Alabama A&M University
Speech-Language-Hearing Clinic

Student Clinician:
Supervisor:
Semester/Date:

Diagnostic Report Checklist

1. Identifying Information:
   - ( ) Full name/ Date of Birth/Age
   - ( ) Address/Phone #
   - ( ) Informant
   - ( ) Examiner
   - ( ) Client's Occupation
   - ( ) Date of Evaluation
   - ( ) Diagnosis
   - ( ) Referral Source
   - ( ) Client's Occupation
   - ( ) Clinician Supervisor

2. Statement of Problem (in short paragraph form- typically 3-5 sentences):
   - ( ) Full Name and Age
   - ( ) Location/Date of Initial Evaluation
   - ( ) Reason Client is Seeking Intervention
   - ( ) Current Communication Status as Reported by Historian/Reporter (normally parent)
   - ( ) Referral Source

3. Background Information (in paragraph form- (utilizes case history, previous testing/treatment, reports from other professionals and client/caregiver interviews):
   - ( ) Prenatal and Birth History
   - ( ) Developmental History
   - ( ) Pre-morbid History
   - ( ) Previous Diagnosis/Treatment/Recommendations
   - ( ) Family/Social/Educational History

4. Observation/Assessment Results (a statement for each area of communication):
   - ( ) Oral Peripheral Exam-addresses both the structure and function of the oral mechanism
   - ( ) Audiological Screening
   - ( ) Articulation (states diagnostic test/informal assessment given, what the test/assessment measures, the average range of composite scores, what the client's scores mean in relation to normal limits i.e. severity rating, overall intelligibility)
   - ( ) Language (states diagnostic test/informal assessment given, what the test/assessment measures, the average range of composite scores, what the client's scores mean in relation to normal limits i.e. severity rating, addresses both receptive and expressive language)
   - ( ) Fluency (states diagnostic test/informal assessment given, what the test/assessment measures, the average range of composite scores, what the client's scores mean in relation to normal limits i.e. severity rating along with frequency and type of dysfluencies, as well as, the client's feelings/attitudes/avoidances)
   - ( ) Voice/Resonance (a statement regarding pitch, loudness, and quality when warranted)

5. Summary of Findings (in paragraph form –states the client's overall status--deficits/strengths)

6. Prognosis (a short statement about the clinician's impressions of how the client will respond to tx based on the following:)
   - ( ) Client's Communicative Status
   - ( ) Client's Medical/Mental Status
   - ( ) Client's Support System, etc.

7. Recommendations (a short statement of whether treatment is warranted)
   - ( ) Based on DX results
   - ( ) States focus/direction treatment should take
   - ( ) States frequency of treatment recommended
   - ( ) Indicates any necessary follow up appointments

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8. Long Term Goals/Objectives (how the client should be performing at the end of ALL treatment- "ABCD": Audience=Client, B=Behavior, C=Condition, D= Degree of success)
    - Action/Do Statement (behavior to be obtained)
    - Condition (situation under which the behavior is to be performed-both stimulus and task)
    - Criterion (how well the target must be performed-may or may not be a %-result)

9. Short Term Goals/Objectives (what the client can accomplish this semester-"ABCD": Audience=Client, B=Behavior, C=Condition, D= Degree of success)
    - Action/Do Statement (behavior to be obtained)
    - Condition (under which the behavior is to be performed-includes materials and cues- stimulus and task)
    - Criterion (how well the target must be performed-typically %- result)