very cooperative and seemed more focused.
It should be noted that the Gray Silent Reading Test (GSRT) was administered toward the end of the first testing session; however, there was considerable concern about whether AM was attending to the task and giving it his best effort. He appeared to rush through the test and mark his answers impulsively, as though he simply wanted to finish quickly. The results of the GSRT are not considered to be valid, and the scores are not reported here. With the exception of the GSRT, test results are felt to be an accurate representation of AM’s speech, language and reading skills.

**Test Data:**

**Clinical Evaluation of Language Fundamentals – Fourth Edition (CELF-4)**
(Subtest Mean=10, Standard Deviation=3)

<table>
<thead>
<tr>
<th>CELF Subtest</th>
<th>Raw Score</th>
<th>Standard Score</th>
<th>Percentile</th>
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<tbody>
<tr>
<td>Concepts and Following Directions</td>
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<tr>
<td>Word Classes-Receptive</td>
<td>9</td>
<td>9</td>
<td>37</td>
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<tr>
<td>Word Classes-Expressive</td>
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<tr>
<td>Word Classes-Total</td>
<td>N/A</td>
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<tr>
<td>Understanding Spoken Paragraphs</td>
<td>10</td>
<td>9</td>
<td>37</td>
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**Test of Language Competence – Expanded Edition (TLC-E)**
(Subtest Mean=10, Standard Deviation=3)

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<thead>
<tr>
<th>TLC-E Subtest</th>
<th>Raw Score</th>
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<th>Percentile</th>
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<tbody>
<tr>
<td>Ambiguous Sentences</td>
<td>37</td>
<td>8</td>
<td>25</td>
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<tr>
<td>Listening Comprehension: Making Inferences</td>
<td>40</td>
<td>12</td>
<td>75</td>
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<tr>
<td>Oral Expression: Recreating Speech Acts</td>
<td>66</td>
<td>5</td>
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</table>

(Subtest Mean=10, Standard Deviation=3)

<table>
<thead>
<tr>
<th>TAPS-3 Subtest</th>
<th>Raw Score</th>
<th>Standard Score</th>
<th>Percentile</th>
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</thead>
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<tr>
<td>Auditory Reasoning</td>
<td>12</td>
<td>10</td>
<td>50</td>
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Oral and Written Language Scales (OWLS)
(Subtest Mean=10, Standard Deviation=3)

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<thead>
<tr>
<th>Written Expression Scale</th>
<th>Raw Score</th>
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<tr>
<td></td>
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Gray Oral Reading Tests – Fourth Edition (GORT-4)
(Subtest Mean=10, Standard Deviation=3)

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<td>Fluency</td>
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<tr>
<td>Comprehension</td>
<td>34</td>
<td>13</td>
<td>84</td>
</tr>
<tr>
<td>Oral Reading Quotient</td>
<td>97</td>
<td></td>
<td>Average Range</td>
</tr>
</tbody>
</table>

Skill Areas:

Articulation and Fluency

AMs speech was intelligible overall in conversational speech, test responses, and oral reading. He demonstrated a slight lisp on /s/ and /z/ sounds. During the Gray Oral Reading Test – Fourth Edition (GORT-4), he occasionally mumbled and slurred words together. At times he failed to enunciate words clearly, though some of these pronunciations remained intelligible.

AMs fluency was evaluated based on informal observation of his speech during routine conversation. He occasionally repeated or revised words and phrases and he frequently used fillers, such as “um.” His speech is not characteristic of a child who stutters, and these patterns do not affect his overall speech fluency or intelligibility.

Semantics

Semantics refers to the study of meaning in language and includes meaning at the word, sentence and discourse levels.

Receptive: AMs receptive semantic skills appear to be age-appropriate. He understood vocabulary during spontaneous conversation and was able to follow instructions while playing and participating in testing. He scored in the average range on the CELF-4 subtests of Concepts and Following Directions, Word Classes-Receptive, and Understanding Spoken Paragraphs. The first subtest evaluates the ability to comprehend oral directions of increasing length and complexity and to complete tasks based on these directions. Additionally, the subtest requires understanding of concepts frequently incorporated into directions, such as “above,” “next to,” “after,” “first,” “then,” “if,” “at the same time.” The second subtest evaluates the ability to understand and explain logical relationships in the meanings of associated words. The last subtest evaluates the ability to understand narratives in the form of spoken paragraphs of
increasing length and complexity and to answer questions about their content. The questions assess understanding of the main idea, details, sequence of events, and the ability to make inferences and predictions from information presented in the paragraph.

AM also scored in the average range on the TLC-E subtest, *Ambiguous Sentences*, which evaluates the ability to perceive more than one meaning from a sentence. He also scored in the average range on the TLC-E subtest, *Listening Comprehension: Making Inferences*, which measures the ability to offer plausible inferences for the situations and outcomes described.

AM’s ability to understand implied meanings and to make inferences about what he hears was also evaluated using the *Auditory Reasoning* subtest of the TAPS-3. This task required him to integrate and relate information as well as to draw conclusions that were not specifically stated in the passage. AM’s performance on this subtest was in the average range. Overall, AM scored in the average range with regard to receptive semantic skills.

*Expressive:*

AM scored in the average range on the CELF-4 subtest, *Word Classes-Expressive*, which evaluates the ability to explain logical relationships in the meanings of associated words. AM did well in providing a verbal rationale for how two words were related. He scored in the average range on the OWLS Written Expression Scale, which evaluates the ability to communicate meaningfully using written format. This test measures writing skills in three areas: *Conventions* (the ability to apply rules of spelling, punctuation, capitalization, etc.); *Linguistics* (the ability to use language forms such as modifiers, phrases, verb forms, complex sentences, etc.); and *Content* (the ability to communicate meaningfully through appropriate subject matter, coherence, word choice, etc.).

AM scored in the below-average range on the TLC-E subtest, *Oral Expression: Recreating Speech Acts*, which evaluates the ability to reflect, evaluate, and produce logical, grammatically complete sentences, given a pictured context and stimulus words. This subtest measures the ability to formulate expressions of intent and include key words related to a familiar situation. Although he typically incorporated the stimulus words into his sentence, he did not always formulate a sentence that was appropriate in meaning, given the pictured context. For example, given the words “home” and “before,” AM responded, “Let’s go to home before we play at the park.” His sentence did not accurately reflect the context of the picture, which showed two children at the entrance of a playground. Typically, children would play first before heading home. AM tended to respond quickly, without planning his responses beforehand. This may have had a negative impact on his performance. His performance may also reflect language formulation weakness, particularly when constraints (e.g., stimulus words and picture contexts) are imposed. In these cases, children may sacrifice one aspect of the task; for example, they may abandon one of the stimulus words but formulate a meaningfully appropriate sentence. This action suggests a pay-off strategy in which the child sacrifices the condition to use both stimulus words in order to meet the condition to formulate a sentence that is consistent with the picture. Usually, the abandoned stimulus words are conjunctions, prepositions, pronouns, or modifiers. AM occasionally exhibited these response characteristic. This task also requires the individual to “take the perspective” of a character in the scenario, and this may have been difficult for AM.
Reading

AMs reading skills were evaluated using the Gray Oral Reading Test (GORT-4). This test requires the individual to read several short passages and answer questions following each passage. The GORT-4 examines reading rate, or the speed at which someone reads, and accuracy, or the number of errors while reading. Rate and accuracy measures are then combined to assess the reader’s overall fluency, or their ability to read naturally and smoothly without making errors. AMs overall reading accuracy on the GORT was below-average. In addition to decoding errors, he occasionally mumbled and slurred words together. At times he also failed to enunciate specific words clearly. Overall he read the passage without precise enunciation, almost as if he was reading through his teeth or without opening his mouth properly, though intelligibility remained intact for the most part. AMs reading rate was average. His overall fluency was in the below-average range. He sometimes ended a sentence at the end of a line, even if the sentence continued. He would start the next line, which was actually part of the sentence begun on the previous line, as a new sentence. This resulted in poor prosody. He occasionally mispronounced words or substituted similarly spelled words. Interestingly, AM would continue reading without revision, even if these substitutions did not make sense in context (e.g., in a passage about cowboys, AM substituted the word “crows” for the word “cows” in the following sentence, “When cows roamed the vast ranges of the Southwest, the herd could not be rounded up without skilled riders on horseback.”). In addition, AM added articles (particularly “the”) many times throughout the texts.

AM’s Reading comprehension was also evaluated using the GORT-4. After reading each passage, the reader selects the best answer for several multiple choice questions based on the passage. These questions are read by the examiner, and the individual does not have access to the passage while answering them. AM scored in the above-average range, despite inaccurate decoding and weak overall fluency. He evidently derived sufficient meaning from context and portions of the passage that were read accurately to compensate.

According to the GORT-4, the Oral Reading Quotient (ORQ), a type of standard score, is the best measure of a student’s overall oral reading ability. The ORQ is base on fluency and comprehension. AMs ORQ is within the average range.

Pragmatics

AMs pragmatic abilities (the social use of language in communication) were assessed during testing breaks and routine conversation with the clinicians. He demonstrated appropriate communicative behaviors, including facial expression, use of gestures, and eye contact. He introduced and maintained the topic of conversation, asked questions, and took turns in conversation. AM demonstrated appropriate pragmatic abilities.
Other Pertinent Data:

Hearing Screening:
Results from a hearing screening suggest hearing within normal limits, bilaterally. The results from the tympanometry screenings indicated normal middle ear function.

SUMMARY AND IMPRESSIONS:

A variety of formal and informal measures were used to evaluate AMs speech, language, and reading skills.

In terms of speech, AM pronounces /s/ and /z/ with a lisp, and his articulation in conversational speech is frequently imprecise. Nevertheless, his overall speech intelligibility in conversation is good.

AM scored within the average range on most expressive and receptive language tasks. He was able to: comprehend oral directions of increasing length and complexity and to complete tasks based on these directions; understand and explain relationships between associated words; and understand narratives in the form of spoken paragraphs of increasing length and complexity. He understood and was able to explain ambiguities in language and make plausible inferences, given specific situations. He also demonstrated age-appropriate ability to communicate meaningfully using written format. AM had some difficulty on the subtest Oral Expressions: Recreating Speech Acts from the TLC; his performance may reflect language formulation weakness, particularly when constraints (e.g., stimulus words and picture contexts) are imposed. This task also requires the individual to “take the perspective” of a character in the scenario, and this may have been difficult for AM.

AMs overall reading ability falls within the average range. Reading fluency (the ability to read naturally and smoothly without making errors) is an area of weakness. He made numerous decoding (accuracy) errors, and his reading speed may have been affected by increased decoding time for unfamiliar words. Despite these weaknesses, AMs overall reading comprehension appears to be in the average range; he was apparently able to derive sufficient meaning from context and portions of the passage that were read accurately. However, although he is able to compensate at this point, he may not be able to do so as academic demands increase and curriculum reading materials increase in difficulty.

RECOMMENDATIONS

Speech-language therapy is recommended to address AM’s lisp. Reading resource services are also recommended to ensure adequate code knowledge for reading accuracy and to teach strategies for more accurate, fluent reading. Classroom accommodations are also encouraged to facilitate AM’s attention to tasks in the classroom, pending the outcome of neuropsychological testing. In addition to speech-language therapy, the following recommendations are made:

- Preferential seating in the classroom to minimize distractions and facilitate focus and attention to task
Reading Resource services focusing on strategies such as:

- Effective application of code knowledge to segment and blend unfamiliar words while reading
- Improving self-monitoring while reading, so that AM recognizes when he substitutes words or makes errors in decoding; use oral reading to promote better self-monitoring
- Tracking with an index finger or using a bookmark or ruler to isolate each line and avoid ‘skipping’ lines while reading
- Having AM summarize information after reading a short section and before continuing with the text, to encourage attending to and retaining information he has read
- Have AM reread if he does not understand or remember something

B.A. Graduate Clinician
M.A., CCC-SLP Licensed Speech-Language Pathologist
Instructions for Initial Therapy Plans

Headings and Identifying Information
These should be positioned and listed as shown on the example.

Pertinent History
In a paragraph form, state the full name and age of the client, the date of the client’s initial diagnosis and pertinent, concise diagnostic information. If the client was referred from another source, tell the date, referral source, chief complaint, and pertinent diagnostic-therapy information. If the client has received therapy previously, give a brief summary of the dates of the most recent therapy and briefly summarize goals and progress.

Semester Goals and Objectives
In an outline form, record pertinent speech-language-fluency-voice-behavioral goals and objectives. A long-term goal is a general statement of what is to be accomplished over the course of the semester. Under the long-term goal, specify relevant initial status/baseline data that has been collected and used as the basis for the short-term objectives which will follow underneath. Include significant behavior and any relevant standardized test results.

An objective is a specific statement which incorporates:
   a) The target performance,
   b) Conditions under which the behavior is expected to occur and
   c) The criterion

Materials and procedures are generally not included as part of goals and objectives.

(Note): For all formal and informal tests give name of test, date and pertinent test results. Underline the names of all formal tests and use abbreviations only after previously giving full name of tests. Ex: Test of Auditory Comprehension of Language—Revised (TACL-R). Do not use nicknames for tests in reports (i.e., Zimmerman for the Preschool Language Scale).

Reinforcement
In paragraph form, indicate type and schedule of reinforcement/feedback to be used to shape targets and attending behavior. Note how the reinforcement schedule will be modified over the course of the semester.

Parental Involvement
In paragraph form, give an indication of how parents will be involved in observation, session participation, counseling and home assignments.

Carryover Program
In paragraph form, specify plans for generalization of target objectives within home, school or work settings.
UNIVERSITY OF MARYLAND
HEARING AND SPEECH CLINIC
College Park, MD 20742
(301) 405-4218

Initial Therapy Plan

Name:  E G  Date of Report:  2/10/200X
Parents:  
Address:  Drive
Silver Spring , MD 20XXX  Date of Birth:
Age: 4-6  Category: Articulation/Phonology
Graduate Clinician:
Supervisor:  , MS, CCC-SLP

PERTINENT HISTORY:

E began speech therapy at the University of Maryland Speech & hearing Clinic in June 200X. He was originally diagnosed with a severe phonological disorder. He received individual treatment for four consecutive semesters (including 2 summer semesters). Recent goals were directed toward reducing velar fronting, stopping, weak syllable deletion, and glottalization of medial consonants. Significant progress was noted. E began the University of Maryland’s Language-Learning Early Advantage Program (LEAP) Preschool on February 5, 200X. He will receive 30 minutes of individual speech therapy three times per week and will participate in the LEAP Preschool program three mornings per week.

TEST INFORMATION:

Articulation

The Goldman-Fristoe Test of Articulation-2 Sounds- In-Words subtest was used to evaluate E’s production of English speech sounds in the initial, medial, and final position of words. This test is normed for children two years and older. E’s results follow.

Goldman-Fristoe Test of Articulation-2
(Mean=100; Standard deviation=15)

<table>
<thead>
<tr>
<th>Raw Score</th>
<th>%ile</th>
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<tbody>
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<td>29</td>
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Sound Production

<table>
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<td>w/j</td>
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<tr>
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<td>s/tΣ</td>
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<tr>
<td>w/r (&quot;wabbit&quot; for &quot;rabbit&quot;)</td>
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<td></td>
</tr>
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</tr>
<tr>
<td>d/δ (&quot;dis&quot; for &quot;this&quot;)</td>
<td>d/δ (&quot;fedder&quot; for &quot;feather&quot;)</td>
<td></td>
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<tr>
<td>b/br</td>
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<td>w/tr</td>
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</table>

E’s standard score 82 and percentile ranking of 20 places him in the low to below-average range for production of speech sounds in words. These results indicate delayed speech sound production for his age and gender at this time. Observed phonological processes included: gliding, stopping of fricatives and affricates, consonant cluster reduction and substitution.

Language

A spontaneous language sample of 100 consecutive utterances was collected on September 17, 200X in order to informally assess E’s use of grammatical morphemes, units of meaning, in his connected speech. Analysis of the sample revealed a mean length of utterance (MLU) of 5.25, which is Brown’s Stage V+. The predicted MLU at 4 years 6 months is 3.96-6.08 (1 standard deviation). This measure indicated age-appropriate length of utterance and use of specific word types and endings. Although the auxiliary forms are later-developing morphemes, there were no instances of appropriate use in obligatory contexts suggesting the forms are not emerging.

Grammatical Morphemes Present in Sample
1. Present Progressive
2. Preposition in
3. Preposition on
4. Regular plural –s
5. Irregular past
6. Uncontractible copula (main verb)
7. Articles (a, the)
8. Regular past –ed
9. Regular third person
10. Irregular third person
11. Contractible copula
12. Possessives

Grammatical Morphemes Not Present in Sample (in obligatory contexts)
1. Uncontractible auxiliary
2. Contractible auxiliary

**SEMESTER GOALS AND OBJECTIVES:**

**Phonology**

Goal I. To improve speech intelligibility through suppression of the phonological process of “velar fronting” in conversation.

*Initial Status on 2/6/0X:* /k/ and /g/ with 100% accuracy in carrier phrases and approximately 75% in connected speech

A. E will differentially produce front and back sounds at the sentence level with 80% accuracy over two consecutive sessions.
B. E will differentially produce front and back sounds in conversation with 80% accuracy over two consecutive sessions.

Goal II. To improve speech intelligibility through suppression of the phonological process of “glottalization of medial consonants” in conversation.

*Initial Status on 2/6/0X:* glottalization of medial consonants 50% in 3 & 4 syllable words

A. E will produce medial consonants in 2-4 syllable words at the sentence level with 80% accuracy over two consecutive sessions.
B. E will produce medial consonants in 2-4 syllable words in conversation with no more than two errors in a five minute conversation over two consecutive sessions.

Goal III. To improve speech intelligibility through suppression of the phonological process of “consonant cluster reduction/substitution” in conversation.

*Initial Status on 2/6/0X:*
Cluster reductions and substitutions at a 100% error rate in single words for: b/br, fw/fr, l/gl, kw/tr, p/pr, w/dr, st/sk, , w/tr, w/fr;
50% error rate in single words for: pl/fl, w/gr, and w/kr.

A. E will produce both sounds in word initial consonant clusters in single words with 80% accuracy over two consecutive sessions.
B. E will produce both sounds in word initial consonant clusters in carrier phrases with 80% accuracy over two consecutive sessions.
C. E will produce both sounds in word initial consonant clusters in sentences with 80% accuracy over two consecutive sessions.
D. E will produce both sounds in word initial consonant clusters in conversation with 80% accuracy over two consecutive sessions.

Language

Goal I. To spontaneously produce the auxiliary verb “is/are” in present progressive tense spontaneously.

Initial Status on 2/6/0X:
is + ing 50% with a model
are + ing 0% with a model

A. Given clinician model, E will imitate the auxiliary verb is/are in present progressive tense in sentences with 100% accuracy over 2 consecutive sessions.
B. Given clinician verbal cue, E will include the auxiliary verb is/are in present progressive tense in sentences with 100% accuracy over 2 consecutive sessions.
C. Given clinician question, E will spontaneously use the auxiliary verb is/are in present progressive tense in sentences with 100% accuracy over 2 consecutive sessions.

REINFORCEMENT:
Continuous verbal reinforcement and token reinforcement will be used when shaping target behaviors. In addition, clinician will choose activities which are intrinsically reinforcing in nature such as games.

FAMILY INVOLVEMENT:
Parent conferences will be held formally during the semester and informally during the week after LEAP sessions. Mr. & Mrs. G will be encouraged to observe therapy sessions and to participate in homework assignments.

CARRYOVER:
EG will be given regular home assignments to help him generalize newly acquired skills. Written and verbal instructions for these assignments will be provided to EG’s parents.

_____________________________  ___________________________________
XXXXXXX, BA  XXXXXXXXXXXX  MS, CCC-SLP
Graduate Clinician  Licensed Speech-Language Pathologist
PERTINENT HISTORY:

"B", a x year-old male diagnosed with Pervasive Developmental Disorder, Not Otherwise Specified (PDD-NOS), began receiving speech and language therapy at the University of Maryland Hearing and Speech Clinic in the spring of 2006. At that time, he demonstrated limited prelinguistic communication skills consistent with PDD-NOS, including lack of eye contact and limited imitation of actions and vocalizations. B’s initial therapy goals targeted expanding early use of eye contact, speech sounds, and expressive and receptive language. More recent goals have included developing communicative intents, receptive and expressive use of concepts, receptive and expressive use of functional vocabulary, and pragmatic aspects of language. B has made significant progress in all of these goals.

PRESENT STATUS

B began therapy in the clinic for the spring 2008 semester on February 1, 2008 and attended two 50-minute individual therapy sessions a week.

TEST INFORMATION

A spontaneous language sample was gathered during B’s initial therapy session on February 1, 2008. B was engaged throughout the session and the resulting sample contained 154 countable utterances. It is therefore considered a representative sample of B’s language. Results were as follows:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Value</th>
<th>Expected range for age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean Length of Utterance (MLU)</td>
<td>4.2 morphemes</td>
<td>3.7-5.7</td>
</tr>
<tr>
<td>Type-Token Ratio (TTR)</td>
<td>.47</td>
<td>.45-.5</td>
</tr>
<tr>
<td>Brown’s Morphological Stage</td>
<td>Expected Age</td>
<td>Morpheme</td>
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<td>-----------------------------</td>
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<td>---------------------------</td>
</tr>
<tr>
<td>II</td>
<td>27-30 months</td>
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<tr>
<td>II</td>
<td></td>
<td>plural</td>
</tr>
<tr>
<td>II</td>
<td></td>
<td>in</td>
</tr>
<tr>
<td>III</td>
<td>31-34 months</td>
<td>on</td>
</tr>
<tr>
<td>III</td>
<td></td>
<td>possessive</td>
</tr>
<tr>
<td>V</td>
<td>41-46 months</td>
<td>regular past</td>
</tr>
<tr>
<td>V</td>
<td></td>
<td>irregular past</td>
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<td>V</td>
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<td></td>
<td>articles a, the</td>
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<tr>
<td>V+</td>
<td>46 months +</td>
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<tr>
<td>V+</td>
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<td>contractible auxiliary to be</td>
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<td>V+</td>
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<td>uncontractible copula to be</td>
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<tr>
<td>V+</td>
<td></td>
<td>uncontractible auxiliary to be</td>
</tr>
<tr>
<td>V+</td>
<td></td>
<td>irregular third person singular</td>
</tr>
</tbody>
</table>

**INTERPRETATION**

Results of the language sample analysis indicate that B’s mean length of utterance and vocabulary diversity are within normal limits, and that he uses word forms consistent with Brown’s stages I through V+. In practical terms, these results show that B uses a variety of sentence types (long, short, questions, statements), and that the number of words he uses and his ability to use small parts of words to convey meaning (s in cats, ing in pulling) are consistent with what is expected for a child his age.

**SEMESTER GOALS AND OBJECTIVES:**

*Expressive Language*

**Goal I.** To build expressive repertoire of terms for parts of the body.

Initial status/baseline: On January 30, 2008 and February 5, 2008, B demonstrated limited awareness of a variety of terms for parts of the body in the following ways:

- Given direct prompts to imitate, he named 1 out of 6 facial features.
• Given direct prompts to imitate, he did not name “shoulders” as a sub-part of “arm” or “hips” as a sub-part of “leg”.
• In his spontaneous speech, he demonstrated several part-for-whole and whole-for-part substitutions (“leg” for “foot”, “toes” for “foot”, “elbow” for “arm”) and several clothing-for-part substitutions (“sock” for “foot” and “shirt” for “tummy” or “belly”).

A. Given a visual prompt [e.g., picture], B will imitatively name unfamiliar body parts with 90% accuracy over two consecutive sessions.
B. Given a visual prompt [e.g., picture] and a verbal prompt [e.g., “What is the pointy part of your arm”], B will name body parts with 90% accuracy over two consecutive sessions.
C. Given a visual prompt [e.g., picture], B will independently name body parts with 90% accuracy over two consecutive sessions.

**Goal II.** To build expressive repertoire of descriptive language.

**Initial status/baseline:** On January 30, 2008, B’s language contained a very small repertoire of adjectives and descriptor words compared to nouns and verbs as follows:
• Number of unique nouns: 60
• Number of unique verbs: 55
• Number of unique adjectives: 12
• Additionally, some of B’s words that could be classified as adjectives had phrase-like features characteristic of noun compounds (“freight car”, “teddy bear”)

A. Given clinician modeling, B will produce appropriate descriptor terms in 75% of all opportunities in a variety of activities over 2 consecutive sessions.
B. B will independently produce appropriate descriptor terms in 75% of all opportunities in a variety of activities over 2 consecutive sessions.

**Emergent Literacy**

**Goal III.** To develop concepts about print

**Initial status/baseline:** On February 5, 2008, given a physical prompt, B imitatively pointed word-by-word in a text with 4 words per page while reading along with the clinician with 100% accuracy.

A. Given a physical prompt, B will imitatively point word-by-word or symbol-by-symbol while jointly reading books containing 8-12 words a page with 90% accuracy over two consecutive sessions.
B. B will independently point word-by-word or symbol-by-symbol while jointly reading books containing 8-12 words a page with 90% accuracy over two consecutive sessions.
Goal IV. To develop phonological awareness

Rhyming

Initial status/baseline: On February 5, 2008, given a field of two words [picture + spoken word] from different rhyme families, B selected a rhyming word from the correct family to complete a familiar poem read by the clinician with 50% accuracy.

The following rime families will be targeted this semester (ack, at, ed, en, in, ip, ock, op, un, um)

A. Given a choice of two words presented as pictures and named by the clinician, B will select the word that rhymes with the targeted rhyming family with 90% accuracy over two consecutive sessions.
B. Given a choice of two words presented as pictures, B will name each word and select the one that rhymes with the targeted family with 90% accuracy over two consecutive sessions.
C. Given a prompt and clinician modeling, B will produce a rhyming word from a familiar rhyming family during a variety of activities [e.g., reading poems and books] with 90% accuracy over two consecutive sessions.
D. Given a prompt, B will produce a rhyming word from a familiar rhyming family during a variety of activities [e.g., reading poems and books] with 90% accuracy over two consecutive sessions.

Sound awareness

Initial status/baseline: On February 14, 2008, B independently named the sounds that letters make with 70% accuracy (76% accuracy for the 21 consonants, 20% accuracy for the 5 vowels).

A. Given a letter and clinician modeling, B will say the sound that it represents with 90% accuracy over two consecutive sessions.
B. Given a letter, B will say the sound that it represents with 90% accuracy over two consecutive sessions.
C. Given a picture prompt of a word from a familiar rhyme family and a field of two letters, B will select the letter that represents the beginning sound of the word with 90% accuracy over two consecutive sessions.

REINFORCEMENT

A continuous verbal reinforcement schedule will be used initially. This will be altered to an intermittent verbal reinforcement schedule as B demonstrates mastery of behavioral objective goals.

FAMILY INVOLVEMENT

Short, informal conferences will be held at the end of sessions once a week. Formal conferences will be held after the development of the initial therapy plan and end of the
semester. Materials used in therapy sessions will periodically be sent home for use there to promote generalization.

_________________________  _______________________
Graduate Clinician                        Licensed Speech-Language Pathologist
**Instructions for Semester Progress Reports**

**Headings and Identifying Information**
These should be positioned and listed as shown on the “Report Headings Format” section.

**STATEMENT OF PROBLEM:**
In paragraph form, state the full name and age of the client and include the following information: (1) date of first therapy session, (2) client’s speech and language status at that time, and (3) session frequency and duration.

**SEMESTER GOALS AND OBJECTIVES:**
In outline form, restate all the short-term objectives listed for each goal in the Initial Therapy Plan, indicate the highest level at which the client met criterion, and cite supporting data for mastery of that objective. Compare the client’s current performance levels to the pretreatment baseline data for the target area. Comment on the degree of improvement represented by this comparison (e.g., significant, moderate, minimal). Note any special procedures, strategies, or cues that facilitated the client’s performance.

**SUMMARY AND ADDITIONAL INFORMATION:**
Summarize all the “criterion met” statements. This summary should provide an overall profile of the client’s progress over time, rather than a simple reiteration of previously stated information. In separate paragraphs, include information about the following:
- Reinforcement (for both targets and attending behaviors)
- Competition of homework assignments
- Family participation/observation
- Parent/client conferences
- Other pertinent issues such as results of additional testing, significant medical information (e.g., changes in medication), change in education placement, and so on

**RECOMMENDATIONS:**
State whether continued speech-language intervention is warranted. If so, give suggestions for specific goals and objectives. Make any other pertinent recommendations (e.g., psychological testing).
“B”, a 6 year-old boy diagnosed with Pervasive Developmental Disorder, Not Otherwise Specified (PDD-NOS), has been receiving speech and language therapy at the University of Maryland Hearing and Speech Clinic since ………… He began therapy for the Spring 2008 semester on February 1, 2008 and attended two 50-minute individual therapy sessions a week. Based on the results of a language sample analysis performed at the beginning of the semester, B demonstrated strong overall expressive language skills. Specific areas of relative weakness were chosen for targeting, as were several emergent literacy goals. B has made significant progress in all of these goals.

**SEMESTER GOALS AND OBJECTIVES:**

**Expressive Language**

**Goal I.** To build expressive repertoire of terms for parts of the body.

Initial status/baseline: On January 30, 2008 and February 5, 2008, B demonstrated limited awareness of a variety of terms for parts of the body in the following ways:

- Given direct prompts to imitate, he named 1 out of 6 facial features.
- Given direct prompts to imitate, he did not name “shoulders” as a sub-part of “arm” or “hips” as a sub-part of “leg”.
- In his spontaneous speech, he demonstrated several part-for-whole and whole-for-part substitutions (“leg” for “foot”, “toes” for “foot”, “elbow” for “arm”) and several clothing-for-part substitutions (“sock” for “foot” and “shirt” for “tummy” or “belly”).

D. Given a visual prompt [e.g., picture], B will imitatively name unfamiliar body parts with 90% accuracy over two consecutive sessions. [Criterion met: 90% on 2/13/08 and 100% 2/18/08].

E. Given a visual prompt [e.g., picture] and a verbal prompt [e.g., “What is the pointy part of your arm”], B will name body parts with 90% accuracy over two consecutive sessions. [Criterion met: 90% on 3/24/08 and 90% on 3/26/08].

F. Given a visual prompt [e.g., picture], B will independently name body parts with 90% accuracy over two consecutive sessions. [Criterion met: 90% on 4/14/08 and 90% on 4/16/08].
Comments: B has met criterion for this goal. He more consistently names parts of the arm accurately (hand, elbow, shoulder) and uses the term “arm” to refer to the whole arm. He refers to parts of the leg accurately (knee and foot) and uses the term “leg” to refer to the whole leg, but he continues to have some difficulty using the term “hip” accurately. He refers to facial features with the correct terms and has begun using the words “belly” and “tummy”. He has generalized his knowledge of body part terms outside of the therapy room setting. For example, when he noticed pictures of body parts on clinic bulletin boards, he named them accurately (e.g., “brain” and “ear” when looking at an anatomical model of the ear). In addition to generalization of knowledge, this suggests an increased skill in commenting and sharing information about the environment.

Goal II. To build expressive repertoire of descriptive language.

Initial status/baseline: On January 30, 2008, B’s language contained a very small repertoire of adjectives and descriptor words compared to nouns and verbs as follows:

- Number of unique nouns: 60
- Number of unique verbs: 55
- Number of unique adjectives: 12
- Additionally, some of B’s words that could be classified as adjectives had phrase-like features characteristic of noun compounds (“freight car”, “teddy bear”)

C. Given clinician modeling, B will produce appropriate descriptor terms in 90% of all opportunities in a variety of activities over 2 consecutive sessions. [Criterion met: 90% on 3/3/08 and 90% on 3/5/08].

D. B will independently produce appropriate descriptor terms in 90% of all opportunities in a variety of activities over 2 consecutive sessions. [Criterion met: 90% on 4/14/08 and 90% on 4/16/08].

Comments: B met this goal. He has used a variety of adjectives to describe the appearance of items used in therapy activities. He has used adjectives outside of the therapy room, including remarking that doors in the clinic hallway are “open”, “closed”, and “locked”. B also began using similes to describe therapy items and activities toward the end of the semester (e.g., “I’ll color you like a tiger”). B’s increased use of adjectives in comments has expanded the kinds of comments he is able to make to share social information.

Emergent Literacy

Goal III. To develop concepts about print

Initial status/baseline: On February 5, 2008, given a physical prompt, B imitatively pointed word-by-word in a text with 4 words per page while reading along with the clinician with 100% accuracy.

C. Given a physical prompt, B will imitatively point word-by-word or symbol-by-symbol while jointly reading books containing 8-12 words a page with 90% accuracy over two consecutive sessions. [Criterion met: 90% on 2/13/08 and 2/18/08].

D. B will independently point word-by-word or symbol-by-symbol while jointly reading books containing 8-12 words a page with 90% accuracy over two consecutive sessions. [In progress: 67% accuracy on 4/14/08 and 4/16/08].
Comments: B made steady progress on this goal this semester. With physical guiding he can accurately point to a considerable number of words on a page while repeating what the clinician reads or making up his own words. When independently pointing and emergently reading he appears to understand the importance of pointing to words, as he consistently points to them rather than to pictures. However, when there are a substantial number of words on the page (e.g., ……), he has not yet independently mastered saying one word as he points to each individual word. He is more proficient at doing this when reading texts with a smaller number of words.

**Goal IV. To develop phonological awareness**

**Rhyming**

Initial status/baseline: On February 5, 2008, given a field of two words [picture + spoken word] from different rhyme families, B selected a rhyming word from the correct family to complete a familiar poem read by the clinician with 50% accuracy.

The following rime families will be targeted this semester (ack, at, ed, en, in, ip, ock, op, un, um)

E. Given a choice of two words presented as pictures and named by the clinician, B will select the word that rhymes with the targeted rhyming family with 90% accuracy over two consecutive sessions. [**Criterion met: 100% on 2/11/08 and 2/13/08**].

F. Given a choice of two words presented as pictures, B will name each word and select the one that rhymes with the targeted family with 90% accuracy over two consecutive sessions. [**Did not address: see Comments**].

G. Given a prompt and clinician modeling, B will produce a rhyming word from a familiar rhyming family during a variety of activities [e.g., reading poems and books] with 90% accuracy over two consecutive sessions. [**Criterion met: 100% on 4/7/08 and 4/9/08**].

H. Given a prompt, B will produce a rhyming word from a familiar rhyming family during a variety of activities [e.g., reading poems and books] with 90% accuracy over two consecutive sessions. [**In progress: 70% on 4/14/08, 90% on 4/16/08**].

Comments: B made excellent progress toward achieving this goal. After mastering selecting a rhyming word from among those named by the clinician, he began to spontaneously offer additional rhyming words. Therefore, the intermediate step of having him name familiar items before selecting the correct rhyming word was dropped. Additionally, because B quickly demonstrated a high level of accuracy in identifying and generating rhymes, the focus on rhyming “families” was discontinued, and the general skill of rhyming was targeted. B occasionally noticed and generated rhymes during activities targeting other objectives; this suggests a high degree of internalization of this important early literacy skill.

**Sound awareness**

Initial status/baseline: On February 14, 2008, B independently named the sounds that letters make with 70% accuracy (76% accuracy for the 21 consonants, 20% accuracy for the 5 vowels).

D. Given a letter and clinician modeling, B will say the sound that it represents with 90% accuracy over two consecutive sessions. [**Criterion met: 90% on 3/3/08, 100% on 3/5/08**].

E. Given a letter, B will say the sound that it represents with 90% accuracy over two consecutive sessions. [**Criterion met: 100% on 3/24/08, 100% on 3/26/08**].
F. Given a picture prompt and a field of two letters, B will select the letter that represents the beginning sound of the word with 90% accuracy over two consecutive sessions. [In progress: 80% on 4/16/08].

Comments: B made very good progress in this goal area. He can independently identify the sounds each letter makes, and he has made begun to make progress toward identifying the beginning sounds and letters of common words. B is still working on mastering the three-way connection of sound, letter, and word. For example, when asked to select the letter that represents the beginning sound of a word, he frequently said the correct sound but select the wrong letter or selected the correct letter without producing the sound. These errors suggest a learning process of transferring his strong letter-sound knowledge to more advanced tasks.

SUMMARY:
B demonstrated noticeable growth in specific areas of expressive vocabulary and its social use this semester. He demonstrated moderate development of important early literacy skills.

RECOMMENDATIONS:
B’s progress this semester together with an analysis of his spontaneous language, indicate that his use of language is currently age-appropriate. Additionally, his progress with early literacy skills this semester indicates a good degree of preparedness for literacy development in preschool and kindergarten. For these reasons it is recommended that future therapy target communication in a group environment, where he can practice communicating with same-age peers and at the same time, further develop his pragmatic skills. Options will be discussed with B’s parents at the final conference this semester.

Graduate Clinician

Licensed Speech-Language Pathologist
**Instructions for Summer Progress Reports**

**Headings and Identifying Information**
These should be positioned and listed as shown on the “Report Headings Format” section.

**STATEMENT OF PROBLEM:**
In paragraph form, state the full name and age of the client and include the following information: (1) date of first therapy session, (2) client’s speech and language status at that time, and (3) session frequency and duration.

**SEMESTER GOALS AND OBJECTIVES:**
In an outline form, record pertinent speech-language-fluency-voice-behavioral goals and objectives. A long-term goal is a general statement of what is to be accomplished over the course of the semester. Under the long-term goal, specify relevant initial status/baseline data that has been collected and used as the basis for the short-term objectives which will follow underneath. Include significant behavior and any relevant standardized test results.

An objective is a specific statement which incorporates:
- The target performance,
- Conditions under which the behavior is expected to occur and
- The criterion

Materials and procedures are generally not included as part of goals and objectives.

(NOTE): For all formal and informal tests give name of test, date and pertinent test results. Underline the names of all formal tests and use abbreviations only after previously giving full name of tests. Ex: Test of Auditory Comprehension of Language—Revised (TACL-R). Do not use nicknames for tests in reports (i.e., Zimmerman for the Preschool Language Scale).

Indicate the highest level at which the client met criterion, and cite supporting data for mastery of that objective. Compare the client’s current performance levels to the pretreatment baseline data for the target area. Comment on the degree of improvement represented by this comparison (e.g., significant, moderate, minimal). Note any special procedures, strategies, or cues that facilitated the client’s performance.

**SUMMARY AND ADDITIONAL INFORMATION:**
Summarize all the “criterion met” statements. This summary should provide an overall profile of the client’s progress over time, rather than a simple reiteration of previously stated information. In separate paragraphs, include information about the following:
- Reinforcement (for both targets and attending behaviors)
- Competition of homework assignments
- Family participation/observation
- Parent/client conferences
- Other pertinent issues such as results of additional testing, significant medical information (e.g., changes in medication), change in education placement, and so on

**RECOMMENDATIONS:**
State whether continued speech-language intervention is warranted. If so, give suggestions for specific goals and objectives. Make any other pertinent recommendations (e.g., psychological testing).
STATEMENT OF PROBLEM/PERTINENT HISTORY:
LW, a 3 year 6 month old male, began speech and language therapy this semester at the Language Early Advantage Program preschool on June 1, 2009. At the beginning of this semester, he demonstrated receptive and expressive speech and language delays, including difficulty with pragmatics, difficulty producing /b/ in all positions, difficulty following one-step commands, and difficulty spontaneously answering “who”, “what”, and “where” questions. LW received 30 minutes of individual speech and language therapy three times per week.

SEMESTER GOALS AND OBJECTIVES:

Goal I. To follow two-step related commands with cues

Initial Status on 6/1/09:
LW followed one-step commands with 42% accuracy.

Objectives and ending status as of 6/24/09
A. Given visual and verbal cues, LW will follow one-step commands with 80% accuracy over two consecutive sessions. [Criterion Met: 83%]
B. LW will spontaneously follow one-step commands with 80% accuracy over two consecutive sessions. [In progress: 80% in one session]
C. Given visual and verbal cues, LW will follow two-step related commands with 80% accuracy over two consecutive sessions. [Not yet addressed]

Comments:
LW has made moderate progress on this goal. At the beginning of the semester, LW seemed to have significant difficulty following one-step commands, however it was discovered that LW required a verbal cue to attend to what the clinician said – “LW, look at me.” After LW was cued to attend to the clinician, he was better able to follow one-step commands. A grab bag with different items was used to accomplish this goal. LW was instructed to take an item from the grab bag and place it on a shape made out of construction paper in front of him. For example, a pink heart and a blue square would be placed in front of LW. He would take an item from the grab bag and was given a one-step command like, “put the blue ball on the pink heart.” LW was given verbal praise and target specific feedback for reinforcement.
Goal II. To spontaneously answer “who” questions

Initial Status on 6/1/09:
LW accurately answered “who” questions with 60% accuracy.

Objectives and ending status as of 6/24/09:
A. Given a clinician model, LW will answer “who” questions with 80% accuracy over two consecutive sessions. [Criterion Met: 100%]
B. Given verbal and visual prompts, LW will answer “who” questions with 80% accuracy over two consecutive sessions. [Criterion Met: 100% in one session]
C. LW will spontaneously answer “who” questions with 80% accuracy over two consecutive sessions. [In Progress: 60%]

Comments:
LW has made significant progress in this goal. Responses were elicited from his “book of friends” – a book with his classmates’ pictures in it. Initially, he learned to respond to the stimulus, “Who is this?” Later in the semester, he was able to respond to more complex questions such as, “Who is driving the truck?” Utilizing pictures of his classmates was very functional for LW and it served as an activity reinforcer.

Goal III. To spontaneously produce /b/ in the initial position of words at the conversation level

Initial status on 6/1/09:
LW produced /b/ in the initial position with 54% accuracy.

Objectives and ending status as of 6/24/09:
A. LW will produce /b/ in the initial position of single words given visual, verbal or tactile cues in structured therapy activities with 80% accuracy over two consecutive sessions. [In progress: 72%]
B. LW will produce /b/ in the initial position of single words at the phrase/sentence level in structured therapy activities with 80% accuracy over two consecutive sessions. [Not yet addressed]
C. LW will produce /b/ in the initial position of single words at the conversation level during structured therapy activities with 80% accuracy over two consecutive sessions. [Not yet addressed]

Comments:
LW has made moderate progress with this goal. Single syllable articulation cards were used to elicit /b/ initial. Fixed ratio reinforcement was given to LW – when he said the word 5 times, he received reinforcement. This semester, he has enjoyed earning the key to open the doors in “Cariboo” as reinforcement for producing /b/. LW typically produced /b/ by placing his lower lip under his upper teeth. In therapy, this was called “the hard /b/ sound.” He was instructed to “make the easy /b/ sound” to elicit the correct production. In addition to the above verbal cues, the clinician would remind him to “put his lips together” or say, “don’t show me your teeth.” LW was also given tactile cues by the clinician – wearing a glove, she would un-tuck his lower lip from his upper teeth and put his lips together.

SUMMARY AND ADDITIONAL INFORMATION:
LW has made good progress on his goals throughout the semester. He is a delight to have in therapy and in the classroom. During therapy, LW attended to the task and worked hard given intermittent reinforcement, verbal praise and activity reinforcement. He benefitted from visual and verbal feedback.
In the LEAP classroom, LW began to participate in classroom activities toward the middle of the semester. Occasionally, LW held a stuffed animal throughout the day. He was also slightly sensitive to loud noise in the classroom and occasionally became visibly upset by crying and refusing to participate in activities.

LW was sent home with homework to work on goals outside of the therapy room. LW’s dad enjoyed watching his therapy sessions. Weekly email updates that summarized the goals addressed in therapy were sent to his parents. One formal conference was held during the semester to review LW’s goals and progress.

**RECOMMENDATIONS:**
It is recommended that LW continue to participate in speech-language therapy 3 times a week for 30 minutes. Therapy goals should include:
1. Pragmatic language skills (e.g., saying hello and goodbye)
2. Answering “wh” questions (who, what and where)
3. Following multistep directions
4. Producing bilabial sounds (/b/, /m/, and /p/).

____________________________  __________________________________
MG, B.A.                                    DH, M.S., CCC-SLP
Graduate Clinician                                         Licensed Speech-Language Pathologist
EQUIPMENT AND MATERIALS ROOM

- Laminator
- Computer
- Boardmaker Software
- Materials Room
The Hearing and Speech Clinic is equipped with a built-in listening and recording system. Here’s a summary of highlights regarding this equipment:

- At least one camera and one microphone are located in every clinical space (some of the larger spaces have multiple cameras/microphones).

- The cameras record directly to DVD units located in electrical cabinets in the observation rooms.

- Pan-zoom-tilt controllers for the cameras are mounted in the observation rooms next to each window.

- In general, the video recording system is operated by one of the clinic supervisors. If you wish to record a session, feel free to ask any supervisor to help you set up the process. At the end of the session, ask a supervisor to finalize the DVD for you.

- For listening purposes, each observation window is equipped with eight headphone jacks. Each jack has its own loudness control.

- Sound from a therapy session can be broadcast through a ceiling speaker located at each window instead of through headphones. The glowing red button on the small white box mounted next to each window is the off/on switch for the overhead speaker.

- Use of the overhead speaker is appropriate when you are the only observer in the room or when there are more than 5-6 observers at a single window.

- With the exception of headphone loudness knobs, clients’ family members and/or other outside observers **should not** touch any of the audio-video system or change any equipment settings.

Please remember that all video recordings are part of the client’s confidential medical record and are considered property of the Hearing and Speech Clinic. You may use the DVD to analyze the client’s status or monitor your own performance. Once analysis has been completed, all recordings must be returned to the appropriate case supervisor.
1. Plug laminator in and turn it on using the red switch on the top right. Temperature control dial (on right side of machine) should be set at 300° for optimal results. **THE DIAL IS SET AT THE DESIRED TEMPERATURE. DO NOT ATTEMPT TO CHANGE THE SETTING. THE LAMINATOR DOES POSE A SERIOUS FIRE HAZARD IF USED INCORRECTLY. TAPE HAS BEEN PLACED OVER THE DIAL TO PREVENT CHANGES TO THE TEMPERATURE SETTING.**

2. Allow 15-20 minutes for the machine to heat up. The light in the on-switch will turn off when it is ready for use.

3. Position materials on the grey feed tray.

4. Push the drive switch (located above the on-switch) toward the “forward” direction. Rolls will start turning and laminator film will pass through them.

5. Let it run for a few seconds (e.g., 3-4 seconds) so that the film feeds through smoothly (no more wrinkles in the film). Then start feeding materials in by sliding them across the feed tray.

6. Do not stop and start the machine—use one continuous run until you have finished your whole job. Once all materials have cleared the machine, flip the drive switch back to the middle (neutral) position to stop the rolls from turning.

7. Using the red cutter tool, cut off your laminator sheet.

8. At the end of the day (or if you are the last person to leave the room), turn off the laminator. Let it cool down for approximately 10 minutes and then unplug it from the wall outlet.
BoardMaker: At-a-Glance

**File Menu:** Open, save, and print
**Edit Menu:** undo Copy, paste, delete, and select
**View Menu:** Screen size, grids, and rulers
**Text Menu:** Font and alignment
**Preferences Menu:** Auto resize (to manipulate actual picture not whole cell), board size, ruler/grid/gap, line thickness, and cell corner

**How to:**

**View the whole sheet of cells:**
When on the board page, go under View then select “Half size” and you can see the entire sheet of pictures at once.

**Create multiple cells that are the same size:**
Click on the cell sprayer “Tool along the side bar on the board page (the button has 4 mini cells). Position the pointer inside the cell. Click and drag the pointer down and to the right until you have as many cells as you want. Release the mouse button and the cells will be created automatically.

**Place symbols on a grid:**
Click on the Symbol finder tool on the board page (the button with the little man). This displays the Symbol Finder Window. Then click the “Draw” button. This will copy the symbol and return the screen to the board page. Position the pointer in the cell and click. This place the picture inside the cell

**Manipulate a picture and text with a cell:**
In order to work within a cell, you must turn off Auto Resize in the Preferences menu. This allows you to select the contents of the cell rather than the entire thing.

**Delete symbols or text from a cell:**
Turn off Auto Resize in Preferences menu. Select the item you wish to delete by clicking on it (shift-click to select multiple items). Press the delete or backspace key to delete what you have selected (either text or picture).

**Manually resize symbols:**
Select the symbol to resize. It will appear inside a dotted square with a small square in the lower right corner. Click and drag the resize box inward or outward to resize the symbol. Release the mouse button when the symbol is the correct size.

**Making text fit within an individual cell:**
Select the Text Tool and position the cursor at one end of the word, Click and drag to select the text, then choose a smaller font size from the Text menu.

**Change the size of the text (for entire board):**
In the Symbol finder window in line 1 next to “English” is the number of the font size.

**Change the label of a picture:**
First select the Text Tool from the tool side bar (the button with the A). Position the cursor at one end of the word and click and drag to select the text. Now you may enter you new text. **DO NOT** change the name of the picture while in the Symbol Finder Window- this will change the name permanently making it very difficult for others to find pictures!

**Change corners of cell:**
Select the cell to change (if none are selected this command will change the default setting for new cell corners). Go to Preferences Menu on the board page to select the radius of the corners of cells (squared, rounded).
Save your board:
Select “Save” from the File menu. Saying your board requires a file name. Using a descriptive name such as “S-words” can be helpful so others can access your board and use it.

Opening a save board:
Select “Open” from the File menu while in the board window. Select the name of the saved board and double click. It will appear in the board window.

**** When searching for a symbol: be creative and try related or similar words. Also the fewer characters you type, the better the chance of finding a symbol that uses those letters (a search for “books” may fail whereas a search for “book” may not), and do not type extra characters, such as spaces, commas, or periods.
The department provides a significant amount of materials and equipment to support the clinical training program. This includes a wide range of standardized tests for diagnostic purposes as well as picture cards, games, workbooks, velcro, and construction paper, etc. which can be used in therapy sessions (obviously, this is not an exhaustive list). With approximately 25 clinicians simultaneously engaging in clinical practice, it is important that this supply of materials be adequately monitored and replenished.

All students are required to sign out materials that are borrowed from the clinic’s inventory. Please remember to sign the materials back in when you return them. You may use the sign-in log to reserve specific materials for a particular date. This is especially important for diagnostic tests. Always check the reserve sheet before you take a diagnostic test – it will be very difficult for your colleague to conduct an evaluation without the necessary tests in hand.

If you borrow tests from the materials room and wish to take them home to review them at length, you may do so after 4:00 pm. You are responsible for making sure that the tests are returned the following morning no later than 8:30 am.

Students are permitted to the use the phone and desktop computer to contact clients and work on clinical reports/class assignments. Don’t save documents to the hard drive since they will be deleted on a regular basis without advanced warning (use your own flashdrive instead).

The door to the student room must be shut and locked whenever the room is empty. If you are the last one to leave – shut the door behind you! It is easy to gain re-entry to the room by swiping your student ID card in the reader mechanism located to the right of the hallway door.
FEEDBACK ON CLINICAL PERFORMANCE AND CLINICAL GRADING POLICIES

- Evaluative Feedback

- Grading Procedures

- Clinical Portfolio

- Feedback to Clinical Instructors

- End-of-Program Paperwork: Application for ASHA Certification
  Sample KASA form
Feedback Regarding Clinical Performance And Grading Policies

Clinical assignments are designed to familiarize students with a wide variety of speech-language impairments across a range of client age levels. The clinical faculty has identified a core set of clinical skills which are fundamental to successful management of all communication disorders. On a regular basis, students are provided with formative and summative feedback regarding their mastery of these essential facets of clinical practice (i.e., technical skills, problem-solving, clinical writing, professional behavior, and personal qualities).

A performance-based course such as clinical practicum is not conducted or graded in the same ways that a typical classroom-based course would be. It’s important for student clinicians to realize that clinical instructors will be giving them evaluative feedback on both technical and professional skills.

The category of technical skills includes behaviors such as writing behavioral objectives, using effective teaching strategies and reinforcers, collecting data, and writing reports. This first major component focuses on short-term behaviors that are generally demonstrated in each session. These tend to be easily observable, are highly dependent on technical knowledge, and are rated using a relatively more objective numerical scale in order to give students formative feedback.

Professional skills are more broadly-based and may include things like initiative, creativity, ability to handle constructive criticism, self-confidence, and effectiveness as a communicator (see Professional Conduct Standards in Appendix). This second major component to be considered in assessment of student performance includes behaviors less easily measured by numerical ratings which encompass longer-range skills/abilities. These tend to be more conceptual in nature and lend themselves more appropriately to a relatively more subjective type of descriptive/summative feedback.

Clinical instructors go to great lengths to present formative feedback in a helpful, nonthreatening manner. Student clinicians are encouraged to develop strategies for processing this feedback from a positive perspective so that they can receive maximal benefit from clinical mentoring.

The supervisor-supervisee relationship varies over time along a continuum from direct to indirect instruction. Direct instruction along with modeling and close guidance, may be provided early in practicum training to ensure that students feel comfortable engaging in trial-and-error learning (i.e., beginning of the program, start of each semester, initiation of an unfamiliar case, etc). As the clinical education program progresses, case supervisors gradually provide less direct instruction and establish expectations for increasing levels of independence and successful performance from student clinicians.

*This means that as students gain more clinical experience, they should expect fewer numbers of observations and less directive feedback from their supervisors.*

The clinical faculty has established multiple mechanisms for providing feedback to student clinicians:
- Session evaluations are returned with ratings and comments on a daily basis
- Therapy logs are reviewed and returned with comments on a daily basis
- Individual supervisory conferences are held on a weekly basis
- Clinical reports are reviewed and returned with comments on a periodic basis
- Individual grade conferences are held at midterm and final points of each semester
Clinical instructors directly observe a substantial percentage of each client's treatment program and evaluate student clinician performance in several areas (see Daily Therapy Evaluation Form on HESP 648B practicum course website). Please note the key which provides a descriptive rating of student performance. These evaluation forms are part of a web-based clinic evaluation system. In this system, supervisors enter ratings and comments for any sessions they have observed. Once the entry is finalized, students can log into the system to view the feedback regarding their clinical performance. In addition, supervisors enter mid-term and final assessments into this numeric system. Students can access only their own evaluations. The number values recorded on these forms will be averaged at the end of the semester. These ratings will be combined and considered in combination with additional evaluative feedback from all relevant clinical faculty members to determine a final semester grade in practicum.

*Please note that these numerical ratings in the web-based system are not the sole factor used to determine a student’s clinic practicum grade. Clinical faculty review each student’s performance in a comprehensive and holistic manner. So, descriptive/subjective feedback from case supervisors regarding conceptual skills/personal qualities in practicum performance has a significant impact on each student’s grade.*

A primary supervisor will be designated to integrate and summarize this information regarding student clinician development and present it during individual grading conferences. When a student consistently exhibits significant difficulty meeting expectations in clinical practicum, the supervisor and/or clinic director will meet with the student and, if appropriate, develop an individualized action plan which identifies specific objectives or benchmarks which must be achieved along with mechanisms for facilitating student success. The following is an example of an individualized action plan:
<table>
<thead>
<tr>
<th>Skill Area</th>
<th>Benchmark</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Programming</td>
<td>Independently program 2 clients with rationales supported by baseline information</td>
<td>By end of 3 sessions in summer semester</td>
</tr>
</tbody>
</table>
|              | Be able to execute programming through multiple materials/activities that elicit the target behavior [with supervisor review] | Immediate: 24 hours in advance of each session, submit written plan to each supervisor:  
  - Specifying one activity/task/materials for each objective for each client  
  - Scripted branching plan...one step up and one step down for each objective |
|              | Be able to adjust materials and activities [branch] on a weekly basis [based on performance data] to facilitate client performance |                                                                 |
|              | Be able to independently execute programming through multiple materials/activities that elicit the target behavior | By end of 3 sessions in summer semester                                   |
| Supervision  | Effectively make use of supervisory resources by:  
  - Attending weekly meetings  
  - Bringing written questions to meetings that demonstrate independent problem solving  
  - Being able to initiate discussion of the case, the session, and own clinical skills and challenges | Immediate |
| Professional Behavior | Take ownership of all aspects of clinical work by:  
  - Rescheduling missed supervisor meetings  
  - Attending to late reports  
  - Rescheduling cancellations / make up sessions | Immediate |
|              | Reach closure on all tasks                                                | Ongoing                                                                 |
| Reports      | Reports:  
  - Utilize proofreading and other strategies to ensure a better first draft  
  - Make sure edits are complete and that you respond to all supervisory comments  
  - Clarify edits with supervisor if unsure | Immediate                                                                 |
| Time Management | To demonstrate effective time management:  
  - Limit work to 10 hours per week  
  - Provide a “sample” week’s schedule of how you’ll handle classes, clinic, work, etc. | Within one week |
Students should note that admission to the academic degree programs does not guarantee access to the clinical training component of the department. Clinical training is required for eventual ASHA Certification, but is not a requirement of any of the degree programs at the University of Maryland.

Departmental permission is required for registration in clinical practicum and is granted only to matriculated students. Students must possess the communicative competencies requisite to satisfactory conduct of usual clinical procedures. Further, as the client population served by this program is predominantly English-speaking, participants in any clinical practicum must be proficient, intelligible speakers of English.

All students enrolled in clinical practicum are expected to abide by the ASHA Code of Ethics, provided to each student upon admission to graduate study. Violations of the Code of Ethics may result in permanent dismissal from practicum placement opportunities, and may additionally subject the student to dismissal from the academic degree program.

**DRESS CODE:** Clinical practicum students are expected to maintain professional dress and demeanor. *In general, attire should be consistent with the clinical setting, show respect for the client/family, and not distract from the provision of services or the student clinician’s professional credibility. Supervisors may vary in what they think is appropriate. If you are unsure about any clothing item, just ask.* Unprofessional conduct, or any conduct which compromises the quality of care to clinic patients, may result in dismissal from clinical practicum placements (see appendix for Professional Conduct Standards).

**Eligibility for outside placements includes the following:**

- A student may not go on outside placement if he/she is on academic probation (GPA below 3.0).

- A student who earns a grade of C+ or less for any HESP 648b registration during their first year will not be eligible for outside placement until they successfully complete an additional semester of clinical training with a grade of B- or better. If a student earns a grade of C+ or less in a second semester during their first year, eligibility for further clinical practicum training will be determined by the clinical instructors, clinic director, and department chair on a case-by-case basis.

- Students will receive clock hour credit for hours earned in clinic registrations which receive a semester grade of “C” or better; no clock hours will be credited for clinic registrations which receive a grade of less than “C” (e.g., C-, D+). In some cases, supervisors may decline to sign off on clock hours associated with a specific task/event (rather than the clock hours for an entire semester) due to problematic clinical performance within that limited context.

- At their own expense, students may need to obtain vaccinations or health records, undergo criminal background checks, or pass drug screenings in order to be eligible for placement at some sites.

- Students must complete a minimum of 15 hours of academic coursework prior to applying for outside placement.

- Students who receive a grade of “C” or less for an outside placement registration, or whose placements are terminated will be advised by the clinic director and department chair on a case-by-case basis regarding eligibility for continued practicum training. If continued training is warranted, the student must re-register in a subsequent semester for placement in the department’s central clinic (through HESP 648B) and earn a final grade of B or better before being permitted to re-apply for outside placement. A minimum of two outside placements must be completed successfully.
Feedback to Clinical Instructors

Clinical supervisors and student clinicians operate in a dynamic relationship that can be characterized as “mentor-mentee” or “senior-junior colleagues”. New clinicians often have concerns about the solidity of their knowledge base and also about their ability to manage constructive criticism. Clinical supervisors see their role as guiding each student through the program in a nurturing and supportive way. Given the potential array of different learning and communication styles that characterize each of us, honest and direct communication is of paramount importance during clinical training.

Clinical supervisors are most effective when they master the art of delivering clear, constructive criticism in ways that students find useful. In addition, it is very important that graduate clinicians establish and master techniques for deriving benefit from constructive criticism and effectively communicating their educational needs to their clinical instructors on an ongoing basis.

Students are encouraged to use their weekly conferences with case supervisors as an opportunity to express their thoughts and concerns. This ensures that necessary changes are implemented in a timely fashion and minimizes the chances of serious miscommunication between supervisor and supervisee. In addition, formal reviews of supervisory performance are conducted at midterm and final points in each semester. Graduate clinicians are encouraged to complete these evaluations in as thoughtful and objective a manner as they would wish the supervisors to use in their evaluations of student clinical performance. This feedback is reviewed by the individual supervisors, the clinic director, and periodically the department chair.
SUPERVISOR EVALUATION

Supervisor _______________________________          Date __________________

Please rate your satisfaction for each of the following questions. Comments may be written at the bottom of each section.

**QUANTITY OF SUPERVISION**

1. I am satisfied with the frequency and duration of direct observation of my therapy sessions.
   - Very satisfied
   - Somewhat satisfied
   - Not satisfied

2. I am satisfied with the amount of time allotted to individual conferencing with my supervisor.
   - Very satisfied
   - Somewhat satisfied
   - Not satisfied

3. I am satisfied with the availability of my supervisor.
   - Very satisfied
   - Somewhat satisfied
   - Not satisfied

Comments:  __________________________________________________________
__________________________

**QUALITY OF SUPERVISION**

4. My supervisor helps me to make productive use of my supervision conference time.
   - Very satisfied
   - Somewhat satisfied
   - Not satisfied

5. The supervision I receive reflects knowledge and expertise related to my client’s speech or language disorder.
   - Very satisfied
   - Somewhat satisfied
   - Not satisfied

6. The supervision I receive stimulates my interest in learning about my client’s speech or language disorder.
   - Very satisfied
   - Somewhat satisfied
   - Not satisfied

Comments:  __________________________________________________________
__________________________
SUPPORT AND FEEDBACK

7. The supervision I receive provides adequate guidance to help me develop independence.
   
   Very satisfied        Somewhat satisfied       Not satisfied

8. I am provided with references, readings, and ideas to give me adequate direction.
   
   Very satisfied        Somewhat satisfied       Not satisfied

9. Feedback on logs and reports is constructive and helpful.
   
   Very satisfied        Somewhat satisfied       Not satisfied

10. I am made aware of my strengths as well as my weaknesses.

   Very satisfied        Somewhat satisfied       Not satisfied

11. I am assisted in developing a plan to improve my clinical weaknesses.

    Very satisfied        Somewhat satisfied       Not satisfied

Comments: ___________________________________________________________

SUPERVISION STYLE

12. My learning style is considered in the supervision process.

    Very satisfied        Somewhat satisfied       Not satisfied

13. I am helped to acquire skills while developing my own clinical style.

    Very satisfied        Somewhat satisfied       Not satisfied

14. I feel comfortable sharing concerns and discussing my strengths and weaknesses.

    Very satisfied        Somewhat satisfied       Not satisfied

15. My input is welcome in the supervision process.

    Very satisfied        Somewhat satisfied       Not satisfied

Comments: ___________________________________________________________

_____________________________________________________________________

_____________________________________________________________________
ASHA CERTIFICATION PAPERWORK, PRAXIS REPORTS and the EXIT PROCESS: PLEASE keep this form and refer to it when preparing for your CFY.

1) Fill out your ASHA application (including the KASA form) FULLY and have your advisor check it for accuracy. It must be signed by Dr. Ratner before you submit it to ASHA.

We have a model KASA form that uses University of Maryland courses as examples to guide you in filling out your form (see the departmental website under MA students) http://www.bsos.umd.edu/hesp/degreePrograms/current/KASA_SLP_sample.xls). This form can be edited with your personal information, and will be accepted in that format by us and by ASHA. Current ASHA CCC application forms are available at the ASHA web site (www.asha.org).

PLEASE READ the instructions and the sample before filling out the application. Remember that some of your knowledge and skills may have been achieved through your candidacy research or practicum, not just in individual classes.

The Department keeps a permanent copy of the full ASHA application in your files for your future employment inquiries and re-accreditation audits. ASHA does NOT keep a copy of the application. Please fill it out completely and neatly. Please be aware that Dr. Ratner will NOT sign off on incomplete applications. Your application will be returned to you or held up until you provide a full copy of your entire ASHA application and KASA for our records. We estimate that more than 20% of applications each year get held up because students apparently forget this guidance.

2) Please list the University of Maryland as a recipient of your NTE ASHA exam scores. Please use the number R0131. There are additional codes for University of Maryland, but your report will not come to the Department unless you use this code.

3) Please provide the department with a copy of your forwarding address if you will be moving after graduation, as well as your new email address. We encourage you to join the HESPTerps email list to keep up with us.

4) Please notify the department chair or clinic director of your CFY site as soon as you know it. This information is collected both by ASHA accreditation and by the University to demonstrate program outcomes.

5) Please make an appointment for an exit interview with Dr. Ratner, or complete the e-mailed exit interview that we will send you automatically. Interviews can be scheduled for anytime within the month prior to graduation, or at any time after graduation. Interviews can be held over the phone if this is more convenient, but should still be scheduled. Exit interviews help the department to identify those aspects of the program which should be improved, as well as those aspects of the program which were satisfying to you.
The KASA form is intended for use by the certification applicant during the graduate program to track the processes by which the knowledge and skills specified in the 2005 Standards for the CCC are being acquired. Each student should review the KASA form at the beginning of graduate study, and update it at intervals throughout the graduate program and at the conclusion of the program.

The student, with input and monitoring of program faculty, must enter a check mark in column B as each of the knowledge and skills is acquired. It is expected that many entries will appear in the course work and the clinical practicum columns, with some entries, as appropriate, in the "Other" (lab, research, etc.) columns. Please enter the course or practicum number and title and description of other applicable activity.

### I. KNOWLEDGE AREAS

<table>
<thead>
<tr>
<th>Standards</th>
<th>Knowledge/ Skill Met? (check)</th>
<th>Course #, title: supply or circle option below</th>
<th>Practicum experiences (see clock hour form)</th>
<th>Other: classes elsewhere, candidacy paper, thesis, comps, indpt study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard III-A. The applicant must demonstrate knowledge of the principles of:</td>
<td></td>
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<tr>
<td>● Biological sciences</td>
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<tr>
<td>● Physical sciences</td>
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<tr>
<td>● Mathematics</td>
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<tr>
<td>● Social/Behavioral sciences</td>
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<tr>
<td>Standard III-B. The applicant must demonstrate knowledge of basic human communication and swallowing processes, including their biological, neurological, acoustic, psychological, developmental, and linguistic and cultural bases</td>
<td></td>
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<tr>
<td>● Basic Human Communication Processes</td>
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<tr>
<td>● Biological</td>
<td>HESP 305,311 or 602</td>
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<tr>
<td>● Neurological</td>
<td>HESP 305,311 or 602</td>
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<tr>
<td>● Acoustic</td>
<td>HESP 403, 407 or 604</td>
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<tr>
<td>● Psychological</td>
<td>HESP 300, 400, PSYCH100</td>
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</tbody>
</table>

UMD CORE or equiv
<table>
<thead>
<tr>
<th>Standard III-C. The applicant must demonstrate knowledge of the nature of speech, language, hearing, and communication disorders and differences and swallowing disorders, including their etiologies, characteristics, anatomical/physiological, acoustic, psychological, developmental, and linguistic and cultural correlates. Specific knowledge must be demonstrated in the following areas:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Articulation</strong></td>
</tr>
<tr>
<td>● Etiologies</td>
</tr>
<tr>
<td>● Characteristics</td>
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<tr>
<td><strong>Fluency</strong></td>
</tr>
<tr>
<td>● Etiologies</td>
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<tr>
<td>● Characteristics</td>
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<tr>
<td><strong>Voice and resonance, including respiration and phonation</strong></td>
</tr>
<tr>
<td>● Etiologies</td>
</tr>
<tr>
<td>● Characteristics</td>
</tr>
<tr>
<td><strong>Receptive and expressive language (phonology, morphology, syntax, semantics, and pragmatics) in speaking, listening, reading, writing, and manual modalities</strong></td>
</tr>
<tr>
<td>● Etiologies</td>
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<tr>
<td>● Characteristics</td>
</tr>
<tr>
<td>Hearing, including the impact on speech and language</td>
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<td>-----------------------------------------------------</td>
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<tr>
<td>● Etiologies</td>
</tr>
<tr>
<td>● Characteristics</td>
</tr>
<tr>
<td>Swallowing (oral, pharyngeal, esophageal, and related functions, including oral function for feeding; orofacial myofunction)</td>
</tr>
<tr>
<td>● Etiologies</td>
</tr>
<tr>
<td>● Characteristics</td>
</tr>
<tr>
<td>Cognitive aspects of communication (attention, memory, sequencing, problem-solving, executive functioning)</td>
</tr>
<tr>
<td>● Etiologies</td>
</tr>
<tr>
<td>● Characteristics</td>
</tr>
<tr>
<td>Social aspects of communication (challenging behavior, ineffective social skills, lack of communication opportunities)</td>
</tr>
<tr>
<td>● Etiologies</td>
</tr>
<tr>
<td>● Characteristics</td>
</tr>
<tr>
<td>Communication modalities (including oral, manual, augmentative and alternative communication techniques, and assistive technologies)</td>
</tr>
<tr>
<td>● Characteristics</td>
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<tr>
<td>Standard III-D: The applicant must possess knowledge of the principles and methods of prevention, assessment, and intervention for people with communication and swallowing disorders, including consideration of anatomical/physiological, psychological, developmental, and linguistic and cultural correlates of the disorders.</td>
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<tr>
<td>Category</td>
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<tr>
<td>Articulation</td>
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<td>Fluency</td>
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<td>Voice and Resonance</td>
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<td>Receptive and Expressive Language</td>
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<tr>
<td>Hearing, including the impact on speech and language</td>
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<td>Swallowing</td>
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<tr>
<td>Cognitive aspects of communication</td>
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<tr>
<td>Social aspects of communication</td>
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<tr>
<td>Standard III-E: The applicant must demonstrate knowledge of standards of ethical conduct.</td>
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<tr>
<td>HESP 648B</td>
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<tr>
<th>Standard III-F: The applicant must demonstrate knowledge of processes used in research and the integration of research principles into evidence-based clinical practice.</th>
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<tr>
<td>HESP 648B</td>
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<td>HESP 724</td>
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<td>HESP 799</td>
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<th>Standard III-G: The applicant must demonstrate knowledge of contemporary professional issues.</th>
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<td>HESP 648B</td>
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<tr>
<th>Standard III-H: The applicant must demonstrate knowledge about certification, specialty recognition, licensure, and other relevant professional credentials.</th>
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<td>HESP 648B</td>
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<tr>
<th>Standard IV-G: The applicant for certification must complete a program of study that includes supervised clinical experiences sufficient in breadth and depth to achieve the following skill outcomes (in addition to clinical experiences, skills may be demonstrated through successful performance on academic coursework and examinations, independent projects, or other appropriate alternative methods):</th>
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<tbody>
<tr>
<td>1. Evaluation (must include all skill outcomes listed in a-g below for each of the 9 major areas)</td>
</tr>
<tr>
<td>a. Conduct screening and prevention procedures (including prevention activities)</td>
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<td>HESP 648a, 728</td>
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<tr>
<td>See clockhour form</td>
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<tr>
<td>b. Collect case history information and integrate information from clients/patients, family, caregivers, teachers, relevant others, and other professionals</td>
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<tr>
<td>c. Select and administer appropriate evaluation procedures, such as behavioral observations nonstandardized and standardized tests, and instrumental procedures</td>
</tr>
<tr>
<td>d. Adapt evaluation procedures to meet client/patient needs</td>
</tr>
<tr>
<td>e. Interpret, integrate, and synthesize all information to develop diagnoses and make appropriate recommendations for intervention</td>
</tr>
<tr>
<td>f. Complete administrative and reporting functions necessary to support evaluation</td>
</tr>
<tr>
<td>g. Refer clients/patients for appropriate services</td>
</tr>
<tr>
<td>● Articulation</td>
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<tr>
<td>● Fluency</td>
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<tr>
<td>● Voice and resonance, including respiration and phonation</td>
</tr>
<tr>
<td>● Receptive and expressive language (phonology, morphology, syntax, semantics, and pragmatics) in speaking, listening, reading, writing, and manual modalities</td>
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<tr>
<td>● Hearing, including the impact on speech and language</td>
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<tr>
<td>● Swallowing (oral, pharyngeal, esophageal, and related functions, including oral function for feeding; orofacial myofunction)</td>
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<tr>
<td>Cognitive aspects of communication (attention, memory, sequencing, problem-solving, executive functioning)</td>
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<tr>
<td>Social aspects of communication (including challenging behavior, ineffective social skills, lack of communication opportunities)</td>
</tr>
<tr>
<td>Communication modalities (including oral, manual, augmentative, and alternative communication techniques and assistive technologies)</td>
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</table>

2. Intervention (must include all skill outcomes listed in a-g below for each of the 9 major areas)

   a. Develop setting-appropriate intervention plans with measurable and achievable goals that meet clients'/patients' needs. Collaborate with clients/patients and relevant others in the planning process

   b. Implement intervention plans (involve clients/patients and relevant others in the intervention process)

   c. Select or develop and use appropriate materials and instrumentation for prevention and intervention

   d. Measure and evaluate clients'/patients' performance and progress

   e. Modify intervention plans, strategies, materials, or instrumentation as appropriate to meet the needs of clients/patients

   f. Complete administrative and reporting functions necessary to support intervention
<table>
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<tr>
<th>g. Identify and refer clients/patients for services as appropriate</th>
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<tr>
<td>● Articulation</td>
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<td>● Fluency</td>
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<tr>
<td>● Communication modalities</td>
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<tr>
<th>3. Interaction and Personal Qualities</th>
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<tbody>
<tr>
<td>a. Communicate effectively, recognizing the needs, values, preferred mode of communication, and cultural/linguistic background of the client/patient, family, caregivers, and relevant others.</td>
</tr>
<tr>
<td>b. Collaborate with other professionals in case management.</td>
</tr>
<tr>
<td>c. Provide counseling regarding communication and swallowing disorders to clients/patients, family, caregivers, and relevant others.</td>
</tr>
<tr>
<td>d. Adhere to the ASHA Code of Ethics and behave professionally.</td>
</tr>
</tbody>
</table>
APPENDICES

- APPENDIX A: Professional Conduct Standards

- APPENDIX B: Student Clinic Participation Consent Forms

- APPENDIX C: Obtaining and Scoring Language Samples

- APPENDIX D: Code of Ethics

- APPENDIX E: State of Maryland Licensure Law
APPENDIX A

DEPARTMENT OF HEARING & SPEECH SCIENCES

PROFESSIONAL CONDUCT STANDARDS\textsuperscript{1}
(May 2005)

Introduction and Rationale

The Department of Hearing & Speech Sciences has a responsibility to the community to ensure that individuals whom the University of Maryland, College Park, recommends to the State of Maryland for licensure and the American Speech, Language, and Hearing Association for certification are qualified to join the professions of Speech-Language Pathology and Audiology. These professions require strong academic preparation and mastery of clinical and other professional competencies. These professions also require non-academic competencies, such as communication or interpersonal skills, which are as critical to success as those in the academic domain. This document sets forth those essential criteria or “professional conduct standards” that are pertinent to academic and clinical preparation in the Department of Hearing & Speech Sciences (HESP) at the University of Maryland.

Professional Conduct Standards serve several important functions, including, but not limited to: (a) providing information to those considering professional careers in Speech-Language Pathology and Audiology that will help such students in their career decision-making; (b) advising applicants of non-academic criteria considered in admissions decisions made by the University’s professional preparation programs; (c) serving as the basis for feedback provided to students in these programs regarding their progress toward mastery of all program objectives; and (d) serving as the basis for the final assessment of attainment of graduation requirements and recommendation for certification.

All candidates in the UMCP professional preparation programs in HESP are expected to demonstrate that they are prepared to work with clients in a variety of settings. This preparation results from the combination of successful completion of University coursework and clinical practicum experiences and the demonstration of important human characteristics and dispositions that all clinicians should possess. These characteristics and dispositions, the Department of Hearing & Speech Sciences \emph{Professional Conduct Standards}, are outlined below.

**Department of Hearing & Speech Sciences Professional Conduct Standards**

The Department of Hearing & Speech Sciences Professional Conduct Standards are grouped into four categories: Communication/Interpersonal Skills, Emotional and Physical Abilities, Cognitive Dispositions, and Personal and Professional Requirements.

Within the professional context to which each candidate aspires, all candidates must:

\textit{Demonstrate Appropriate Communication/Interpersonal Skills}

- Express themselves effectively in written and oral English in order to communicate concepts, instructions, evaluations, and expectations with faculty, practicum supervisors/administrators, clients, families, peers, and other professionals, given reasonable levels of feedback.

\textsuperscript{1}The primary sources used in the preparation of this document were the University of Texas at San Antonio and the College of Education at the University of Maryland-College Park.
o Candidates write clearly and legibly and use correct grammar and spelling. They demonstrate sufficient skills in written English to understand content presented in the program and to complete adequately all written assignments, as specified by faculty.
o Candidates communicate effectively with other students, faculty, staff, and professionals. They express ideas and feelings clearly and demonstrate a willingness and an ability to listen to others.
o Candidates demonstrate sufficient skills in spoken English to understand content presented in the program, to adequately complete all verbal assignments, and to meet the objectives of clinical practicum experiences.

- Utilize communication skills that are responsive to different perspectives represented in diverse classrooms and/or other professional environments
  o Candidates appreciate the value of diversity and look beyond self in interactions with others. They must not impose personal, religious, sexual, and/or cultural values on others.
o Candidates demonstrate an awareness of appropriate social boundaries between clients and clinicians and show that they are ready and able to observe those boundaries.

- Demonstrate the necessary interpersonal competencies to function effectively with clients, families, practicum supervisors and to function collaboratively as part of a professional team
  o Candidates demonstrate positive social skills in professional and social interactions with faculty, colleagues, clients and families.
o Candidates demonstrate the ability to express their viewpoints and negotiate difficulties appropriately, without behaving unprofessionally with instructors, peers, or clients.

Demonstrate Acceptable Emotional and Physical Abilities

- Work under time constraints, concentrate in distracting situations, make subjective judgments, and ensure safety in emergencies
  o Candidates demonstrate the ability to work with frequent interruptions, to respond appropriately to unexpected situations; and to cope with extreme variations in workload and stress levels.
o Candidates possess the ability to make and execute quick, appropriate, and accurate decisions in a stressful environment.
o Candidates have the capacity to maintain composure and continue to function well in a myriad of situations.

- Demonstrate the physical stamina to engage in fulltime clinical responsibilities and perform extended and additional duties of a professional such as client/family conferences, and other assigned duties
  o Candidates exhibit motor and sensory abilities to attend and participate in class and practicum placements.
o Candidates are able to tolerate physically demanding workloads and to function effectively under stress.

Demonstrate Appropriate Cognitive Dispositions

- Organize time and materials, prioritize tasks, perform several tasks at once, and adapt to changing situations
  o Candidates have the mental capacity for complex thought as demonstrated in prerequisite course work and in standardized testing.
o Candidates have sufficient cognitive (mental) capacities to assimilate the technically detailed and complex information presented in formal lectures, small group discussions, and individual teaching, counseling, or administrative settings, and in various practicum settings.
- Candidates are able to analyze, synthesize, integrate concepts, and problem-solve to formulate clinical judgments.
- Candidates demonstrate the ability to think analytically about clinical issues. They are thoughtfully reflective about their practice.
- Candidates demonstrate the ability to multi-task and to adapt to and display flexibility in changing situations.
- Candidates are able to perform the above skills independently. The use of a trained intermediary is not acceptable in many clinical situations, because a candidate must be able to exercise independent judgment without relying on or having the filter of someone else’s power of observation and selection.

**Demonstrate Appropriate Personal and Professional Behaviors**

- **Arrive on time and be prepared for professional commitments, including classes and practicum experiences**
  - Candidates meet deadlines for course assignments and program requirements. A pattern of repeated absences, lateness, and failure to meet deadlines in courses or practicum is not acceptable.

- **Seek assistance appropriately and follow supervision in a timely manner, and accept and respond appropriately to constructive review of their work from supervisors/instructors**
  - Candidates show that they are ready to reflect on their practice and accept constructive feedback in a professional manner. They demonstrate the ability to act upon reasonable criticism.
  - Candidates are flexible, open to new ideas, and willing and able to modify their beliefs and practices related to their work.

- **Demonstrate attitudes of integrity, responsibility, and tolerance**
  - Candidates demonstrate honesty and integrity by being truthful about background, experiences, and qualifications, doing their own work, giving credit for the ideas of others, and providing proper citation of source materials.
  - Candidates interact courteously, fairly, and professionally with people from diverse racial, cultural, and social backgrounds and of different genders or sexual preferences. Conduct in violation of the University’s Human Relations Code is not acceptable (see http://www.inform.umd.edu/PRES/policies/vi100b.html).
  - Candidates must not make verbal or physical threats; engage in sexual harassment; become involved in sexual relationships with their clients, clients’ families, supervisors, or faculty; or abuse others in physical, emotional, verbal, or sexual ways.
  - Candidates demonstrate the ability to understand the perspectives of others in the context of teaching, counseling, administration, etc. and the ability to separate personal and professional issues.
  - Candidates exhibit acceptance of and are able to make appropriate adjustments for exceptional learners.
  - Candidates protect the confidentiality of client information unless disclosure serves professional purposes or is required by law.

- **Show respect for self and others**
  - Candidates exhibit respect for all University of Maryland and practicum personnel, as well as peers, clients and their families and members of their communities.
  - Candidates are expected to be free of the influence of illegal drugs and alcoholic beverages in classes and practicum settings. They are expected to abide by the University of Maryland’s Code of Student Conduct (http://www.inform.umd.edu/PRES/policies/v100b.html). The
Code prohibits the use of any controlled substance or illegal drug on university premises or at university sponsored activities.

- Candidates demonstrate the ability to deal with current life stressors through the use of appropriate coping mechanisms. They handle stress effectively by using appropriate self-care and by developing supportive relationships with colleagues, peers, and others.
- Candidates use sound judgment. They seek and effectively use help for medical and emotional problems that interfere with scholastic and/or professional performance.

- **Project an image of professionalism**
  - Candidates demonstrate appropriate personal hygiene habits.
  - Candidates dress appropriately for their professional contexts.
  - Candidates possess maturity, self-discipline, and good judgment.
  - Candidates demonstrate good attendance, integrity, honesty, conscientiousness in work, and teamwork.

**Implementation and Review Procedures**

During the orientation phase of their professional programs, candidates will receive a copy of the Department of Hearing & Speech Sciences Professional Conduct Standards Policy and be asked to sign a *Professional Conduct Standards Acknowledgement Form*. In addition, candidates in the clinical training programs may be required to submit an updated Professional Conduct Standards Acknowledgement Form in each semester of their graduate training program.

Self-assessments of candidates and supervisor evaluations of students on the Professional Conduct standards may occur during each practicum experience (see *Candidate’s Self Assessment* and *Professional Conduct Standards Evaluation Form*). Students will be monitored and given feedback throughout the program. At specified points, students will be notified of inadequacies that may prevent them from progressing through their program. Documentation and consensus regarding the student’s functioning will be sought before any action is taken. Candidates who experience deficiencies in any areas will be encouraged to seek appropriate professional help from University or other sources. If the problem seems to be beyond remediation, continuation in professional programs, graduation or recommendation for certification may be denied.

**Assistance For Individuals With Disabilities**

Professional Conduct standards may be met with, or without, accommodations. The University complies with the requirements of Section 504 of the Rehabilitation Act and the Americans with Disabilities Act of 1990. Therefore, the Department of Hearing & Speech Sciences will endeavor to make reasonable accommodations with respect to its Professional Conduct standards for an applicant with a disability who is otherwise qualified. “Disability” shall mean, with respect to an individual, (1) a physical or mental impairment that substantially limits one or more of the major life functions of such individual; (2) a record of such an impairment; or (3) being regarded as having such an impairment. The University reserves the right to reject any requests for accommodations that are unreasonable, including those that would involve the use of an intermediary that would require a student to rely on someone else’s power of selection and observation, fundamentally alter the nature of the University’s educational program, lower academic standards, cause an undue hardship on the University, or endanger the safety of students or others.

Questions or requests for accommodations pertaining to the Department of Hearing & Speech Sciences Professional Conduct Standards should be directed to the faculty via written notification to the Department Chair. **For all other requests for accommodations, students should contact the University’s Disability Support Services and follow established university policy and procedures.**
Confidentiality

Unless a student has expressly waived his or her privilege to confidentiality of medical records provided to substantiate either a disability or a recommendation for an accommodation, the Department of Hearing & Speech Sciences faculty to which such information has been communicated shall maintain such information in a manner that preserves its confidentiality. Under no circumstances shall such information become part of a student’s academic records.
Within the professional context to which each candidate aspires, all candidates must:

Communication/Interpersonal Skills

- Express themselves effectively in written and oral English in order to communicate concepts, assignments, evaluations, and expectations with members of the professional community such as University faculty, clients, client family members, administrators, and other staff.
- Utilize communication skills that are responsive to different perspectives represented in diverse professional environments.
- Demonstrate the necessary interpersonal competencies to function effectively with clients and their families, and to function collaboratively as part of a professional team.

Emotional and Physical Abilities

- Work under time constraints, concentrate in distracting situations, make subjective judgments, and ensure safety in emergencies.
- Demonstrate the physical stamina to engage in a fulltime clinical workload and perform extended and additional duties of a professional such as client/family conferences, and other assigned duties.

Cognitive Dispositions

- Organize time and materials, to prioritize tasks, to perform several tasks at once, and to adapt to changing situations.

Personal and Professional Requirements

- Arrive on time and prepared for professional commitments, including classes and practicum experiences.
- Seek assistance and follow supervision in a timely manner, and accept and respond appropriately to constructive review of their work from supervisors.
- Demonstrate attitudes of integrity, responsibility, and tolerance.
- Show respect for self and others.
- Project an image of professionalism.

I have reviewed the Department of Hearing & Speech Sciences Professional Conduct Standards Policy. I understand that if the criteria listed above are not met satisfactorily, I may be denied participation in the Department’s clinical/academic professional preparation program and/or denied the opportunity to complete the externship component of the curriculum.

______________________________  _______________________
Candidate Signature                      Date

NOTE: The University has a legal obligation to provide appropriate accommodations for students with documented disabilities. If you have a documented disability and are seeking accommodations, you should register with the University’s Office of Disability Support Services and notify your course instructor, and/or academic advisor of your specific needs, as appropriate. Students should initiate this process as soon as possible (prior to the start of classes and/or practicum).
Within the professional context to which I aspire (for example, Speech/Language Pathology or Audiology), I believe I am able to (check all that apply):

Communication/Interpersonal Skills

_____ Express myself effectively in written and oral English in order to communicate concepts, assignments, evaluations, and expectations with members of the learning community such as University faculty, clients, client family members, administrators, and other staff.

_____ Demonstrate communication skills that are responsive to different perspectives represented in diverse professional environments.

_____ Exhibit the necessary interpersonal competencies to function effectively with clients and their families, and to function collaboratively as part of a professional team.

Emotional and Physical Abilities

_____ Work under time constraints, concentrate in distracting situations, make subjective judgments, and ensure safety in emergencies.

_____ Demonstrate the physical stamina to engage in a fulltime clinical caseload and perform extended and additional duties of a professional such as family conferences, and other assigned duties.

Cognitive Dispositions

_____ Organize time and materials, prioritize tasks, perform several tasks at once, and adapt to changing situations.

Personal and Professional Requirements

_____ Arrive on time and prepared for professional commitments, including classes and practicum.

_____ Seek assistance and follow supervision in a timely manner, and accept and respond appropriately to constructive review of their work from supervisors.

_____ Demonstrate attitudes of integrity, responsibility, and tolerance.

_____ Show respect for self and others.

_____ Project an image of professionalism.

I have reviewed the Department of Hearing & Speech Sciences Professional Conduct Standards Policy. I understand that if the criteria listed above are not met satisfactorily, I may be denied participation in the Department’s clinical/academic professional preparation program and/or denied the opportunity to complete the externship component of the curriculum.

Candidate Signature ___________________________ Date __________

NOTE: The University has a legal obligation to provide appropriate accommodations for students with documented disabilities. If you have a documented disability and are seeking accommodations, you should register with the University’s Disability Support Services and notify your course instructor, and/or academic advisor, of your specific needs, as appropriate. Students should initiate this process as soon as possible (prior to the start of classes and/or practicum).
DEPARTMENT OF HEARING & SPEECH SCIENCES
PROFESSIONAL CONDUCT STANDARDS

EVALUATION FORM

Candidate Name: ____________________________________________
Program Area: ____________________________________________

Rate the candidate on each of the standards listed below:

**KEY:**  A – Frequently  B – Sometimes  C – Rarely Ever  N/A – Not Applicable/ Insufficient Opportunity to Observe

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<td>B</td>
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<td><strong>Professional Conduct Standards</strong></td>
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<tr>
<td>Expresses him/herself effectively in written and oral English in order to communicate concepts, assignments, evaluations, and expectations with members of the learning community such as University faculty, clients, their families, administrators, and other staff</td>
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<tr>
<td>Demonstrates communication skills that are responsive to different perspectives represented in diverse professional environments</td>
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<tr>
<td>Exhibits the necessary interpersonal competencies to function effectively with clients and their families, and to function collaboratively as part of a professional team</td>
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<td>Works under time constraints, concentrates in distracting situations, makes subjective judgments, and ensures safety in emergencies</td>
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<td>Has the physical stamina to work a contractual day and perform extended and additional duties of a professional such as family conferences, and other assigned duties</td>
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<td>Organizes time and materials, prioritizes tasks, performs several tasks at once, and adapts to changing situations</td>
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<td>Arrives on time for professional commitments, including classes and practicum; submits clinical/academic assignments in a timely manner</td>
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<td>Seeks assistance and follows supervision in a timely manner, and accepts and responds appropriately to constructive feedback from supervisors</td>
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<td>Demonstrates attitudes of integrity, responsibility, and tolerance</td>
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<tr>
<td>Projects an image of professionalism</td>
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Recommendation for program continuance: _____ yes  _____ no  _____ probationary

Additional Comments:

________________________________________________________________________
________________________________________________________________________

Faculty Signature/Date  Student Signature/Date
I. Clinic Procedures and Policies

This is to certify that I have participated in clinic orientation, and I understand and agree to abide by the procedures and policies related to the operations of the University of Maryland Hearing and Speech Clinic.

______________________     __________________________________________
Date                      Signature

II. ASHA Code of Ethics

This is to certify that I have read the ASHA Code of Ethics and agree to preserve the highest standards of integrity and ethical principles set forth in these guidelines.

______________________     __________________________________________
Date                      Signature

III. Consent for observation and recording.

This is to certify that I agree:
(1) That I may be observed during my clinical sessions with the authorization of a Hearing and Speech Sciences faculty member.

______________________     __________________________________________
Date                      Signature

(2) That recordings (audio, video, photographic, etc.) of my practicum experience may be permanently stored for review by authorized students and faculty of the Dept. of Hearing and Speech Sciences for the purposes of clinical training for students and professionals, classroom instruction, and research.

______________________     __________________________________________
Date                      Signature

IV. Commitment and Responsibility

I understand that once I have initiated therapy with speech clients assigned to me, it is my ethical obligation to complete the clinical practicum (HESP 648). I fully understand that failure to meet this obligation may result in an unfavorable recommendation from this department.

______________________     __________________________________________
Date                      Signature
Obtaining & Scoring Language Samples

By
Rachel E. Brown
and
Stacy W. Silverman

(former graduate students)
OBTAINING A LANGUAGE SAMPLE:
(Information taken from Stickler, 1987 and Lund & DUCHAN, 1988)

Advantage: Excellent picture of the child’s language production abilities (when done correctly)

Disadvantage: Time consuming

Nature of the Interaction:
1. Miller suggests a number of language samples with the child interaction with a variety of people including the speech—language clinician, a parent, a sibling, or a peer.
2. A conversation where one partner only asks questions and the other responds is not a natural interaction. As conversational partners, clinicians should make efforts to reduce the number of questions asked and to permit the child to take the lead in the interaction. However, complete absence of questions on the part of the clinician would be impossible to attain and may not result in a representative sampling of the child’s productive abilities.

Setting:

Miller suggests using more than one setting during the language sample. I.e., home, school, residential facility, or the clinic. Differences may arise in the language of the child because of the setting. The resulting differences will add to the description of the child’s communication abilities

Materials:

Different materials may result in differences in language frequency and complexity. The differences, however, do not seem to be predictable for children. Therefore it is wise to provide a variety of developmentally appropriate materials and to encourage the child to interact with as many materials as possible. Differences again will contribute to the overall picture of the child’s communication abilities.

SAMPLE SIZE:

1. First—obtain a specific number of utterances from the child. Various authors have suggested number of utterances ranging from 50-200 for the sample to be representative.
2. A 30 minute session (with a child at the 24-month old level or older) will most likely result in a sample of 100-200 utterances.
3. The more utterances, the better. However, 100 utterances gathered under various conditions typically results in a respectably diverse sample.

Method of Recording:

1. The optimum method of recording is video—tape recording, because it permits the clinician to interact freely with the child or to watch undistracted as others interact with the child. Transcription from video—tape recordings is considered to be the most reliable method and permits detailed delineation of changes in nonverbal context.
2. The second method of recording is audio—tape recording. Again the clinician in free to interact with the child, but making notes about the child’s activities during the taping is important for providing the
nonverbal context for transcription. One advantage of audiotape is that they are readily available in the clinical setting and are battery operated so they can be taken anywhere the sample is being collected.

3. The third method of recording is on-line transcription. This is particularly useful in recording the child’s productions on outings away from the clinical setting. Miller suggests time sampling that is transcribing for a couple of minutes and then resting before continuing with the transcribing. The alternative, writing down everything the child says, can be cumbersome and exhausting.

**Guidelines for interaction:**

1. Begin with parallel play and parallel talk. With a young child at the one-word stage, imitate his verbalizations and use many animal sounds and vehicle noises. With a child older than two years, talk about what you are doing as you play and use role playing dialogue (e.g., “I’m gonna make my guy drive. Here’s the tractor for him. ‘Wow, what a big tractor. I’m gonna go fast’”)

2. Move into Interactive conversation. With a young child, use some routine questions (e.g., “what’s a doggie say?”) and elicit finger plays such as patty cake. With an older child, invite him to participate in play. Continue with role playing dialogue, unless establishing rules for play. Encourage this child to participate in plans for play, including what toy people/animals will be doing.

3. Continue with the child’s topic. If he is role playing, stay in the role. If he shifts out of role, follow his lead. Respond to questions, acknowledge comments, solicit more information about a topic.

4. Attempt to restrict your use of questions to approximately one question every four speaking turns. Use of questions may reduce the length of the child’s utterance. Instead, try using a phrase such as “tell me about this…”

5. Give the child options that are presented as alternative questions (i.e., “should we play with XXX or XXX?”). This makes the child feel in control.

6. Use utterances that are slightly longer than the child’s utterances. Keep the number of utterances per speaking turn to approximately the same number as the child.

7. Learn to be comfortable with pauses in the conversation give the child opportunity to talk!

8. Have a variety of materials to keep the child’s motivation high, but do not move abruptly from one activity to the other. Offer the child the option of changing activities and follow his interests. A diverse combination of materials might include role playing toys like cars, trucks, and people, farm sets, and kitchen sets as well as manipulative materials like clay, paints, paper, pens, markers, and items for making a snack.

9. Do not be afraid to be silly and have fun! Many shy children can be brought into the interacting by asking silly, obvious question (i.e., “those are great shoes. Can I wear them?”) Or by making silly comments (i.e., “there’s a mouse in your pocket!”). Enjoy the child and he will enjoy he interaction.
Transcribing Language Samples:

1. Adult and child utterances can be transcribed in English except when utterances are unintelligible or the child’s approximation deviates substantially from expectations.
2. It is important to make context notes during the interaction so that the situational context may be specified in the transcript.

Numbering Language Transcripts:

1. The final step in preparing a language transcript is numbering the child’s utterances. Each fully intelligible child utterance to be analyzed should be assigned an utterance number.
2. If an utterance is repeated with no intervening activity or utterance by the other speaker, the utterance is considered a repetition and does not receive an utterance number.
3. Totally or partially unintelligible utterances should not be assigned an utterance number.
4. Incomplete utterances resulting from self—interruption/overlapping sprks, are not assigned utterance #s.
5. Utterance boundaries are determined by a rise or fall in pitch, followed by a pause in speech. The end of a sentence indicates the utterance boundary, whether or not a pause in speech is detected. Compound and complex sentences are always counted as one utterance.

Example (Taken from Lund & Duchan, 1988, p. 209)

Sample as Transcribed

Well in school I always go to a a / kind of a / silly kid of school / (laugh) / well what we do is / with big pieces of papers / an we what we do is make make writing things like that with a H and O and all those kinds of homeworks // we make math homeworks on littl

Segmented Sample

1. (Well in school) I always go to (a a) kind of a silly kind of school.
2. (Well) what we do is with big pieces of papers (an we).
3. (Well) what we do is make (make) writing things like that with a H and O and all those kinds of homeworks.
4. We make math homeworks on little little pieces of squares.

Not all children will be eager to talk to the clinician during the language sample. Here are some hints for getting reluctant children to talk:

1. Keep the focus off your attempt to get the child to talk. With children who are very hesitant to say anything, offer contexts that demand little verbalizations for participation, such as drawing pictures or playing a game. This allows the child to become a participant with you in a nonthreatening way. During the event you should comment on what you are doing and allow for, but not directly request, the child’s verbal participation.

2. Do not talk too much and do not be afraid to allow silent pauses during the conversation. Do not fill up every empty space with a question. This encourages the child to let you take the lead.
3. Select materials appropriate to the child’s interest level. For example, children operating at the preschool level tend to be more interested in toys than in books or games. Older children tend to like unusual objects or things that can be manipulated.

4. Toys with detachable or moving parts and broken toys generally stimulate interest. If possible, you might have the child or caretaker bring in one or two of the child’s favorite toys. Children often have more to say about familiar things than about new ones.

5. Most children are naturally curious. If they know you have something concealed from them, they usually want to find out more about it, having a big bag (or pillow case) from which you withdraw objects may prompt conversation about what else it contains. Likewise, noise sources they cannot see or mechanisms that make toys move stimulate curiosity.

6. If the child will initiate conversation about your materials, let him or her take the lead, and you ask questions or comments briefly on what the child is saying.

7. If the child does not initiate, make comments yourself about the materials and ask open—ended leading questions, such as “That looks broken. What do you suppose happened to it?” or “Can you figure out what’s goin on here?” If these prompts do not elicit verbalization, try more specific questions which require minimum output, such as “Do you...?” “Where...?” “What is...?” and then build up to more open ended questions, such as “Tell me...” or “What about?”

8. If statements or questions trigger no reaction, demonstrate what you expect of the child. For example, take toy yourself and play with it, tell about what you are doing, and personalize your account using an imaginary situation. Engage the child in the play as soon as possible and begin to prompt indirectly.

9. If the child is reluctant to talk about pictures or tell stories, go first and set the stage. A series of sequence pictures provides more story structure than a single picture and therefore is generally easier for a beginning story. You can have the child tell the same story after you or create a new story using different pictures or characters. Unless you are analyzing for storytelling structures, do not ask the child to tell a familiar story, since it might be memorized and unlike more natural output.

10. Include another person in the elicitation or collection procedure. This might be another clinician or aide who can model the responses you expect from the child or it might be the child’s parent, sibling, or friend who can be included in the activities. Having a third party involved tends to take the focus off the child and makes talking more comfortable.
Brown’s Rules for Counting Morphemes

To compute the mean length of utterance:

1. Count the number of morphemes on each utterance using the rules below.

2. Compute the total number of morphemes in the sample and divide by the number of utterances.

<table>
<thead>
<tr>
<th>MORPHEME</th>
<th>EXAMPLE</th>
<th>AGE OF MASTERY (MONTHS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Present progressive –ing (no auxiliary verb)</td>
<td>Mommy driving</td>
<td>19=28</td>
</tr>
<tr>
<td>IN</td>
<td>Ball in cup</td>
<td>27-30</td>
</tr>
<tr>
<td>On</td>
<td>Doggie on Sofa</td>
<td>27-30</td>
</tr>
<tr>
<td>Regular Plural –s</td>
<td>Kitties eat my ice cream Forms: /s/, /z/, and /lz/ Cats /k ts/ Dogs /d gz/ Classes /kl slz/</td>
<td>24-33</td>
</tr>
<tr>
<td>Irregular Past</td>
<td>Came, Fell, broke, went</td>
<td>25-46</td>
</tr>
<tr>
<td>Possessive ’s</td>
<td>Mommy’s balloon broke. Forms: /s/, /lz/ as in regular plural</td>
<td>26-40</td>
</tr>
<tr>
<td>Un-contractible Copula (Verb to be as main verb)</td>
<td>He is, (i.e. Response to “Who’s sick?”)</td>
<td>27-39</td>
</tr>
<tr>
<td>Articles</td>
<td>I see a kitty. I throw the ball to daddy</td>
<td>28-46</td>
</tr>
<tr>
<td>Regular past –ed</td>
<td>Mommy pulled the wagon. Forms: /d/, /t/, /ld/ Pulled /p ld/ Walked /w kt/ Glided /glaldid/</td>
<td>26-48</td>
</tr>
<tr>
<td>Regular third person</td>
<td>Kathy hits. Forms: /s/, /z/ &amp; /lz/ as in regular plural</td>
<td>26-48</td>
</tr>
<tr>
<td>Irregular third person</td>
<td>Does, has</td>
<td>28-48</td>
</tr>
<tr>
<td>Un-contractible auxiliary</td>
<td>He is. (response to “Who’s wearing your hat?”)</td>
<td>29-48</td>
</tr>
<tr>
<td>Contractible Copula</td>
<td>Man’s big. Man is big.</td>
<td>29-49</td>
</tr>
<tr>
<td>Contractible auxiliary</td>
<td>Daddy’s drinking juice. Daddy is drinking juice.</td>
<td>30-50</td>
</tr>
<tr>
<td>RULE</td>
<td>EXAMPLE</td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>COUNT AS ONE MORPHEME:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reoccurrences of a word for emphasis</td>
<td>No, no, no; Railroad, Birthday; Billy Sue; Night-night, Choo-Choo; Went, Ate, Got, Came; Daddie, Doggie; Is, Have, Do; Gonna, Hafta</td>
<td></td>
</tr>
<tr>
<td>Compound words (two or more free morphemes), Proper Names, Ritualized reduplications, Irregular past tense verbs, Diminutives, Auxiliary Verbs</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>COUNT AS TWO MORPHEMES:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Possessive Nouns, Plural Nouns, Third person singular present tense verbs, Regular past tense verbs, Present Progressive Verbs</td>
<td>Tom’s, Daddie’s’ Doggies, Kitties; Walks, Eats; Walked, Jumped; Walking, Eating</td>
<td></td>
</tr>
<tr>
<td><strong>DO NOT COUNT</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dys-fluencies, except for most complete filler</td>
<td>C-c-c-candy, bab-bab; um-m, ah-h, oh</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STAGE</th>
<th>MLU</th>
<th>APPROXIMATE AGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>1.0-2.0</td>
<td>12-26 Months</td>
</tr>
<tr>
<td>II</td>
<td>2.0-2.5</td>
<td>27-30 Months</td>
</tr>
<tr>
<td>III</td>
<td>2.5-3.0</td>
<td>31-34 Months</td>
</tr>
<tr>
<td>IV</td>
<td>3.0-3.75</td>
<td>35-40 Months</td>
</tr>
<tr>
<td>V</td>
<td>3.75-4.5</td>
<td>41-46 Months</td>
</tr>
<tr>
<td>V+</td>
<td>4.5+</td>
<td>47+</td>
</tr>
</tbody>
</table>

1. Scan the language sample for instances where the child uses a word or phrase differently than an adult would. Record those instances, providing the context in which they occur. Include all correct and incorrect productions of the item. Note the overextension or under extension of words or phrases.

2. Examine the sample for indefinite words, phrases, and gestures (e.g. “things” and “stuff”). If the sample seems to have disproportionately high number of these, suspect lexical deficits. Determine the lexical type under which most of these occur (e.g. action verbs, nouns, etc.)

3. Look for the overall absence of word classes in the sample.
Grammatical Classifications of First 50 Words Produced:

<table>
<thead>
<tr>
<th>Grammatical Function</th>
<th>Percentage of Vocabulary</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Benedict (1979)</td>
<td>Nelson (1973)</td>
</tr>
<tr>
<td>Nominals</td>
<td>50</td>
<td>51</td>
</tr>
<tr>
<td>General Specific</td>
<td>11</td>
<td>14</td>
</tr>
<tr>
<td>Action Words</td>
<td>19</td>
<td>14</td>
</tr>
<tr>
<td>Modifiers</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>Personal-Social</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>Functional</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

Sequence of Language Skills for children, ages 5-9

The following charts will be helpful for clinicians who are not sure what is considered “normal” for ages 5-9. Additionally, these charts will be useful for speech language clinicians when developing objectives

### Five- to Six- Year-Olds

**Listening Skills**

Child can identify environmental sounds  
Child can respond to a musical pattern.  
Child can give rhyming words when given a model word and the beginning sound of the next word.  
Child can identify the following consonant sounds in any position in words: w, k, y, p.

**Following and Giving Instructions**

Child can follow on direction using a position in space.  
Child can manipulate objects by following two verbal directions.  
Child can verbalize and perform oral direction.  
Child can orally give 1-step directions to peers.

**Narrative Abilities**

Child can tell a personal experience in a complete sentence containing 3-5 words with one beginning.  
Child can express emotions as shown in a picture.  
Child can express emotions as shown in a picture.  
Child can explain why she has certain feelings. Given a series of 3 pictures, child can make up her own story of at least 3 (3-5 word) simple sentences.  
After hearing a sequence of 3 series of 4 sounds, child can reproduce 3 of the 4 sequences in the same order.  
After hearing 4 series of 5 numbers, child can reproduce 3 of the 4 sequences in the same order.

**Vocabulary**

Child can name parts of the body.  
Child can identify objects that are alike.  
Child can describe simple objects.  
Child can give a cause of an action or an event.

**Syntax**

Child can use sentences 4-5 words in length.
Six- to Seven-Year-Olds

**Listening Skills**

Child can respond to intonation by differentiating another’s questions from statements.  
Child can differentiate between commands, questions, and exclamations, by the examiner’s intonation.  
When given the following words, child can rhyme one word with each in 4 out of 5 trials: cat, met, red, hit, tree, say.  
After hearing a story, child can recall events at beginning and end.

**Following and Giving Instructions**

Child can follow 3 or 4 directions meteorically.  
Child can verbalize and follow 2-step oral directions 4 out 5 times.  
Child can give 2-step directions to her peers.

**Narrative Abilities**

Child can imitate or dramatically express a character of choice in a given story with intonation and inflection (role play or puppetry)  
Given a picture, the child can tell a story of 3 or more sentences, inventing an ending

**Vocabulary**

Child can describe objects in terms of their position in space.  
Child can classify objects according to a specific criterion.

**Syntax**

Child uses compound sentences.  
Child uses possessive pronouns, singular and plural. Child uses regular and irregular simple verbs in past tense.  
Child uses common regular plurals correctly.  
Child ask questions using “wh” question words.
# Seven- to Eight-Year-Olds

## Listening Skills

- Child can complete a sentence with a rhyme.
- Child can identify the following consonant sounds in all positions in words: the, ch, sh.
- Child can identify the positions of the following sounds: l, k, w, th, ch, sh, r, s in nonsense words.

## Following and Giving Instructions

- Child can manipulate objects by following 3-4 verbal directions.
- Child can verbalize and perform 3-4 step oral directions correctly, 4 out of 5 times.
- Child can give orally 3-step directions to his peers.

## Narrative Abilities

- Child can describe emotions using synonyms, words, phrases or sentences.
- Child can tell a creative story of 3-5 sentences.
- Child can create and dramatize her own story.
- Child can express anticipated need and wants for a task to be completed that day.
- Child can tell an experience in sequence with a beginning and an end.
- Child can tell an experience with a beginning, a middle, and an ending, telling in sequential order what happened first, second, third.
- Child can describe an event with voice intonations and inflections.

## Vocabulary

- Child can categorize in a group of similar objects all those that are like in some specific way.
- Child can produce at least three descriptive words on a chosen topic.
- Child can tell what he thinks will happen as the result of an action or an incident.

## Syntax

- Child can produce sentences showing cause and effect.
- Child can use plural pro nouns correctly.
- Child can use interrogative pronouns correctly.
- Child can use simple verbs in future tense correctly.
- Child can use common irregular plurals correctly.
- Child can ask questions using when, why and how with a clarifier- e.g., How many? How big?
Eight- to Nine- Year- Olds

Listening Skills

Child gives evidence of understanding of rhythm and intonations by participating in a group recitation of rote materials. Child can rhyme nonsense words. After hearing a story, child can recall events happening in the beginning, middle and end.

Following and Giving Instructions
Child can follow and give 4-step directions.

Narrative Abilities

Child can assess and express needs or wants for an anticipated project to be completed in a week. Child can assess and express needs for a teacher-suggested project. Child can tell an experience with the elements of (who, what), (where, when, how) and (why). Child can describe emotions, using phrases or sentences with intonation and inflection. Child can tell a well-organized original story. Child can participate in and/pr contribute to the creation and dramatization of a group story or group activity. Child can participate in the adaptation of a familiar story into script form for dramatization.

Vocabulary

Child can name orally the function of familiar objects. Child can name orally pictures of activities or situations. Child can associate objects with common qualities.

Syntax

Child can use reflexive pronouns. Child can use present perfect tense correctly. Child can use simple regular and irregular plurals correctly. Child can use s, es, or ies ending correctly. Child can ask why, what if, how come, how about, whose, which. Child can change a statement into a question.
Eliciting Questions from Children

This is a suggested procedure for eliciting questions from a child who does not ask them spontaneously. This method works best when 3 people are involved. The child asks as a messenger, carrying information from one person to another. It is also more realistic if the two people who are exchanging messages through the child are not within view of one another. A problem with the question formulation might be revealed if the child uses the request as a model for forming his or her own questions: e.g. Adult: Ask her how she got to this school. Child: How you to this school?

<table>
<thead>
<tr>
<th>MESSAGE CARRIED BY THE CHILD</th>
<th>QUESTION FORM ELICITED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ask her where she lives.</td>
<td>Where + Do</td>
</tr>
<tr>
<td>2. Ask her when her birthday is.</td>
<td>When</td>
</tr>
<tr>
<td>3. Ask her how she got to this school</td>
<td>How + Did</td>
</tr>
<tr>
<td>4. Ask her to tell you what this is for.</td>
<td>What + For</td>
</tr>
<tr>
<td>5. Ask her who she eats with.</td>
<td>Who + Do</td>
</tr>
<tr>
<td>6. Ask her what time it is.</td>
<td>What</td>
</tr>
<tr>
<td>7. Ask her which one she wants – this one or that one</td>
<td>Which</td>
</tr>
<tr>
<td>8. Ask her how many shoes she has on</td>
<td>How many</td>
</tr>
<tr>
<td>9. Ask her when she is going home.</td>
<td>When</td>
</tr>
<tr>
<td>10. Ask her if she will eat out tonight.</td>
<td>Will</td>
</tr>
<tr>
<td>11. Ask her what color her hair is.</td>
<td>What</td>
</tr>
<tr>
<td>12. Ask her if she wants this.</td>
<td>Do</td>
</tr>
<tr>
<td>13. Ask her if she likes what she is doing.</td>
<td>Do (complex)</td>
</tr>
<tr>
<td>14. Ask her how she catches a ball.</td>
<td>How + Do</td>
</tr>
<tr>
<td>15. Ask her when you can go to lunch</td>
<td>When + Can</td>
</tr>
<tr>
<td>16. Ask her why she isn’t home now.</td>
<td>Why + Aren’t</td>
</tr>
<tr>
<td>17. Ask her if she can jump.</td>
<td>Can</td>
</tr>
<tr>
<td>18. Ask her if she will help you snap your fingers</td>
<td>Will (Complex)</td>
</tr>
<tr>
<td>19. Ask her why this won’t work.</td>
<td>Why+ Won’t</td>
</tr>
<tr>
<td>20. Ask her why this is dirty.</td>
<td>Why</td>
</tr>
<tr>
<td>Your Question to the Child</td>
<td>Meaning Elicited</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>When</td>
<td>Time</td>
</tr>
<tr>
<td>Where</td>
<td>Space</td>
</tr>
<tr>
<td>Why</td>
<td>Cause- effect</td>
</tr>
<tr>
<td>Who</td>
<td>People</td>
</tr>
<tr>
<td>Whose</td>
<td>Possessive</td>
</tr>
<tr>
<td>Is, are, was, were, am</td>
<td>Identity, quality description</td>
</tr>
<tr>
<td>How</td>
<td>Manner-Method</td>
</tr>
<tr>
<td>How many- few</td>
<td>Number</td>
</tr>
<tr>
<td>Much – little</td>
<td>Quantity</td>
</tr>
<tr>
<td>Often – Soon</td>
<td>Tune</td>
</tr>
<tr>
<td>Far- Near</td>
<td>Distance</td>
</tr>
<tr>
<td>Long</td>
<td>Linear Measure</td>
</tr>
<tr>
<td>Heavy- light</td>
<td>Weight</td>
</tr>
<tr>
<td>Big small</td>
<td>Size</td>
</tr>
<tr>
<td>Would</td>
<td>Probability, Cause- effect</td>
</tr>
<tr>
<td>Which</td>
<td>Selection, Multiple Choice</td>
</tr>
<tr>
<td>Do, Does</td>
<td></td>
</tr>
<tr>
<td>What If</td>
<td>Inference, Cause- Effect</td>
</tr>
<tr>
<td>What Kind, color, shape, size,</td>
<td>Classification</td>
</tr>
<tr>
<td>day</td>
<td></td>
</tr>
<tr>
<td>What + be</td>
<td>Identity</td>
</tr>
<tr>
<td>What + do</td>
<td>Action</td>
</tr>
<tr>
<td>What + do + verb + with</td>
<td>Function</td>
</tr>
<tr>
<td>May</td>
<td>Permission</td>
</tr>
<tr>
<td>Will you</td>
<td>Request and future</td>
</tr>
<tr>
<td>Can</td>
<td>Possibility</td>
</tr>
<tr>
<td>Should</td>
<td>Judgment</td>
</tr>
<tr>
<td>What happened</td>
<td>Event description</td>
</tr>
</tbody>
</table>
**Early Pragmatic Functions**

<table>
<thead>
<tr>
<th>Functions</th>
<th>Examples</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Instrumental</td>
<td>I want. I need.</td>
<td>Child attempts to satisfy needs or desires.</td>
</tr>
<tr>
<td>Regulatory</td>
<td>Do as I tell you.</td>
<td>Child attempts to control the behavior of others</td>
</tr>
<tr>
<td>Interactional</td>
<td>You and Me.</td>
<td>Child establishes and defines social relationships and attempts to participate in social intercourse.</td>
</tr>
<tr>
<td>Personal</td>
<td>Here I come</td>
<td>Child expresses individually or gives personal opinions or feelings.</td>
</tr>
<tr>
<td>Imaginative</td>
<td>Let’s pretend.</td>
<td>Child expresses fantasies or creates imaginary word</td>
</tr>
<tr>
<td>Heuristic</td>
<td>Tell me why.</td>
<td>Child seeks information</td>
</tr>
<tr>
<td>Informative</td>
<td>I’ve got something to tell you</td>
<td>Child provides information.</td>
</tr>
</tbody>
</table>
## Dore’s Primitive Speech Acts

<table>
<thead>
<tr>
<th>Primitive Speech Acts</th>
<th>Child’s utterance</th>
<th>Child’s Non-Linguistic Behavior</th>
<th>Adult Response</th>
<th>Relevant Contextual Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requesting (Answer)</td>
<td>Want</td>
<td>Addresses adult; may make gesture regarding object</td>
<td>Utters a response</td>
<td>No change in situations</td>
</tr>
<tr>
<td>Calling</td>
<td>Word (With marked Prosodic contour)</td>
<td>Addresses adult by uttering adults name loudly; awaits response</td>
<td>Responds by attending to child or answering child</td>
<td>Before child’s utterance adult is some distance away; adults orientations typically changes</td>
</tr>
<tr>
<td>Greeting</td>
<td>Word</td>
<td>Attends to adult or object</td>
<td>Returns a greeting utterance</td>
<td>Speech event is initiated or ended</td>
</tr>
<tr>
<td>Protesting</td>
<td>Word or Marked prosodic pattern</td>
<td>Attends to adult; addresses adult; resists or denies adult’s action</td>
<td>Initiates Speech events by performing an action the child does not like</td>
<td>Adult’s action is completed or child prevents action</td>
</tr>
<tr>
<td>Practicing</td>
<td>Word or Prosodic pattern</td>
<td>Attends to no specific object or event; does not address adult; does not await response</td>
<td>No response</td>
<td>No apparent aspect of context is relevant to utterance</td>
</tr>
<tr>
<td>Labeling</td>
<td>Word</td>
<td>Attends to object or event; does not address adult; does not await response</td>
<td>Most often none’ occasional repetition of child’s utterance</td>
<td>Salient feature focused on by child; no change in situation</td>
</tr>
<tr>
<td>Repeating</td>
<td>Word or Prosodic Pattern</td>
<td>Attends to adult utterance before his utterance; may not address adult; does not await response</td>
<td>Most often none; occasional repetition of child’s utterance</td>
<td>Utterance focused on; no change in situation</td>
</tr>
<tr>
<td>Answering</td>
<td>Word</td>
<td>Attends to adult utterance before his utterance; addresses adult</td>
<td>Await child’s response; after child’s utterance, most often acknowledges response; may then perform action</td>
<td>Utterance focused on; no change in situation, unless child’s response prompts adult reaction</td>
</tr>
<tr>
<td>Requesting (Action)</td>
<td>Word or Marked prosodic Pattern</td>
<td>Attends to objects or event; addresses adult; awaits response; most often performs signaling gesture</td>
<td>Performs action</td>
<td>Salient feature focused on by child and adult; change in condition of object or child</td>
</tr>
</tbody>
</table>
**Preamble**

The preservation of the highest standards of integrity and ethical principles is vital to the responsible discharge of obligations by speech-language pathologists, audiologists, and speech, language, and hearing scientists. This Code of Ethics sets forth the fundamental principles and rules considered essential to this purpose. Every individual who is (a) a member of the American Speech-Language-Hearing Association, whether certified or not, (b) a nonmember holding the Certificate of Clinical Competence from the Association, (c) an applicant for membership or certification, or (d) a Clinical Fellow seeking to fulfill standards for certification shall abide by this Code of Ethics.

Any violation of the spirit and purpose of this Code shall be considered unethical. Failure to specify any particular responsibility or practice in this Code of Ethics shall not be construed as denial of the existence of such responsibilities or practices.

The fundamentals of ethical conduct are described by Principles of Ethics and by Rules of Ethics as they relate to the responsibility to persons served, the public, speech-language pathologists, audiologists, and speech, language, and hearing scientists, and to the conduct of research and scholarly activities.

Principles of Ethics, aspirational and inspirational in nature, form the underlying moral basis for the Code of Ethics. Individuals shall observe these principles as affirmative obligations under all conditions of professional activity.

Rules of Ethics are specific statements of minimally acceptable professional conduct or of prohibitions and are applicable to all individuals.

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**Principle of Ethics I**

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

**Rules of Ethics**

1. Individuals shall provide all services competently.
2. Individuals shall use every resource, including referral when appropriate, to ensure that high-quality service is provided.
3. Individuals shall not discriminate in the delivery of professional services or the conduct of research and scholarly activities on the basis of race or ethnicity, gender, gender identity/gender expression, age, religion, national origin, sexual orientation, or disability.
4. Individuals shall not misrepresent the credentials of assistants, technicians, support personnel, students, Clinical Fellows, or any others under their supervision, and they shall inform those they serve professionally of the name and professional credentials of persons providing services.
5. Individuals who hold the Certificate of Clinical Competence shall not delegate tasks that require the unique skills, knowledge, and judgment that are within the scope of their profession to assistants, technicians, support personnel, or any nonprofessionals over whom they have supervisory responsibility.
6. Individuals who hold the Certificate of Clinical Competence may delegate tasks related to provision of clinical services to assistants, technicians, support personnel, or any other persons only if those services
are appropriately supervised, realizing that the responsibility for client welfare remains with the certified individual.

7. Individuals who hold the Certificate of Clinical Competence may delegate tasks related to provision of clinical services that require the unique skills, knowledge, and judgment that are within the scope of practice of their profession to students only if those services are appropriately supervised. The responsibility for client welfare remains with the certified individual.

8. Individuals shall fully inform the persons they serve of the nature and possible effects of services rendered and products dispensed, and they shall inform participants in research about the possible effects of their participation in research conducted.

9. Individuals shall evaluate the effectiveness of services rendered and of products dispensed, and they shall provide services or dispense products only when benefit can reasonably be expected.

10. Individuals shall not guarantee the results of any treatment or procedure, directly or by implication; however, they may make a reasonable statement of prognosis.

11. Individuals shall not provide clinical services solely by correspondence.

12. Individuals may practice by telecommunication (e.g., telehealth/e-health), where not prohibited by law.

13. Individuals shall adequately maintain and appropriately secure records of professional services rendered, research and scholarly activities conducted, and products dispensed, and they shall allow access to these records only when authorized or when required by law.

14. Individuals shall not reveal, without authorization, any professional or personal information about identified persons served professionally or identified participants involved in research and scholarly activities unless doing so is necessary to protect the welfare of the person or of the community or is otherwise required by law.

15. Individuals shall not charge for services not rendered, nor shall they misrepresent services rendered, products dispensed, or research and scholarly activities conducted.

16. Individuals shall enroll and include persons as participants in research or teaching demonstrations only if their participation is voluntary, without coercion, and with their informed consent.

17. Individuals whose professional services are adversely affected by substance abuse or other health-related conditions shall seek professional assistance and, where appropriate, withdraw from the affected areas of practice.

18. Individuals shall not discontinue service to those they are serving without providing reasonable notice.

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**Principle of Ethics II**

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

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**Rules of Ethics**

1. Individuals shall engage in the provision of clinical services only when they hold the appropriate Certificate of Clinical Competence or when they are in the certification process and are supervised by an individual who holds the appropriate Certificate of Clinical Competence.

2. Individuals shall engage in only those aspects of the professions that are within the scope of their professional practice and competence, considering their level of education, training, and experience.

3. Individuals shall engage in lifelong learning to maintain and enhance professional competence and performance.

4. Individuals shall not require or permit their professional staff to provide services or conduct research activities that exceed the staff member's competence, level of education, training, and experience.

5. Individuals shall ensure that all equipment used to provide services or to conduct research and scholarly activities is in proper working order and is properly calibrated.
Principle of Ethics III
Individuals shall honor their responsibility to the public by promoting public understanding of the professions, by supporting the development of services designed to fulfill the unmet needs of the public, and by providing accurate information in all communications involving any aspect of the professions, including the dissemination of research findings and scholarly activities, and the promotion, marketing, and advertising of products and services.

Rules of Ethics

1. Individuals shall not misrepresent their credentials, competence, education, training, experience, or scholarly or research contributions.
2. Individuals shall not participate in professional activities that constitute a conflict of interest.
3. Individuals shall refer those served professionally solely on the basis of the interest of those being referred and not on any personal interest, financial or otherwise.
4. Individuals shall not misrepresent research, diagnostic information, services rendered, results of services rendered, products dispensed, or the effects of products dispensed.
5. Individuals shall not defraud or engage in any scheme to defraud in connection with obtaining payment, reimbursement, or grants for services rendered, research conducted, or products dispensed.
6. Individuals' statements to the public shall provide accurate information about the nature and management of communication disorders, about the professions, about professional services, about products for sale, and about research and scholarly activities.
7. Individuals' statements to the public when advertising, announcing, and marketing their professional services; reporting research results; and promoting products shall adhere to professional standards and shall not contain misrepresentations.

Principle of Ethics IV
Individuals shall honor their responsibilities to the professions and their relationships with colleagues, students, and members of other professions and disciplines.

Rules of Ethics

1. Individuals shall uphold the dignity and autonomy of the professions, maintain harmonious interprofessional and intraprofessional relationships, and accept the professions' self-imposed standards.
2. Individuals shall prohibit anyone under their supervision from engaging in any practice that violates the Code of Ethics.
3. Individuals shall not engage in dishonesty, fraud, deceit, or misrepresentation.
4. Individuals shall not engage in any form of unlawful harassment, including sexual harassment or power abuse.
5. Individuals shall not engage in any other form of conduct that adversely reflects on the professions or on the individual's fitness to serve persons professionally.
6. Individuals shall not engage in sexual activities with clients, students, or research participants over whom they exercise professional authority or power.
7. Individuals shall assign credit only to those who have contributed to a publication, presentation, or product. Credit shall be assigned in proportion to the contribution and only with the contributor's consent.
8. Individuals shall reference the source when using other persons' ideas, research, presentations, or products in written, oral, or any other media presentation or summary.
9. Individuals' statements to colleagues about professional services, research results, and products shall adhere to prevailing professional standards and shall contain no misrepresentations.
10. Individuals shall not provide professional services without exercising independent professional judgment, regardless of referral source or prescription.

11. Individuals shall not discriminate in their relationships with colleagues, students, and members of other professions and disciplines on the basis of race or ethnicity, gender, gender identity/gender expression, age, religion, national origin, sexual orientation, or disability.

12. Individuals shall not file or encourage others to file complaints that disregard or ignore facts that would disprove the allegation, nor should the Code of Ethics be used for personal reprisal, as a means of addressing personal animosity, or as a vehicle for retaliation.

13. Individuals who have reason to believe that the Code of Ethics has been violated shall inform the Board of Ethics.

14. Individuals shall comply fully with the policies of the Board of Ethics in its consideration and adjudication of complaints of violations of the Code of Ethics.

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ASHA’s State Advocacy Team monitors state and local changes in licensing, regulations, and coordinated campaigns. The State Policy Team works with state associations and state network volunteers to coordinate grassroots advocacy, legislative action and change.

State Legislative and Regulatory Changes

- **Quick Action Results in Revised Virginia Endoscopy Policy** (September 02, 2010)

State Licensing Laws, Teacher Requirements and Contact Information

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About the information linked above.

More State-Specific ASHA Resources

**State Policy Resources**
Find out about issues being addressed within/across state legislative systems.

- State Teacher Credentialing Requirements
- State Licensure Trends and Quarterly Updates
- State Insurance Mandates for Hearing Aids
- State Insurance Mandates for Autism Spectrum Disorder
- Early Hearing Detection & Intervention

Take Action at the local and state levels on bills that affect the professions of speech-language pathology and audiology.

**Building Blocks for State Associations** section provides a variety of resources and links designed specifically to meet the needs of state association leaders.

**Student Advocacy**
Promote student participation in your state capitol advocacy day.

**State Networks**
Learn about volunteer opportunities and activities
Innovative Programs to Address Personnel Vacancies in Health Care and Education [PDF]

- Academic Program Capacity Building in Audiology and Speech-Language Pathology
- State Education Agencies Communication Disabilities Council
- Council of State Association Presidents (CSAP)

State Advocacy Events and Presentations of ASHA State Networks.

- State Education Advocacy Leaders (SEALs)
- State Reimbursement Representatives (STARs) (Members-only)
- State Medicare Administrative Contractor Network (SMAC) (Members-only)
Maryland State Contact Information

Speech and Hearing Association

Maryland Speech-Language-Hearing Association
P.O. Box 31
Manchester, MD 21102

Contact: Lisa Oriolo
Phone: 410-239-7770
Fax: 410-239-7774
E-mail: office@mdslha.org

For meeting information, visit the Maryland Speech-Language-Hearing Association Web site.

State Regulatory Agencies

Regulatory Agency for Licensing and Hearing Aid Dispensing

Maryland Board of Examiners for Audiology, Hearing Aid Dispensers, and Speech-Language Pathologists
4201 Patterson Avenue, Room 308
Baltimore, MD 21215

Contact: Gwen Wheatley, Board Administrator
Phone: 410-764-4725
Fax: 410-358-0273
E-mail: wheatley@dhmh.state.md.us

Language, Speech and Hearing Contacts in State Education Agency

Maryland Department of Education
Division of Special Education/Early Intervention
200 West Baltimore Street
Baltimore, MD 21201

Contact: Carol Ann Heath-Baglin, Assistant State Superintendant
Phone: 410-767-0238
Maryland State Characteristics of Licensure Law

Updated December 2009

The information below is collected from state licensure boards or regulatory agencies responsible for regulating the professions of Speech-Language Pathology and/or Audiology. It is intended for informational use only, and should not be construed as legal advice.

Contact the state's licensure board or regulatory agency for exact licensure, certification, or registration requirements in your jurisdiction.

**Speech-Language Pathology**

Is of good moral character

Master's degree

Supervised training as required by the Board

Supervised postgraduate professional practice

Must demonstrate oral English competency

Passage of a national exam

Passage of an open-book jurisdictional exam

**Waiver**

The Board may waive any of the qualifications required for a license for an individual who:

Is of good moral character and pays the application fee

Holds or held a national certification in speech language pathology from a Board-recognized organization that meets the practice requirements established by the Board

or

Holds a current license in another state that that has equivalent requirements

Note: As of October 1, 2007, new school speech-language pathologists and assistants must be licensed by the Board.
**Exemptions**

Federal employees

Students or trainees

Physicians

Volunteers working in free speech and hearing screening programs

Audiologists or speech language pathologists licensed in another state while waiting for Board approval of their licensure application

Employees of public or state schools providing speech-language pathology services that have practiced continuously on or before September 30, 2007

Individuals continuously employed to practice audiology since June 30, 1988, in a county or state school system.

**Reciprocity/Endorsement**

The Board may waive the examination requirement to an applicant who meets the qualifications otherwise required by this title, and is licensed in another state with equivalent standards.

Audiologists, speech language pathologists, and speech language pathology assistants licensed in another state may practice while their completed application for licensure is pending before the Board.

**Interim Practice/Temporary Licensure (for Clinical Fellowship Year)**

The Board may allow an individual licensed in another state to practice in Maryland if the individual has recently become a Maryland resident and the individual has an application for license pending before the Board.

The Board may issue a limited license to individuals who meet the licensure requirements except for the examination and supervised clinical training/postgraduate professional practice, and have a master's degree in speech language pathology or a doctoral degree in audiology or both, and have their Certificate of Clinical Competence or certification from the American Board of Audiology that was in effect at the time their degree was obtained. Practice must be under a licensed supervisor or an individual who holds a national certification accepted by the Board. Applicant must also demonstrate oral English competency. A limited license expires after one year and is renewable once.

Applicants without a master's degrees who are enrolled in a post-baccalaureate doctoral training or hold a master's degree from a university program that is not accredited by the CAA may seek a limited license under equivalency requirements specified by the Board in regulation.
Continuing Education for License Renewal

30 Continuing Education Units (CEUs) per two-year renewal cycle; 50 CEUs for dual licensees

Continuing education credits may not be carried over from one renewal cycle to another

The Board will prorate CEUs for individuals newly licensed, reinstated, or transfers from other states if license is obtained between six months and two years of renewal cycle and shall waive requirements for those obtaining full licensure within six months of renewal cycle.

Board Oversight

Department of Health and Mental Hygiene, State Board of Examiners for Audiologists, Hearing Aid Dispensers, and Speech-Language Pathologists

Board Composition

The Board shall comprise 13 members; three members shall be licensed audiologists with at least five years of work experience and are currently practicing, three members shall be licensed speech-language pathologists with at least five years of work experience and currently practicing, two members shall be licensed physicians who hold a certificate of qualification from the American Board of Otolaryngology and currently practicing, two shall be consumer members one of whom shall be a consumer of services by a licensee and three shall be licensed hearing aid dispensers with at least five years of experience and currently practicing. The Governor and Secretary shall accept speech language pathologist nominees from the Maryland Speech-Language-Hearing Association (MSHA), audiologist nominees from MSHA and the Maryland Academy of Audiology, physicians from the Maryland Society of Otolaryngology; hearing aid dispensers from the Hearing Society of Maryland, District of Columbia, and Delaware, and consumers from the Department of Disabilities list.

Telehealth

Telehealth means the use of telecommunications and information technologies for the exchanges of information from one site to another for the provision of health care to an individual from a provider through hardwire or Internet connection. See also regulations at 10.41.06.

Resources

The information contained herein was collected and summarized annually. For detailed information on state licensure requirements, contact the state board and visit this website:

Board of Audiologists, Hearing Aid Dispensers & Speech-Language Pathologists