PLEASE FAX TO 812-378-7054

SIHO Speech Therapy Discharge Assessment

Patient Name: ______________________ Member ID # ________________

Date: ______________ Facility: ______________________________

Therapist: ______________________

1. Length of Treatment: ______________________
2. Number of Sessions: ______________________
3. Functional Limitations at Evaluation? ______________________
4. Functional Limitations at Termination: ______________________
5. Were Treatment Goals Met? Yes ☐ No ☐

   If not, why not?
   - ☐ Patient prematurely terminated
   - ☐ Patient moved away
   - ☐ Patient resistance
   - ☐ Treatment was inadequate
   - ☐ Other (explain)

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6. Are additional services likely to be needed in the future? Yes ☐ No ☐

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Therapist Signature Date

js/01/01