Diagnostic Clinic Procedures

A half-hour planning meeting with the supervisor takes place prior to the onsite evaluation, at a time determined by the supervisor and diagnostic team members. Each case is assigned one Leader and one Assistant; each Diagnostic clinician will have training opportunities in both roles. Assistants for diagnostic cases will accrue diagnostic hours according to ASHA standards. Students complete a minimum of two onsite cases in lead and assistant roles. Additional onsite DX leads will be scheduled as dictated by the student's performance on their first two onsite cases in which they must achieve a minimal competency rating of 3.0 as defined by CALIPSO. All clinicians will conduct at least four offsite assessments under the supervision of various Speech-Language Pathologists SLPs working in the S.F. Bay Area as assigned by the Clinic Director. Students often have opportunities to complete offsite assessments before registration in the course.

**Leader Responsibilities**

1. Prior to a planning meeting
   a) Review client’s chart, research disorder, contact other professionals involved with case as appropriate and if authorization for releases are in place (e.g., speech pathologist, teacher, doctor, audiologist,).
   b) Review diagnostic tests and interview procedures.
   c) Prepare a Diagnostic Plan

2. During a planning meeting
   a) Present Diagnostic Plan to supervisor and assistant for discussion.
   b) Make appropriate changes to Diagnostic Plan as indicated and submit electronic revisions if the supervisor requires them.
   c) Determine duties of Assistant.
   d) Obtain test protocols from Clinic Receptionist if not available in Resource Room.

3. Prior to an evaluation
   a) Contact parent/caregiver by phone a few days prior to introduce yourself, answer any questions, check for allergies, motivators, etc.
   b) Enter information on test protocols neatly and in ink (or typed). Use only one protocol per client with assistant using a photocopy.
   c) Secure snack if appropriate to the evaluation.
   d) Confirm authorization for release, permission to record, and client agreement forms are available to complete if the client has not previously submitted them.
   e) Ask the supervisor if they require a copy of the Diagnostic Plan or copies of test protocols in the observation room for reference during the evaluation. If the evaluation is to be observed by students, ask instructor if the Diagnostic Plan and copies of protocols need to be available for them.
   f) Set up room for interview and organize materials for testing.

4. During the evaluation
   a) Conduct interview.
   b) Explain evaluation procedures.
   c) Administer measures and take on-line data.
   d) Note behavioral observations.

5. Staffing
   a) While the client waits in reception area, clinical impressions and recommendations are briefly discussed in preparation for the exit interview.
6. Exit Interview
   a) Discuss clinical impressions and recommendations with parent/client, allowing time for questions.
   b) In some cases of re-evaluation or DX within TX, the supervisor may choose not to have an exit interview.

7. Clean-up
   a) Collaborate with assistant regarding their data, impressions, etc.
   b) Return tests and other materials to Resource Room.
   c) Disinfect and return audiometric equipment
   d) Check that assistant has turned off recording equipment.
   e) Retrieve plan and protocols from Observation Room.

8. Report Writing
   a) Rough draft of report and letter to clients/caregivers is to be typed double spaced in Arial 11 point font with pagination at the bottom center, and is due as an electronic or hard copy as determined by Supervisor. Late reports will be marked down one-third grade per day according to clinic policy. Include test protocols, language samples and other relevant assessment data with report submission.
   b) Letter to client/caregiver must be individualized and appropriate to their needs. Typically these are written in a natural tone, summarizing the exit interview and without jargon or reference to tests or results. Discuss the content with supervisor. Priority is to mail letters out within two weeks of assessment. Letters are typically one page, single-spaced, and on letterhead once finalized.
   c) Write entire diagnostic report without aid of assistant.
   d) Subsequent edits of report will be due as determined by your supervisor, and initial grade can be lowered if timelines are not met.
   e) Once report is finalized, supervisor and clinician sign report. A copy is given or mailed to client for their personal records.
   f) File final report (original) and copy of letter to parent or client and test protocols in client’s chart, and file chart under Active if currently scheduled for therapy, Waiting List if not scheduled, or give to Clinic Director if therapy at Cal State East Bay is not indicated.

9. Other diagnostic case management responsibilities
   a) Ensure that client or family member sign authorization for release, permission to record, and client agreement forms before beginning interview.
   b) Complete Client Summary Data Sheet in client’s chart.
   c) Complete identifying information sections for all test forms.

10. Please be mindful that all information from client’s chart and diagnostic interview/testing/exit meeting and subsequent discussions with the supervisor is confidential and should not be discussed outside of the clinic conference room.

11. All test manuals and client charts remain in the Clinic at all times. Graduate Diagnostic Team Members may check-out Diagnostic Tools overnight with prior permission to be returned the following morning. Client charts may not be borrowed overnight or photocopied. Students must review client files within the confines of the Clinic, which is open Monday through Friday from 8:00-5:00. Weekend building passes are available with prior planning, and require an approval signature from a permanent staff supervisor of faculty member.
**Assistant Responsibilities**

1. Prior to the planning meeting, review client chart for participation in meeting.

2. During the evaluation, the assistant will participate in the evaluation as determined during the planning meeting and as needs arise during the evaluation session.
Diagnostic Competencies

A "3" rating is required to meet the minimum clinical competency requirement. Please refer to the CLINICAL GRADES AND ASSESSMENT Policy Statement on grade expectations.

The Clinician will demonstrate the following competencies:

1. Review the available background information in a diagnostic case file and determine the purpose of the evaluation.

2. Plan a complete, well-organized interview, appropriate for the problem and information available.

3. Plan diagnostic testing or screening for the problem presented and for the client’s age and functional level, utilizing behavioral observation, non-standardized and standardized assessment measures, and instrumental procedures.

4. Conduct a well organized interview appropriate to the situation and the informant with careful attention to the needs of the client and/or the family.

5. Correctly administer all diagnostic and screening procedures. This includes completing test protocols, language samples, phonological analyses, behavioral checklists.

6. Correctly score, analyze and interpret all evaluation procedures.

7. Interpret, integrate and synthesize background information from a variety of sources, observations, assessment findings in order to formulate appropriate clinical impressions and recommendations.

8. Present overall impressions and recommendations to clients and or families in a complete and organized fashion using language appropriate to the needs of the listener.

9. Write a complete, accurate professional report that follows the established format and which succinctly, but completely summarizes the outcome of each evaluation.

10. Write an individualized letter to the client of family summarizing the outcome and recommendations of each diagnostic evaluation in language appropriate to the reader.

11. Promptly complete all written documentation associated with the diagnostic clinic and the maintenance of clinic records, including information releases as necessary to disseminate information to appropriate individuals or agencies for further referrals.

12. Adhere to the ASHA, California Speech-Language-Hearing Association and California Board of Speech-Language Pathology and Audiology Codes of Ethics with special attention to privacy regulations and appropriate referrals. The clinicians will engage in discussion of these issues in the planning meetings and staffings for each assessment.
Diagnostic Report Grading Rubric

Statement of the Problem (present tense)
- Written in past tense
- Personal information included
- Statement of the problem is clearly stated
- Succinct, but includes most important, relevant info, including reason for assessment (e.g. family concerns)

History (past tense)
- Written in past tense
- Includes all pertinent info, including previous testing (what, where, by whom, results)
- Headings and/or paragraphs in logical sequence according to supervisory suggestions

Evaluation Results (past tense)
- Sub-headings used and organized by area of primary problem first. Ask supervisor about collapsing sub-headings as appropriate (Speech Parameters, Oral Mechanism and Audiometric Screenings, etc.)
- Discussion/analysis/presentation of specific communication behaviors within each domain
- Contains information of significance (vs. irrelevance)
- Scores presented relative to norms (i.e., SS and percentiles most meaningful); less meaningful are age scores.
- Areas that are WFL are described in brief, without inclusion of lengthy detail or examples. Do not comment on unremarkable.
- Analysis goes beyond reporting scores and behaviors.
- Analysis synthesizes the language/behaviors into an organized summary of information.
- Analysis answers the why’s of the behaviors that were or were not demonstrated.
- Specific tests are cited and underlined throughout.
- Includes, as appropriate, non-verbal behavior, pragmatics, play/cognitive skills, etc.
- Reports client’s response to cues or stimulability, as appropriate.

Diagnostic Impression (present tense)
- Restatement of client information and past remarkable history (e.g., previous treatment, special day class placement, complicating medical history/problems, etc.)
- Summary of significant findings from evaluation in functional terms as opposed to test data.
- Report any possible contributing factors.
- Should be able to stand alone, providing reader with a thumbnail synopsis of case.
- Successfully integrates and synthesizes the results with no introduction of new information, etc.
  You are building a logical case that leads to your Recommendations.
- Relates current findings to past reports, testing, functioning.

Recommendations (present tense)
- Recommendation for therapy is stated, with mention of frequency and type.
- Initial goals are presented in list form.
- Goals are appropriate and specific to the client.
- Mention of any additional assessments/referrals needed.
- Mention specific recommendation to parent/caregiver, including a Home Program as appropriate.
- Prognostic statement needs to be realistic and specific based on both positive and negative factors, as appropriate.

Grading reference: Refer to the CALIPSO Evaluation of Performance in Clinical Practicum information posted in the Policies and Procedures section of the clinic manual.
DIAGNOSTIC PLAN FORMAT

NAME: First Last                EXAMINER(S):
AGE: (Years – Months)          INFORMANT(S): (Name and relationship)
BIRTH DATE: Month-Day-Year     NATURE OF DISORDER:
DATE OF EXAMINATION: Mo-Day-Yr SUPERVISOR: First Last, Degree, CCC-SLP

I. STATEMENT OF PROBLEM

State the full name of the client, age, date, and place of examination. Include the name of individual or agency making the referral. Note any previous evaluations or relevant medical problems. Provide a statement of the problem in the words of the client or informant and indicate the type of service requested. Include purpose of the evaluation or re-evaluation. This section is usually about as long as this paragraph, but not more than twice as long.

II. PLAN

Insert a numerical list of all activities, tests and procedures to be included in the evaluation, along with the time (in minutes) allocated to each. The order may vary based on the needs of the individual client. All evaluations routinely include client or informant interview, hearing screening, oral exam, consulting time (15 minutes), and exit interview (15 minutes). During Planning meeting the supervisor may suggest re-ordering to maximize client performance or efficiency of process. Indicate which clinician is responsible for each procedure. Total time is generally 120 minutes and should not exceed 150 minutes, even for the most complex cases.

<table>
<thead>
<tr>
<th>Event</th>
<th>Time Allocated</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Interview</td>
<td></td>
</tr>
<tr>
<td>2. Hearing Screening</td>
<td>(concurrent with interview if it does not include client)</td>
</tr>
<tr>
<td>3. Oral Mechanism Exam</td>
<td></td>
</tr>
<tr>
<td>4. (Assessment activities)</td>
<td></td>
</tr>
<tr>
<td>5. Consult with Supervisor</td>
<td></td>
</tr>
<tr>
<td>6. Exit interview with client/caregiver</td>
<td></td>
</tr>
</tbody>
</table>

(Max. time 120 min.)

III. RATIONALE

For each number item above, a rationale must be included. For specific tests include support for your choice, including appropriateness for age, disorder, linguistic and cultural background. Include data about statistical validity and reliability. For required procedures, simply indicate “routine clinic procedure”.

1. 
2. 
3. 
4. 
5. 
6. 
IV. **INTERVIEW QUESTIONS**

Using the broad headings of communication, medical, academic, social, etc., list proposed interview questions. Begin with a general, all purpose question then list possible specifics as bullet points so that the interview will contain fewer questions and instead, be more of a conversational exchange. Questions should flow naturally and do not necessarily need to be asked in the order listed. The interview should result in new or clarified information and should not seek information that is already known from the application. Remember that active listening should guide interview and is required to ensure all necessary information is obtained.

V. **ETHICS ISSUES**

Indicate possible ethics issues or questions (e.g. appropriate referrals, collaboration with other personnel, intervention practices, prognostic factors, scope of practice, privacy protection) in regards to this specific case for discussions in planning meeting and/or staffing. As appropriate, the exit interview, letter and/or Dx report will include these issues as they affect case disposition and specific recommendations.
CALIFORNIA STATE UNIVERSITY, EAST BAY  
DEPARTMENT OF COMMUNICATIVE SCIENCES AND DISORDERS  
norma s. and ray r. rees speech, language and hearing clinic

confidential

DIAGNOSTIC EVALUATION

NAME   First Last
Age   (Years/Months)
Birthdate   Month/Day/Year
Date of Examination

 Examiner(s)
 Informant(s)  (Name; relationship to client)
 Nature of Disorder
 Supervisor  First Last, Degree, CCC-SLP

i. statement of problem

State the full name of client, age, remarkable pertinent background history or diagnosis. Include the name of the individual or agency making referral. Provide a statement of the problem in the words of the client or informant and note purpose of evaluation.

ii. history  (past tense)

Unless case is extremely complex, simply paragraph history, covering the following areas without using subheadings, ending with purpose of assessment. Paragraphing history requires writer to be succinct and construct meaningful transitions, focusing on relevant and remarkable information.

A. Communication
Describe the onset of the problem, relevant prelinguistic behavior and speech development milestones, response to communication (e.g., attention, comprehension, responsiveness), and current communicative behavior (where and with whom client uses communication). Discuss the general course of the problem, including treatment within the family and through other agencies. Describe the client’s awareness of and response to the problem.

B. Physical Development
Discuss any complications or abnormal circumstances surrounding the mother’s pregnancy, the birth and delivery of the child, or the motor development of the client. Report any difficulties in vision or hearing. If no difficulties are reported, state: “Pregnancy, birth, and delivery were reportedly unremarkable. No problems were reported in the areas of physical and/or motor development.”

C. Medical
Describe any major illnesses or injuries reported, as well as any medications which the client uses regularly. If none, state: “Informant denied any significant medical problems.”

D. Family – Social
Discuss the client’s family constellation and the relationships among the family members which appear relevant to the client’s problems. Describe any other speech, language, or hearing problems within the family. Include exposure to languages other than English. Include information concerning the client’s
social relationships which may be related to the problem. Describe the child’s general personality or temperament.

E. **School History / Cognitive Development**
Discuss any relevant information relating to client’s academic performance, behavior in the classroom, or special problems noted. For pre-school children, include any relevant information concerning client’s attention span, memory, concept development, etc.

III. **GENERAL IMPRESSIONS / BEHAVIORAL OBSERVATIONS (past tense)**
Provide general impressions of the client. This paragraph may include a description of the behavior during an initial observation period with the parent, separation from the parent for testing (only appropriate for a young or significantly impaired child), and other impressions (cooperation, attention span, engagement, etc.), client’s primary means of communication. Include speech and non-speech behaviors noted outside of standardized testing.

IV. **EVALUATION RESULTS (past tense)**
Use a sub-heading for each area assessed. Begin with the primary problem area and list other areas in decreasing order of severity. Group together any areas which are within normal limits in a concluding statement. When reporting results of a formal test, state and underline the full name of the test and compare client’s performance to norms in test manual. Raw scores are not reported. If testing was invalidated, state why, providing a more qualitative description of test performance. Utilize a chart to summarize assessments with multiple sections and then in your analysis don’t repeat the same info, but instead comment on remarkable subtests, doing an item analysis and comparing info to other measures or observations.

A. **Receptive Language**
(In the event that assessment included a mixed language assessment, combine Sections A & B, into Language.)
Analyze results of testing for all receptive language tests, such as PPVT, etc., (e.g., child demonstrated difficulty following complex and lengthy directions, etc). Report results of informal testing for receptive skills when appropriate. If possible, include a general summary statement concerning child’s level or receptive functioning. If normal, state (e.g., receptive language performance revealed adequate single word and syntactic comprehension).

B. **Expressive Language**
Analyze results from all expressive language tests. Describe language performance in terms of semantics, syntax and pragmatics. If the major area of concern is social language or pragmatics, then that should be a separate sub-heading. Analyze child’s spontaneous language using structured analysis or informal measure. An analysis and interpretation of tests may include: description of child’s syntactic and morphological errors, level of complexity of grammatically correct sentences, use of child’s utterances to illustrate errors, child’s response to clinician model, etc. If possible, make a general statement about child’s communicative behavior (e.g. rarely initiated conversation, poor eye contact, behavior, etc.) With a nonverbal child, describe all attempts at communication, (e.g., gestures, facial expressions, laughing, crying, etc.). Describe play behavior, but consider if this should be a separate sub-heading if significantly impaired or if client is very young or non verbal. If normal, indicate that expressive language performance appeared appropriate, with brief remarkable observations, if appropriate.
C. Articulation / Phonology*
(As appropriate; if unremarkable utilize heading Speech Parameter to capture Articulation, Voice and Fluency)
Report results of phonological/articulation testing. An analysis and interpretation of tests should include: description of error patterns (with examples), developmental levels, response to stimulation (stimulability), facilitating phonetic contexts, consistency of errors, level of intelligibility. Otherwise report as adequate or WNL.

D. Structure and Function of the Oral Mechanism*
(*Can be combined with Hearing Screening under a single sub-heading.)

E. Hearing Screening*
State results of audiometric screening, (e.g., a pure tone, air conduction audiometric screening for the frequencies 500 to 8000 Hz administered at 25 db (ISO) indicated that hearing sensitivity was within normal limits bilaterally. Screenings are pass/no pass. Do not report a specific frequency in which client did not respond. Report tympanometric screening results as appropriate.

V. DIAGNOSTIC IMPRESSIONS (present tense)
Reiterate client’s name, age, and state the client’s speech and language diagnosis, including severity. Describe in general (summarize) the reason for evaluation, the significant aspects of the problem(s) identified during the evaluation. In separate paragraphs, present each area of significance in order of severity as it relates to the diagnoses provided. Discuss possible contributing and maintaining factors, e.g., poor oral motor functioning, foreign language influences in the home, low intellectual functioning, etc.

This portion of the report should provide the reader with an overall picture of the client, even if the rest of the report has not been read. This section should serve as a summary that includes client’s skills as well as potential problem (e.g., inattention, medical fragility, limited response to treatment, fatigue, poor responsiveness, etc.) In this section the clinician attempts to integrate and synthesize the findings of the evaluation. It is not sufficient to merely restate test scores or re-present information. In fact, test scores should rarely be included. It is in this section that the clinician’s hypotheses, impressions, and predictions are noted.

VI. RECOMMENDATIONS (present tense)
Based on the results of the evaluation, state whether therapy is recommended and if not, why. If therapy is recommended, discuss frequency and type of therapy (group, individual, intensive), and suggest initial therapy goals, that may address as appropriate caregiver involvement, inclusion of literacy and/or multi-modalities, etc. List and discuss other recommendations (e.g., psychological evaluation, family counseling, implementation of a home program). Discuss prognosis in terms of the recommendations made and your knowledge of the client’s behavior, e.g., based on the child’s inconsistent attention during the evaluation, it is expected that progress in therapy will be slow initially. Where relevant, make a statement concerning the client’s or family’s acceptance of the recommendations.

Your Name
Student/Graduate Clinician

Supervisor’s Name, Degree, CCC-SLP
Clinical Supervisor or Appropriate Title
Instructions: Rough draft submitted typed, double-spaced in Arial 11 point font with final copy single spaced, except between headings. Clinic Director will provide sample reports appropriate to case as guidelines. Be sure to include page numbers at the bottom of report. Please ask your supervisor if they prefer hard or electronic submissions and what they require in reviewing subsequent submissions. Submit with all test protocols used.

CALIFORNIA STATE UNIVERSITY, EAST BAY
DEPARTMENT OF COMMUNICATIVE SCIENCES AND DISORDERS
NORMA S. AND RAY R. REES SPEECH, LANGUAGE AND HEARING CLINIC

CONFIDENTIAL

SPEECH-LANGUAGE RE-EVALUATION

NAME First Last EXAMINER(S)
AGE (Years/Months) INFORMANT(S) (Name; relationship to client)
BIRTHDATE Month/Day/Year NATURE OF DISORDER
DATE OF EXAMINATION SUPERVISOR First Last, Degree, CCC-SLP

I. PRESENTING PROBLEM

Include the client’s age, sex, etiology, speech and language problem(s), total number of quarters at Cal State East Bay, dates and overall assessment of response to treatment. Indicate any treatment elsewhere since last seen and the outcome of treatment. State purpose of re-evaluation.

II. HISTORY

(Include a general statement that history is not inclusive and only covers information since last seen or evaluated at Cal State East Bay.)

Information gathered from documentation from other facilities, client/caregiver interviewer, including current concerns, etc. Paragraph history to provide a pertinent summary.

III. BEHAVIORAL OBSERVATIONS Same as in the Initial Evaluation report.

IV. RESULTS (Same as the Initial Evaluation report.)

V. DIAGNOSTIC IMPRESSIONS (Same as Initial Evaluation report if the re-evaluation is comprehensive.)

VI. RECOMMENDATIONS (Same as Initial Evaluation report.)

Your Name Supervisor’s Name, Degree, CCC-SLP
Student/Graduate Clinician Clinical Supervisor or Appropriate Title
SELECTED GUIDELINE FOR PREPARING DIAGNOSTIC REPORTS AND LETTERS

FORMAT:
1. Only page 1 of Diagnostic Letters is on letterhead; subsequent pages on plain bond.
2. Margins of 1 inch at top and bottom of page for reports and letters.
3. Use pagination, bottom center.
4. Cannot have topic heading, e.g., RECEPTIVE LANGUAGE, alone at the bottom of the page without additional text. Adjust your page breaks accordingly.
5. Cannot have signatures alone on page; adjust text accordingly.
6. Double space between paragraphs.
7. Allow 4 spaces between end of text and signature lines.

PUNCTUATION/STYLE:
1. Refer to adults as Mr., Mrs., or Ms.
2. Do not include months in reporting the age of adults (over 18).
3. Write ages with a dash, not a period, i.e., 3 years, 3 months = 3-3.
4. Quotes must be exactly what the client said. Cannot say: Miss Smith reported that “people do not understand her due to her speech.” This would have to be “people do not understand me due to my speech.”
5. Only use quotes when the statement is important or significant enough to quote. Otherwise, report the client’s information in direct form, e.g., the client said that people do not understand her.
6. Avoid using the client’s name in every sentence. Use pronouns as referents after mentioning the client’s name the first time.
7. The first mention of any test or formal procedure must be written out in full and underlined, e.g., the Peabody Picture Vocabulary Test – Revisited (PPVT-R). Subsequent references may use abbreviations, e.g., PPVT-R.
8. Punctuation goes inside of quotation marks. “She seems to understand everything.” He omitted the final sound in the words “house,” “book,” and “watch.”
9. You must keep your constructions parallel or equivalent. For example, you cannot say: She washes and dries her hands, plays interactive games and will attend kindergarten in the fall.
10. Avoid wordy passive voice and is/was able/unable.
11. Use quotation marks to indicate client’s verbal responses, but in referring to test items of say adjectives within clients repertoire, italicize.
PUNCTUATION/STYLE:

12. Commas: In a compound sentence, use a comma if there is a separate subject in the second clause. For example:

She reported that he walked early, but he was late in all other developmental areas.

vs.

She reported that he walked early but was late in all other developmental areas.

He is able to dress and undress himself and take care of his toilet needs.

vs.

He is able to dress and undress himself, and he takes care of his toilet needs.

He initiated conversation and used a variety of sentence types.

vs.

He initiated conversation, and he was responsive to conversation addressed to him.

13. Please avoid semicolons except when separating lists of phrases in place of commas.

14. e.g. and i.e.: Examples are listed using e.g., which means “for example.” You will see many examples of e.g. used throughout this paper. The other form, i.e., means “that is” and is used to clarify or define your meaning, i.e., to specify exactly what you mean. During the next quarter, i.e., fall, we will be introducing a new course.

15. PROOFREAD your work.

PROFESSIONAL:

1. Do not report raw scores. Report percentiles, age equivalents, ranges, etc.
   Example: On the Peabody Picture Vocabulary Test-Revised (PPVT-R), Form L, Nick scored at the 75th percentile.

2. Try to include a brief statement of what a test or subtest assesses, e.g., On the Peabody Picture Vocabulary Test-Revised (PPVT-R), a test of single word receptive vocabulary, Nick scored at the 75th percentile with an age equivalent of 6 years, 6 months. This score falls in the high average range.

3. Do not submit work with missing phonetic symbols.

4. Refer to sample reports and letters for professional style and content.