

ENHANCING
CLINICAL
EXPERIENCES

A Student Resource

Naomi Chivell, Nicole Haspell,
Rebecca Hillis, Rebecca Molina,
Melissa Warren

Introduction

This student resource has been created as one of several early steps in the long journey toward increasing clinical placements for Speech Pathology students.

This resource was designed to assist Speech Pathology students both as they prepare for their clinical placements and during the course of their placement and any difficulties that may be encountered. The authors believe that through providing this resource to aide students in the management of potential difficulties encountered during clinical placements, they will be equipping students with the tools they require. The authors hope that this will develop in students the desire to become future clinical educators themselves. Also, it is believed that supervisors who have a positive experience with well-prepared students during the placement will be more likely to offer clinical placement to students in the future.

This resource contains suggested guidelines for students as they complete their clinical placements. The authors recommend that this resource be used in conjunction with students' internal and external La Trobe clinical supervisors' preferences and recommendations. Therefore, please seek the advice of your clinical supervisors and the La Trobe University Clinical Handbook in all situations.

The authors would like to take this opportunity to thank everyone who has contributed to the development of their Pass Degree Project. In particular, they wish to extend a very special thankyou to Donna McNeill-Brown for all her supervision and suggestions during the completion of this project.

Contents

Student Profile Template.....	1
Clinical Contact Checklist	2
Guidelines for student progress.....	5
2 nd year	5
3 rd year	6
4 th year	7
Conflict Resolution	10
Problem Solving	11
Formal Language.....	14
Language Registers	16
Abbreviations	17
Professionals/Referrals	19
Example agencies	19
Allied Health Assistant	20
Audiologist	21
Dietician	22
Guidance Officer	23
Neurologist	24
Nurse.....	25
Occupational Therapist.....	26
Otolaryngologist (ENT)	27
Paediatrician	28
Physiotherapist.....	29
Podiatrist.....	30
Psychologist.....	31
Social Worker.....	32
Visiting Teacher	33

Facilities	34
La Trobe Communication Clinic	34
Early Intervention Centre	35
Hospital – Rehabilitation	36
Hospital – Acute	37
Education – Kindergarten/Preschool	38
Education – School	39
Community Health	40
Drugs that affect Speech and Swallowing	41
Speech Pathology Tests/Assessments	43
Useful Resources	47
Appendices	49
Appendix 1 – Case history questions	49
Appendix 2 – Example session plan	57
Appendix 3 – Oral peripheral examination	61
Appendix 4 – Example handover report	66
Appendix 5 – Example dysphagia report	69
Appendix 6 – Example mealtime assessment report.....	73
Appendix 7 – Example speech & language assessment report.	75
Appendix 8 – Intensive fluency progress report	81
Appendix 9 – Fluency review report	84
Appendix 10 – Camperdown Program report	87
Appendix 11 – Hyperfunctional voice report	91
Appendix 12 – Dysphoric voice report	93

Student Profile Template

Name:
DOB:
Address:
Phone:
Mob:
Email:

Details of past clinical experience:

Special interest within the profession:

Other skills or qualifications: eg. Languages spoken, Makaton, professional memberships (eg. SPA)

Your strengths from previous clinics:

What you need to learn from this clinic:

Your learning style:

Clinical Placement Commencement Checklist

The following is not an exhaustive checklist. You may need to include or exclude questions which are specific to your clinical placement. (However, try not to drill your supervisor with too many questions!!)

It's recommended that you contact your supervisor at least 3 weeks before you are due to commence the placement.

Before commencing your placement, ask your supervisor:

What day/date will the placement begin?	
What time do I start at the facility? What time do I finish? <small>Note: only ask for a finishing time if you rely on public transport – otherwise, your supervisor may feel you are not motivated.</small>	
Are there any days your supervisor is unavailable to oversee clinic? Inform your supervisor if there are any days that you are unable to attend clinic and organise alternate times as required.	
Is parking available? Is there a cost? Do I need loose change? Is there public transport available close to the clinic?	
What do I need to bring on my first day? Eg. resources	
Should I bring food with me or are there food outlets nearby?	

Should I expect to be working with any clients on the first day or will it be primarily orientation/ observation?	
What are some recommended readings for this placement?	
What type of caseload should I expect?	
What is the dress code in this facility?	
<p>Try to locate the facility, e.g. using Melways, if you have problems, confirm facility's address etc. with your supervisor.</p> <p>If it's remote, it's a good idea to ask for directions.</p> <p>NOTE: www.whereis.com.au and www.street-directory.com.au are two websites that hold street maps of regions around Australia.</p>	
Where should I meet my supervisor?	
Do I need to sign in? If so, where?	
Should I bring a copy of the Learning Agreement?	

First Day:

Usually, your supervisor will give you a tour of the facility. However, it is important that you are aware of the following from the first day.

Take your Police Check!	
Complete Learning Agreement with your supervisor	
Where you can work	
Where you can keep your bag. Is it secure?	
Map of the facility	
How to access files	
Ask for sample reports as templates	
List of abbreviations used in the clinic	
Who is in charge of what within the facility	
Emergency procedures	
Occupational Health & Safety information	
The policies and procedures manual	

Guidelines for student progress – 2nd year

The following 5 pages of information have been extracted from a previous Pass Degree Project titled “Clinical Orientation Package” (2004). This was developed by Lauren Brett, Katrina Brodzik, Anna Clark, Jane Pruys, Andrea Scully & Clare Stempel

Please note this checklist is a **guide** for student progression throughout the clinic to be modified to suit individual settings and participants.

The tasks have been set using the expectations outlined in the clinic handbook 2004 (p.20-21) and the examples of behaviours for emerging competence across the CBOS range indicators (Appendix 5).

Orientation

- To the place, people, procedures and emergencies
- Learning agreement: learning styles, expectations, workload, type of feedback.

The indicators of emerging competence terms should cover the following skill areas:

- ◆ Procedural/Therapeutics
- ◆ Problem Solving
- ◆ Interpersonal
- ◆ Self evaluation
- ◆ Professional

Stage 1

- The student will observe the supervisor with clients, and seek information about the client's management **with guidance**.

Stage 2

- The student will observe the supervisor or 3rd/4th year student partner with clients, seek information about and participate in the management of the client **with guidance**.

Stage 3

- The student will observe the supervisor or 3rd/4th year student partner with clients, seek information about , participate and describe the management of the client **with guidance**.

Congratulations!!! You have finished your placement. We suggest you revise the above checklist to remind you of the skills you have developed and how hard you have worked to achieve this.

Guidelines for student progress – 3rd year

Please note this checklist is a **guide** for student progression throughout the clinic to be modified to suit individual settings and participants.

The tasks have been set using the expectations set out in the clinic handbook 2004 (p.20-21) and the examples of behaviours for emerging competence across the CBOS range indicators (Appendix 5).

Orientation

- To the place, people, procedures and emergencies
- Learning agreement: learning styles, expectations, workload, type of feedback.

The indicators of emerging competence terms should cover the following skill areas:

- ◆ Procedural/Therapeutics
- ◆ Problem Solving
- ◆ Interpersonal
- ◆ Self evaluation
- ◆ Professional

Stage 1

- The student will observe supervisor demonstrating basic therapeutic skills, seek information about, participate and describe the client's/patient's management with **guidance**.

Stage 2

- The student will observe supervisor demonstrating basic therapeutic skills, seek information about, participate and describe the client's/patient's management with **minimal guidance**.

Stage 3

- The student will apply, interpret, compare, critically question and analyse within the management of client's/patient's with **guidance**.

Stage 4

- The student will apply, interpret, compare, critically question and analyse within the management of clients/patients with **minimal guidance**.

Congratulations!!! You have finished your placement. We suggest you revise the above checklist to remind you of the skills you have developed and how hard you have worked to achieve this.

Guidelines for student progress – 4th year

Please note this checklist is a **guide** for student progression throughout the clinic to be modified to suit individual settings and participants.

The tasks have been set using the expectations set out in the clinic handbook 2004 (p.20-21) and the examples of behaviours for emerging competence across the CBOS range indicators (Appendix 5).

Orientation

(Suggest week 1-2)

- The supervisor will provide the necessary information to orient the student to layout of the facility, other staff members and their roles, emergency procedures, policies and procedures of the organisation (including documentation), expectations of the clinic and a learning agreement.
- Supervisor and student will discuss (in accordance with completing learning agreement) the student's preferred learning styles and supervision needs on the basis of past clinical learning experiences.

Stage 1

Week(s) _____

- The student will observe the supervising clinician demonstrating all basic therapeutic skills necessary when assessing, evaluating, and managing the therapy of clients/patients.
- The student will record relevant information found through observing clinician with clients/patients, seek information about, participate and describe the client/patient management with supervising clinician. (Underline = terms used in the indicators of emerging competence I.E.C at beginning level) (refer to Appendix 5 Clinic handbook)
- The student will observe the supervising clinician administer the following formal assessments where necessary: _____

- The student will attend staff meetings where appropriate.
- The student will familiarise him/herself with the assessment procedures and tools used at the placement.
- The student will involve family/carer, and other disciplines in management plan where necessary.

Stage 2

Week(s) _____

- The student will make observations of clinician with clients/patients and continue to record relevant information.
- The student will apply, interpret, compare, critically question and analyse within the management of clients / patients (observation or direct participation). (Underline = Intermediate level terms used in I.E.C)
- The student will administer a formal speech pathology assessment to a client following ethical guidelines (eg informed consent from client/family, confidentiality).
- The student will draft a written report from information gathered during assessment session. Report should demonstrate ongoing skills in accurate recording of events, attempts to summarise relevant information and draw conclusions from assessment results and other information.
- The student will write client/patient files entries with assistance from supervisor (eg drafts, discussion etc)
- The student will plan and complete intervention sessions with clients/patients using assistance from supervising clinician where necessary.
- The student will discuss and begin to plan future discharge/management of clients/patients from moment of contact.
- The student will begin to liaise with family/carers, and other disciplines where appropriate.

Stage 3

Week(s) _____

- The student will further develop report-writing skills with emphasis on consolidating information into a summary and drawing an appropriate conclusion.
- The student will continue to write client/patient file entries with minimal guidance.
- The student will plan intervention sessions with clients/patients using minimal guidance if necessary.
- The student will implement therapy with clients/patients using minimal guidance where necessary.
- The students will move towards independently liaising with family/carers of clients/patients and other disciplines for management of clients/patients.

Stage 4

Week(s) _____

- The student will show emerging competence in developing discharge plans for clients/patients.
- The student will continue to develop report-writing skills.
- The student will independently write in client/patient files.
- The student will improve ability to problem solve about clients/patients assessment results, and possible management plan.
- The student will plan and implement intervention to clients/patients with minimal to no guidance where appropriate.
- Mid-placement feedback. The student will reflect on abilities (strengths and weaknesses) and will focus on improving these areas over next two weeks

Stage 5

Week(s) _____

- The student will concentrate on improving in areas identified as more difficult for them during mid-placement. These areas are: _____

- Clinician will demonstrate ability to accurately report to other colleagues about client/patient management during meetings where appropriate.
- Student will focus on the element of time management with aim towards working at the level of a new graduate Speech Pathologist.

Stage 6

Week(s) _____

- The student will show emerging ability to discuss knowledge of research findings in the related literature in terms of his/her client/patient management. (e.g. why one treatment is recommended over another, why a client presents with particular deficits after specific brain injury etc)
- The student will develop a useful client management tool (Eg assessment form, therapy resource, analysis/summary of relevant article, list of helpful references for type of clinic)
- The student will start to show independence in the management of clients/patients (This includes assessment, analysis of results, evaluation of circumstances, seeking relevant information from other colleagues/the literature, discharge planning, selecting appropriate intervention, implementing this intervention, and evaluating/improving own procedures/skills)

Stage 7

Week(s) _____

- The student, requesting information and assistance when necessary, will demonstrate ability to independently critically evaluate, select, integrate, create and plan assessment / intervention for clients / patients. (Underline = advanced level terms from I.E.C) This will be represented in the form of a report (e.g. progress notes, assessment report, hand over/discharge report etc) where necessary.
- The student will independently collate summaries and draw conclusions/make recommendations for the management of a client/patient. (Also in the form of a report where appropriate)
- The student will independently liaise with client's family/carers and other disciplines where necessary reporting accurate/relevant information depending on the target audience.
- The student will demonstrate the ability to assess and provide appropriate intervention to the client/patient. This should involve on-line problem solving throughout the assessment/therapy session.
- Final placement meeting.

Congratulations!!! You have finished your placement. We suggest you revise the above checklist to remind you of the skills you have developed and how hard you have worked to achieve this

Conflict Resolution

0. Independently try to solve the problem by increasing your knowledge about the area in which you are working.

- Look up relevant resources in the La Trobe University library.
- Ask your supervisor if they have any resources you can borrow to develop your skills in working effectively with the client population.

1. Discuss your difficulties directly with your supervisor. Try to remain positive, and ensure that your statements do not give the impression that you are blaming your supervisor for any difficulties encountered. “I feel” statements can be used effectively for this.

- Meet with your supervisor to address the issue.
- Discuss with your supervisor their contribution to your learning, and they could provide you with additional resources, observation time, additional opportunities or any other form of help or support. The Learning Agreement is a good tool with which to begin discussions, as both the student and supervisor have agreed upon the expectations and level of responsibility to which the student is to perform. The mid-placement agreement is another opportunity to discuss with your supervisor the difficulties you may encounter during the placement.
- Discuss with your supervisor your preferred learning style and how the clinical environment could be employed to maximise your learning. Discuss ways to overcome this problem with your supervisor and ways to facilitate your learning. The Learning Agreement is a good tool to inform your supervisor about your learning style. Mid-placement feedback is another opportunity for you to raise these concerns with your supervisor.
- Discuss with your supervisor your experience with the population focused on during your placement and discuss any concerns you may have regarding working with this population. Your supervisor may provide you with valuable information regarding how to interact with these clients, for example, they may provide you with ways to approach each individual client so that you are in the best position to establish a rapport with them.

2. Discuss your difficulties with an outside source; Eg, clinical education coordinator.

- If speaking directly to your supervisor does not help to resolve the difficulties you may have encountered in your clinic, and then you should discuss your difficulties with your clinical education co-ordinator at La Trobe University. Your co-ordinator will be able to provide you with strategies to help deal with the situation and/or may discreetly discuss these difficulties with your supervisor.
- Inform your La Trobe University Clinical Education Coordinator about the issue and how you are attempting to resolve it. This will ensure that if the issue becomes more complicated or serious your internal supervisor will already be aware of the detail.
- Consult resources at the La Trobe University library or at clinic if appropriate. Ask your supervisor to recommend resources that may assist the development of your skills and knowledge.

Professional Development following Mid-Placement assessment

The following are some suggestions to consider, following difficulties from mid-placement feedback. These address the five C-BOS behavioural skills assessed during mid-placement and final-placement feedback.

PROCEDURAL

If you are not meeting pass criterion for Procedural, to facilitate your development of skills in this area you could:

- Role play sessions with your supervisor
- Tape record or video session to critically evaluate your own performance
- Create your own game/motivation task or a list of games or idea activities that you could use in sessions.

PROBLEM SOLVING

If you are not meeting pass criterion for Problem Solving, to facilitate your development of skills in this area you could:

- Ask to write extra reports – either for the supervisor’s patients or for a mock client.
- Ask your supervisor to create a ‘mock patient,’ maybe loosely based on one of their current clients. Depending on your area of difficulty, plan long- and short-term goals, plan therapy, etc.
- Make up your own data collection sheets relevant to the clients you may see.
- Look at results from previous clients and discuss with your supervisor your analysis of the results and what future steps you would take with the client
- Write further session plans for clients whom you may not see
- Create a mini project drawing up the hierarchy of goals within therapy. For example, an articulation flow chart: sound in isolation → CVs → words etc.

INTERPERSONAL

If you are not meeting pass criterion for Interpersonal, to facilitate your development of skills in this area you could:

- Role play case history taking with your supervisor or other students
- Role play explanations that you might give parents/clients regarding feedback about assessment results or plans for therapy
- Make up a list of things you can do to interact more effectively. For example, increase eye contact, alter body language etc

SELF-EVALUATION

When completing clinical placements it is essential to self-evaluate your developing clinical skills. The following questions will help you to critically evaluate your skills.

For students completing first year clinics:

- What were the skills that you observed the supervisor demonstrating?
 - Professional skills
 - Problem-solving skills
 - Interpersonal skills
- What things did you not understand during the session? Discuss these with your supervisor.

For students completing second year clinics:

- Think about and then discuss with your supervisor
How well did you:
 - Plan the session?
 - Explain the goals of the session to the client?
 - Build rapport with the client?
 - Reinforce and prompt the client?
 - Keep the client motivated?
 - Deal with any problems that were encountered during the session?
 - Record the client's progress and end the session.

For students completing third year clinics:

- Continue asking the questions from the previous list
- Were your sessional goals achieved? Why or why not?
- What were the things that worked really well in the session? Why did they?
- What would you change from that session? Why?
- How will you use these reflections when planning for your next session?

For students completing fourth year clinics:

- Continue asking the questions from the previous lists.
- Did the session follow your plan? Was this a good thing? How will this impact the planning of your next session?
- What theoretical knowledge did you use during this session? Do you need to research anything before the next session?
- Critically evaluate your professional skills (procedural, problem-solving, professional, interpersonal and self-evaluative). Pick out two or three things that you want to focus on developing during your next session.
- What did the client take away from the session? Are they demonstrating expected progress? Why or why not?
- Was the session planned appropriately for the specific client? Did you provide an appropriate environment?
- What concerns do you have regarding:
 - Your professional development and skills?
 - Your client's progress?
 - Discuss these and any other concerns with your supervisor.

PROFESSIONAL

If you are not meeting pass criterion for Professional, to facilitate development of skills in this area you could:

- Ask your supervisor to give you a hypothetical case load, then make up a timetable to manage your clients, include a prioritisation list of clients
- Make sure you are familiar with relevant administration duties. For example, practise making new files, entering data into computers etc.
- Research possible referral sources relevant to your clinic, make up a list with information on ways to contact each facility/professional
- Review the Speech Pathology Australia Code of Ethics
- Research/plan ways in which you can continue your own professional development. For example, seminars or courses that you could attend, books/journals that you could read, etc.

The following are ideas that may help prevent problems from arising during placements.

- Ensure that you and your supervisor discuss the Learning Agreement at the beginning of the placement. Include in your discussion any areas that you feel you may need to focus on, the amount of observation to be included and your individual learning style. Also, discuss time allocation for reports/notes and amount of support provided at the beginning of the placement compared to the end of the placement.
- Ask for feedback after each session. Encourage your supervisor to allow you to comment on the session before they does. This will give you the opportunity to demonstrate self-evaluation skills. It will also allow your supervisor to see your problem-solving skills regarding issues from the session and how they could be resolved.
- Ask for regular formal feedback related to the C-BOS units used for assessment (i.e. procedural, problem solving, interpersonal, self-evaluation and professional). This will allow you and your supervisor to address issues as they arise rather than having any nasty surprises at mid-placement feedback (or worse still... final placement feedback).
- Clarify instructions that you haven't understood. This will ensure that something like a communication breakdown doesn't create an issue between you and your supervisor.
- Ask for sample reports and file notes before writing your own. Supervisors will have an individual report writing styles. Many will respect individual differences in therapy and report writing styles, however, some supervisors will expect you to adopt their preferred style. Be aware of these issues and be prepared to respect your supervisor's decision. It may be helpful to ask your supervisor for a sample report before submitting your own.
- Create detailed session plans with comprehensive procedures and in-depth contingencies. This will assist you in conducting your sessions in a concise and timely manner and ensure that you are prepared for the unexpected in the session. At the end of your session, critically evaluate your performance. (See 'Self-Evaluation' on page 12).

Casual vs Formal Language

<u>Casual language</u>	<u>Formal language</u>
We saw	It was observed / It was noted
We think	It is recommended
About	In regards to
Below average	Below the limits expected for his age
She can understand short and simple sentences	She demonstrated an understanding of short sentences of minimal complexity
He uses sign language to communicate	He utilises sign language as his primary means of communication
She is not good at	she had some difficulty with
I saw a deviation from the midline	A deviation from the midline was observed
He could answer all the questions correctly	He accurately responded to all presented stimuli
A range of assessments were administered to Frank	Frank participated in several assessments
Julie worked well and did not go over the time limit	Julie remained attentive and completed all tasks within the allotted time
Sarah should have scored at least ten	The recommended minimum score for Sarah's age group is ten
His score is between the average ranges	He scored within the normal range
The test was completed to make sure John's trouble with reading is because of phonological awareness difficulties not because of a language delay	This assessment was essential to determine whether John's difficulties can confidently be attributed to phonological awareness difficulties.
She was able to tell the difference	She was able to accurately discriminate
She asked	She requested
She needed	she required
She said	She reported, she mentioned, she stated, she commented
She was told to	she was instructed to
He was involved in	He actively participated in
He did not want to work	He became un-willing to participate
He did not concentrate	He appeared to be easily distracted
He answered correctly with help from the clinician	with prompting

She was given	She was provided with
At first he was	Initially, he was
Mary came to the clinic	Mary attended the clinic
The child was happy to join in with the tasks	The child was cooperative and participated well in tasks
The child looked happy during the session	The child appeared happy during the session
The client showed he understood	The client demonstrated good understanding of
The client should do	It was recommended/advised that the client complete
X can...	X demonstrated an understanding of
X can...	X demonstrated the ability to
X has good comprehension	X demonstrated age appropriate comprehension of spoken language.
X has bad expressive language/X cannot talk	X has a mild/moderate/severe delay in expressive language
Get the client to	Encourage the client to
Got a score of	Received a score of

Registers of Language

There are five different registers of language:

Frozen

Frozen language is language that always stays the same, for example, the Lord's Prayer, wedding vows, criminal rights, etc.

Formal

Formal language contains the standard sentence syntax and word choice of education and work environments. This register of language always uses complete sentences and specific word choices.

Consultative

Consultative language is the formal register used in general conversation. The discourse pattern is not quite as direct as in the formal register, however interruptions are common such as "I see" and "uh-ha."

Casual

Casual language is the language used between friends and is characterised by a 400- to 800- word vocabulary. Word choices are general and are not specific. Conversations are dependent upon non-verbal behaviour, for example, head nodding and gesture as the sentence syntax is often incomplete.

Intimate

Intimate language is rarely used in public. This is the language used between lovers or twins, however it is often the language used for sexual harassment.

If a person does not have access to the formal register of language, many issues may get more personal as they may not have the language required to deal with the issue. For example, rather than discussing the actual issue (for example, my wages are too low), the language tends to get more personal (for example, you are holding me back).

It is important for all health care professionals, not just Speech Pathologists, to be able to code-switch, that is, to be able to fluently move between these registers of language. For example, if working with a child, you would use a casual register when talking to the child, then the consultative register when talking with the child's parent, then the formal register when writing file notes, reports and when reviewing the session with your supervisor.

If the clinician does not have the ability to fluently code-switch, many difficulties may arise including: Your supervisor may feel you are not professional if you cannot access the formal register

The client and/or their parents may not comprehend what you are saying if you consistently use jargon and the formal register.

Reference:

Payne, RK (1998) A Framework for Understanding Poverty Aha! Process Inc: Texas, USA

Naomi Chivell, Nicole Haspell, Rebecca Hillis, Rebecca Molina, Melissa Warren (2005)

Some common abbreviations:

AAC	Augmentative and alternative communication
ACAS	Aged care assessment service
ADD	Attention deficit disorder
ADHD	Attention deficit with hyperactivity disorder
ADL	Activities of daily living
ASD	Autism spectrum disorder
Ax	Assessment
BP	Blood pressure
Ca	Cancer
CAHMS	Child and Adolescent Mental Health Services
CAPD	Central auditory processing disorder
COAD	Chronic obstructive airway disease
Com ⁿ	Communication
CT	Computer Tomography (CAT scan)
CVA	Cerebrovascular accident (stroke)
Dx	Diagnosis
Dev ^{mt}	Development
DE&T	Department of Education and Training
DHS	Department of Human Services
DNA	Did not attend
DT	Dietician
ECG	Electrocardiogram
EEG	Electroencephalogram
ENT	Ear, Nose and Throat specialist
fdbk or fd/bk	Feedback
F ^o	Father
FTA	Failure to attend
GI	Gastrointestinal
GP	General Practitioner
HI	Hearing impairment
HT	Hypertension
Hx	History
ID	Intellectual disability
IDDM	Type 1 Diabetes (Insulin dependant diabetes mellitus)
IV	Intravenous
M ^o	Mother
MOW	Meals on wheels
MRI	Magnetic resonance imaging
MS	Multiple Sclerosis

NAD	No apparent delay
NBM	Nil by mouth
NGT	Nasogastric tube
NIDDM	Type 2 Diabetes (Non-Insulin Dependent Diabetes Mellitus)
NO	Nil orally
OA	Osteoarthritis
OMA	Oral motor assessment
OPE	Oral peripheral examination
OT	Occupational therapy
PEG	Percutaneous endoscopic gastrostomy (enteral feeding tube into the stomach)
PEJ	percutaneous endoscopic jejunostomy (enteral feeding tube into the small intestine)
PD	Professional development
Pt	Patient
PT	Physiotherapy
RDNS	Royal district nursing service
RIB	Resting in bed
ROM	Range of movement
R'ships	Relationships
Rx	Review
SCS	Specialist children's services
SIB	Sitting in bed
SOOB	Sitting out of bed
SP	Speech Pathology/Pathologist
SUIB	Sitting up in bed
SW	Social work
TIA	Transient ischemic attack
TMJ	Temporomandibular joint
Tx	Therapy/Treatment
URI	Upper respiratory infection
UTA	Unable to attend
UTI	Urinary tract infection
VI	Visual impairment
WNL	Within normal limits
Ŵ or é	With
ŵ/ or é/	Without
↓	Decreased
↑	Increased

Referrals and Health-Care Professions

Speech Pathologists often provide therapy to clients who have complex needs. They may be required to refer these clients on to other organisations or professionals to ensure that their clients receive a holistic approach in their therapy.

These may include:

Agencies and organisations such as:

- **The Department of Human Services** – this is a State Government Department which aims to provide all Victorians with quality services that protect and enhance their physical, mental and social well-being.
www.dhs.vic.gov.au
- **Yooralla** – Yooralla provides specialist services to people of all ages who have disabilities. These services include early childhood and school services, day services and programs for adults, residential services and respite care.
www.yooralla.com.au
- **ComTEC** - ComTEC is a branch of Yooralla which offers advisory services throughout Victoria to people of all ages with a disability who have communication and technology needs e.g. clients who may require a communication device.
www.yooralla.com.au/comtec.php
- **Home & Community Care (HACC)** - The HACC Program provides funding for services which support people with disabilities and their carers. These services provide basic support to people living at home whose capacity for independent living is at risk.
www.health.vic.gov.au/hacc
- **Scope** - Scope provides disability services throughout Victoria to children and adults who have physical and complex disabilities. These services include assessment, therapy, training and advice on numerous issues affecting the lives of people with disabilities, their families and carers.
www.scopevic.org.au

Support services such as self-help groups which are run for, and often by, specific groups of people who are affected by a particular issue.

The following are websites that contain information about networks of primarily Australian support groups which may be provided to clients. You should not, however, refer clients on to support group unless you agree with the specific support group's values.

- www.coshg.org.au
- www.wish.org.au
- www.supportfind.com

Other professionals – clients who have multiple issues/difficulties often require support from a number of different professionals. The following describes some of the professionals to whom Speech Pathologists may refer their clients.

Allied Health Assistant

Who:

Allied Health Assistants assist allied health professionals by visiting clients and preparing written and verbal reports. They may perform a number of tasks under the supervision of the relevant professional e.g. Physiotherapist, Occupational Therapist and Speech Pathologist.

Some example tasks include:

- assisting in the provision of client services in the home, clinic, hospital or day centre
- assisting clients with exercise or rehabilitation programs
- demonstrates the use of equipment
- assisting in the provision of therapy to clients once an allied health professional has assessed and devised a suitable program
- assisting and trains clients in the use of alternative electronic and non-electronic communication systems

Allied Health Assistants generally work in a hospital or rehabilitation centre.

When:

An Allied Health Assistant will perform tasks with a specified patient only when requested by an allied health professional.

This may be to assist with Caseload management of the Allied health professional and/or to ensure that a client is receiving adequate therapy.

Relation to Speech Pathologists:

Allied Health Assistants may assist Speech Pathologists with the administration of speech/language therapy.

How to refer:

Referrals will vary depending on the institution. A specific referral is often not necessary, just a verbal request. A meeting may also be held with the Allied Health Assistant to ensure a thorough explanation of what is required.

Audiologist

Who:

Audiologists specialise in the study of normal and impaired hearing, identify and assess hearing and balance difficulties and are responsible for the non-medical management and rehabilitation of balance and hearing loss. They also work to prevent hearing loss, for example, in industrial workers.

Audiologists see a variety of patients who have complications with an ear or hearing related pathology that may or may not cause a hearing loss. It is their responsibility to determine if there is a hearing deficit.

Some example clients:

- an adult suffering from Meniers disease
- a child who suffers from a sensory neural hearing loss
- a client who has a hearing deficit and now has a Cochlear Implant
- a client suffering from an acquired hearing loss
- a child who has suspected speech and/or language difficulties who has not previously had a hearing screen

When:

A Speech Pathologist generally refers to an Audiologist if a hearing loss is present or suspected. A hearing assessment is recommended for any paediatric or child language clients who have not yet received one. Infants or children who are not responding well to sounds should also receive a hearing assessment.

Relation to Speech Pathologist:

At facilities such as the Eye and Ear hospital, Speech pathologists and Audiologist work closely together to effectively assess and treat patients with hearing difficulties. In some cases a Speech Pathologist may have continued their education and also be a fully qualified Audiologist.

Audiologists and Speech Pathologists work together to ensure clients with hearing difficulties are able to participate optimally in communication.

How to refer:

Referrals will vary depending on the institution. Sometimes it can be a verbal referral through professions, sometimes a simple letter, and sometimes a form. Ask your supervisor when you start a placement or job.

Dietician

Who:

Dieticians apply the science of human nutrition to help individuals, groups and communities select foods to attain, maintain and promote health.

Dieticians see a variety of people within the community.

For example:

- A patient in a hospital who's food and fluid intake is not sufficient for their nutritional needs
- An individual suffering from diabetes or celiac disease
- A young girl suffering anorexia who needs to improve her health
- Someone who wants to lose or gain weight with the use of a healthy diet
- Students at a school, where the school have asked for the Dietician to come and give a presentation on healthy eating

Most Dieticians/nutritionists work in public and private hospitals, food service management, community health centres or in private practice. They may also be employed in teaching, research, as consultants in food production companies, or to design media campaigns for promoting good health.

When:

A Speech Pathologist may refer to a Dietician when they feel a client's nutritional needs are no longer being met by their food and fluid intake. This may be at the suggestion of nursing staff who work with the patient. Speech Pathologists should refer if a client has little to no food intake or appears to be underweight or losing weight.

Dieticians may also be part of the team who decide whether a client requires nasogastric feeding or a percutaneous endoscopic gastrostomy feed.

Relation to the Speech Pathologist:

Speech Pathologists commonly work along side Dieticians in hospitals with patients who have difficulty swallowing,

Speech Pathologists refer clients to a Dietician when they are concerned in any way about their client's nutritional health. Dieticians may also refer clients to a Speech Pathologist if their clients are having difficulties swallowing.

How to refer:

Referrals will vary depending on the institution. Sometimes it can be a verbal referral through professions, sometimes a simple letter, and sometimes a form. Ask your supervisor when you start a placement or job.

Guidance Officer

Who:

A Guidance Officer may adopt various roles depending on their own preference. Many choose to be involved in the assessment of cognitive and academic abilities particularly those related to behavioural issues. On the other hand, some choose to take on a support worker role, providing therapy sessions to assist children with psychological issues.

When:

A Guidance Officer is generally sought when a child shows behavioural or psychological issues which impact on their academic achievements. Guidance Officers conduct assessments to determine whether these issues are related to language difficulties, environmental factors, learning difficulties or have no obvious cause.

Relation to the Speech Pathologist:

Clients are not referred to Guidance Officers by Speech Pathologists as they often work concurrently with the same clients. Often behavioural difficulties occur as a result of not being able to communicate effectively.

How to refer:

Referrals will vary depending on the institution. Sometimes it can be a verbal referral through professions, sometimes a simple letter, and sometimes a form. Ask your supervisor when you start a placement or job.

Neurologist

Who:

A Neurologist is a medical doctor who is trained in the diagnosis and treatment of nervous system disorders, including diseases of the brain, spinal cord, nerves, and muscles. Such diseases include multiple sclerosis, Alzheimer's disease, headaches, stroke, or injury. Neurologists perform neurological examinations of the nerves of the head and neck, speech, language, memory, sensation, reflexes, muscle strength and movement, balance, ambulation and other cognitive abilities.

They also perform diagnostic tests such as the following:

- CAT (computed axial tomography) scan
- MRI/MRA (magnetic resonance imaging/magnetic resonance angiography)
- Lumbar puncture (spinal tap)
- EEG (electroencephalography)
- EMG/NCV (electromyography/nerve conduction velocity)

Most Neurologists work in hospitals and are often key members of a client's medical team. They will refer a client to another specialist when required, for example, a Physiotherapist, Occupational Therapist, Speech Pathologist, Nurse and so on.

When:

Speech Pathologists and Neurologists will work together when a client has a neurological condition which involves the speech and swallowing mechanism, for example a client who has had a stroke which has damaged Broca's area of the brain.

Relation to the Speech Pathologist:

A Neurologist will often work in a team of health professionals, including Surgeons, Nurses, Speech Pathologists and other therapists.

How to refer:

Referrals will vary depending on the institution. Sometimes it can be a verbal referral through professions, sometimes a simple letter, and sometimes a form. Ask your supervisor when you start a placement or job.

Nurse

Who:

The Speech Pathologist generally encounters Nurses in the hospital setting. There are two main types of Nurses: division one and division two. Division two Nurses are responsible for ward care such as personal care of patients, distributing meals and regular checks on patients' physical status. Division one Nurses may be responsible for things such as medications, intravenous fluid insertions, injections and tracheotomy care. They may also be involved in surgery as scout Nurses, where they are required to ensure all equipment is prepared and available for surgery and provide the correct tools to the surgeon as required.

When:

In hospitals, Nurses are frequently involved in all patients care. They are not sought out for particular patients but have a number of patients in their care for the duration of their shift.

Relation to the Speech Pathologist:

A Speech Pathologist would not refer to a Nurse or vice-versa. However, communication between the professions is essential as the Nurse can provide important patient information and they are most likely to be the individual responsible for ensuring the Speech Pathologist's recommendations are carried out.

Occupational Therapist

Who:

Occupational Therapists assist people to overcome limitations caused by injury or illness, psychological or emotional difficulties, developmental delay or the effects of aging. Occupational Therapists help clients not only to improve their basic motor functions and reasoning abilities, but also to compensate for permanent loss of function. They assist clients with a wide range of activities, using physical exercises to promote strength and dexterity and assist in the use of adaptive equipment such as wheelchairs and splints.

Occupational Therapists work with children to promote normal development and stimulate those who are physically delayed, have learning impairments or are recovering from illness or injury. Occupational Therapists work with adolescents to promote self-esteem and increase their independence and quality of life. Occupational Therapists work with adults and the elderly to promote recovery for those who have been affected by illness, accident or a work place injury. They assist people in returning home and/or to work, and make changes to the home and/or work environment to make it easier and safer for the individual.

When:

Speech Pathologists, Occupational Therapists and Physiotherapists will often work together in early intervention centres, hospitals, developmental centres and so on.

Relation to the Speech Pathologist:

Speech Pathologists and Occupational Therapists often work together as communication skills and a person's quality of life are closely related.

How to refer:

Referrals will vary depending on the institution. Sometimes it can be a verbal referral through professions, sometimes a simple letter, and sometimes a form. Ask your supervisor when you start a placement or job.

Otolaryngologists (Ear, Nose and Throat Specialists)

Who:

Otolaryngologists are doctors who specialise in the ear, nose and throat (ENT) and other related structures of the head and neck. These specialists work with the medical and surgical management and treatment of patients with diseases and disorders of these structures. This includes diagnosing and treating diseases of the larynx, sinuses, oral cavity, pharynx, as well as structures of the neck and face.

There are seven subspecialty areas within otolaryngology. These are:

- **Paediatric otolaryngology** – work with diseases in children with special ENT problems including birth defects in the head and neck and developmental delays. This includes otitis media, tonsil and adenoid infection, airway problems, Down's syndrome, asthma and allergy/sinus disease

- **Otology/neurotology** – work with diseases of the ear, including chronic ear disorders, trauma (repairing of the external ear), cancer, and cranial nerve pathway disorders, which affect hearing and balance. This includes ear infection; swimmer's ear; hearing loss; ear, face, or neck pain; dizziness, and tinnitus (ringing in the ears)

- **Allergy** - treatment by medication, immunotherapy (allergy shots) and/or avoidance of pollen, dust, mould, food, and other sensitivities that affect the ear, nose, and throat. This includes hay fever, seasonal and perennial rhinitis, chronic sinusitis, laryngitis, sore throat, otitis media, and dizziness.

- **Facial plastic and reconstructive surgery** - includes cosmetic, functional, and reconstructive surgical treatment of abnormalities of the face and neck, including deviated septum, rhinoplasty (nose), face lift, cleft palate, drooping eyelids and hair loss.

- **Head and neck** – work with rehabilitation of facial paralysis and cancerous and non-cancerous tumours in the head and neck area, including the larynx, saliva glands, thyroid and parathyroid.

- **Laryngology** – work with disorders of the larynx, oesophagus, and velopharyngeal area, including voice and swallowing problems. Some examples include: chronic sore throat, hoarseness, dysphagia and gastroesophageal reflux disease (GERD).

- **Rhinology** - work with disorders of the nose and sinuses, including sinus disorder, chronic nose bleeds and blocked nose, surgical intervention for infectious conditions, breathing as well as loss of taste and smell.

Some Otolaryngologists limit their practices to just one of these seven areas.

Relation to the Speech Pathologist:

Otolaryngologists and Speech Pathologists will often work together in hospitals with clients who have difficulties with their hearing, speech, voice or swallowing.

How to refer:

Referrals will vary depending on the institution. Sometimes it can be a verbal referral through professions, sometimes a simple letter, and sometimes a form. Ask your supervisor when you start a placement or job.

Paediatrician

Who:

A Paediatrician is a doctor who specializes in the treatment of children's illnesses. They have precise knowledge and skills in the area of child health and development, and work toward the treatment, diagnosis and prevention of illnesses which affect children from birth to adolescence.

Where:

Paediatricians generally work in hospitals and may specialise in specific areas or diseases, for example behavioural disorders. These professionals are key members of a child's medical team, which can often include many other health professionals.

It is not uncommon for a child's Paediatrician to be the leader or coordinator of the team of different specialists who work with the child and his or her family.

Relation to the Speech Pathologist:

Speech Pathologists often work within these teams, particularly when a child has multiple health issues, for example: developmental delays or disorders, congenital syndromes (eg Down's syndrome), spectrum disorders (eg. autism), congenital or acquired hearing impairments, acquired brain injuries and prematurity.

How to refer:

Referrals will vary depending on the institution. Sometimes it can be a verbal referral through professions, sometimes a simple letter, and sometimes a form. Ask your supervisor when you start a placement or job.

Physiotherapist

Who:

The main aim of Physiotherapy is to help restore functioning or reduce the impact of a permanent disease or injury. Physiotherapists work in many areas of health, however the three main types include:

- Musculoskeletal – treating muscle, bone and joint injuries (orthopaedic physiotherapy). This includes sport injuries, posture, arthritis, sprains and strains, as well as incontinence and reduced mobility.

- Neurological – treating disorders of the nervous system. This includes working with patients with MS, Parkinson’s disease, Motor Neurone Disorder, spinal cord injuries, stroke, acquired head injuries, etc.

- Cardiothoracic – treating disorders of the cardio-respiratory system including chronic bronchitis, asthma, emphysema and rehabilitation after thoracic surgery.

Physiotherapists use a variety of therapies to suit different needs including manual manipulation, electrotherapy, exercise programs and other options including taping and splinting.

When:

Speech Pathologists may receive referrals from Physiotherapists for a variety of reasons including a patient with a stutter or a patient with Parkinson’s disease who is beginning to have difficulties with their speech or swallowing.

Likewise, Speech Pathologists can refer patients to Physiotherapists.

Examples of patients who may be referred to Physiotherapy include:

- Patients with Parkinson’s disease who are having respiratory or muscle difficulties

- A patient who arrives at your agency with an unrelated sports injury.

How to refer:

Referrals will vary depending on the institution. Sometimes it can be a verbal referral through professions, sometimes a simple letter, and sometimes a form. Ask your supervisor when you start a placement or job.

Podiatrist

Who:

Podiatrists deal with the prevention, diagnosis, treatment and rehabilitation of medical and surgical conditions of the feet and lower limbs.

Podiatrists work to improve mobility and enhance the independence of individuals by the prevention and management of pathological foot conditions and associated morbidity. This is achieved by providing advice on foot health, assessment and diagnosis of foot conditions, identification of treatment and other requirements, formulation of care plans for the future, and provision of direct care as required and agreed upon with the individual.

Podiatrists treat a variety of conditions of the feet and lower limbs. For example:

- Bone and joint disorders such as arthritis and soft-tissue and muscular problems
- Neurological and circulatory disease affecting the feet and lower limbs
- Skin and nail disorders
- Corns,
- Calluses
- Ingrown toenails
- Foot injuries and infections gained through sport or other activities

Also, Podiatrists are often called to attend to the feet of individuals who are unable to do so themselves.

When:

As a Speech Pathologist, you would have few referrals to a Podiatrist. However you may encounter a client or patient who voices concern regarding the condition of their feet or whom you notice may have a problem.

Relation to the Speech Pathologist:

As a Speech Pathologist feet, and lower limbs are not closely related to our specialty. Refer on if appropriate.

How to refer:

Referrals will vary depending on the institution. Sometimes it can be a verbal referral through professions, sometimes a simple letter, and sometimes a form. Ask your supervisor when you start a placement or job. It would be rare for a Speech Pathologist to refer clients to a Podiatrist.

Psychologist

Who:

Psychologists are involved in the prevention, diagnosis and treatment of psychological disorders. Sdorow & Rickabaugh (2002) divide practicing Psychologists (as opposed to lecturers or researchers in the field) into two major categories: clinical psychology and counselling psychology. The two are very similar. Clinical psychology is “the field that applies psychological principles to the prevention, diagnosis and treatment of psychological disorders” and counselling psychology is “the field that applies psychological principles to help individuals deal with problems of daily living, generally less severe ones than those treated by clinical Psychologists.”

Speech Pathologists may refer clients who are having difficulty coping with their communication and/or swallowing impairment to a Psychologist.

For example:

- A teenager who does not want to go to school because he is constantly teased about his stutter
 - A stroke victim who is no longer independent.
 - An anxious parent whose child has just been diagnosed with autism
 - A traumatic brain injury patient suffering from post-traumatic stress syndrome
 - Individuals with psychogenic disorders (e.g. psychogenic voice disorder).
- (However, in this situation need to very careful not to suggest it's all ‘in their head’)

When:

A Speech Pathologist should refer to a Psychologist when they are no longer able to deal with the situation within the client's best interests. The issue should not be ignored but should be addressed in an empathetic way. For example, “I know it must be hard for you and I'm happy to chat about it but have you ever spoken to a counsellor or Psychologist. They may be better able to meet your needs.”

Relation to the Speech Pathologist:

Some communication difficulties may occur concurrently with psychological conditions. It is essential for the Speech Pathologist to recognise when a client needs to be referred.

How to refer:

Referrals will vary depending on the institution. Sometimes it can be a verbal referral through professions, sometimes a simple letter, and sometimes a form. Ask your supervisor when you start a placement or job.

Social Worker

Who:

A Social Worker will often work in multidisciplinary teams in organizations such as hospitals, welfare agencies, community healthcare centres and schools, where they provide information, counselling, emotional and practical support to patients, their families and their carers. Social Workers advocate the improvement in the general social and emotional welfare and the quality of life of both individuals and their communities. They are concerned with the living conditions of their clients who may often come from a background of drug addiction, mental illness, poor housing and neglect or abuse of children or of the elderly.

Social Workers may also plan and develop services, act as case managers and clinicians, and provide information regarding services and other resources which are available to their clients.

When:

Speech Pathologists may refer clients to a Social Worker for a number of reasons, such as counselling and support after a major health crisis or sudden loss, when there are language or cultural barriers, and when domestic violence, abuse or self-harm is present or suspected. Social Workers may refer their clients to a Speech Pathologist when a speech, language or swallowing disorder is present, if the referral has not previously been made.

Relation to the Speech Pathologist:

The role of the Speech Pathologist and the Social Worker overlaps slightly as the Speech Pathologist's role often includes providing some immediate affective and/or informational counselling; however, clients should be referred to a Social Worker as well, as Social Workers are professionally qualified in these skills.

How to refer:

Referrals will vary depending on the institution. Sometimes it can be a verbal referral through professions, sometimes a simple letter, and sometimes a form. Ask your supervisor when you start a placement or job.

Visiting Teachers

Who:

A Visiting Teacher is a qualified teacher who attends various schools to assist with the education of individuals who have a vision or hearing impairment, physical disability or health complications (e.g. cancer). They aim to enhance the learning environment for these individuals rather than educate them. Where the individual has a serious health complication that prevents them from attending school, the Visiting Teacher will go to the child's house.

The Visiting Teacher may provide visual, tactile or other sensory information to enhance the child's learning environment and increase their ability to take in the curriculum.

Relation to the Speech Pathologist:

A Visiting Teacher would not necessarily be referred by the Speech Pathologist or vice-versa, due to co-existing issues, this population is likely to be seen by both of these professionals. The Visiting Teacher and the Speech Pathologist must work together to enhance the child's education and communication.

How to refer:

Referrals will vary depending on the institution. Sometimes it can be a verbal referral through professions, sometimes a simple letter, and sometimes a form. Ask your supervisor when you start a placement or job.

Facilities where Speech Pathologists may work:

La Trobe Communication Clinic-

Hierarchy of the facility:

The Clinic Manager is the head of the clinic. Each Speech Pathologist specializes in one or more areas of therapy.

Dress code:

The La Trobe Communication Clinic requires neat casual clothing and neat shoes. Shoes do not have to be closed toed, but cannot be runners. The clinic does not allow denim clothing, bare midriffs and plunging necklines.

How to access file notes:

You need to fill in a pink form for requesting files and hand it to the receptionist, along with your student card. The receptionist will locate the file for you and you can only use it on the fourth floor of HS1. The files are not to be seen by others or left unattended.

Case load:

This clinic runs several specialized clinics, these include the following:

- Fluency – Intensive Smooth Speech, Camperdown Program & Lidcombe Program,
- Pre-school speech and language therapy,
- Pre-school speech and language using Music and Movement techniques,
- Voice therapy for adults and children, and
- Adult speech and language.

Other important information for LCC:

-Other information can be found on the notice boards around the clinic, including location of first aid kits and emergency procedures. For further information have a look at the Policy and Procedures manual found in the student room on the fourth floor of HS1.

Early Intervention Centre

Hierarchy of facility:

There are many Teachers in Early Intervention facilities. Usually, one Teacher takes on the lead role. 'Teachers' usually have a degree in childhood disabilities and preschool teaching. 'Teachers aids' have less educational experience than 'teachers'. The services of a full time/part time or casual Speech Pathologist, Physiotherapist or Occupational Therapist in these facilities is dependant on the facility's funding case load.

Dress code:

Early Intervention Centres require neat casual clothing neat shoes, preferably close toed.

How to access file notes:

Files are usually kept in a filing cabinet. Always ask before removing files and never take them away from the facility.

Case load:

Early Intervention Centres predominantly provide speech and language therapy to preschoolers. You will see a variety of children, predominately those with special needs. For example: autism, dyspraxia, global delay, ADD, ADHD, Aspergers and more.

Other important information for Early Intervention Centres:

Early Intervention Centres are different to other preschool speech and language clinics and the demands and case load are very different.

Early Intervention Centres are a lot like a kindergarten with smaller groups and much more structure. Be aware that these children are not necessarily there specifically for language and may have a multitude of other difficulties. They attend the centre to try and target all of these if possible. Eg. Physical limitations, behaviour management, cognitive delays etc. Follow the lead of those more experienced and be prepared to sit on the floor and get messy.

Hospital - Rehabilitation

Hierarchy of the facility:

Many different hospitals employ different structures hence there are many different hierarchies. Within each hospital there are many different teams and programs, with different professionals working in different areas.

In general, doctors have control over interns. All allied health professionals' liaise with each other.

Dress code:

Hospitals require professional clothing, with closed toe shoes. They do not allow bare midriffs and plunging necklines.

File notes:

Each facility will have a different procedure for obtaining file notes. Please make yourself aware of the procedure for the facility you are attending.

Caseload:

The caseload in a hospital may range from traumatic brain injury, to stroke and progressive neurological diseases.

Other information relevant to this facility:

You should revise speech and swallowing lecture notes and neuroscience lecture notes. Keep in mind that each individual is different and you need to work out what are the best strategies for each person. Also remember that clients may have more than one problem and it is often difficult to know which one to begin working on.

Hospital -Acute

Hierarchy of the facility:

Within a Hospital, the Head of Department has leads the doctors and allied health professionals working in the facility. Doctors are responsible for interns. All allied health professionals' liaise with each other.

Dress code:

Hospitals require professional clothing with closed toe shoes. They do not allow bare midriffs and plunging necklines. They also require glasses, gowns etc. to be worn if you are in a contagious ward.

File notes:

File notes are located on the ward at the Nurses' station. Files are rarely in a patient's room except if a doctor has them. For outpatients, you need to go to medical records to get the file.

Caseload:

The caseload in a hospital may range from burns, to infectious diseases, to trauma or stroke.

Other information relevant to this facility:

Most acute hospitals require a solid understanding of neuroanatomy and physiology along with motor speech and swallowing disorders. An in-depth knowledge of the cranial nerves for speech and swallowing is highly beneficial in this setting.

Education, Kindergarten/Preschool

Hierarchy:

Preschool speech and language clinics are often found in kindergartens. These facilities are usually run by one or more kindergarten teachers and their assistants, who are often parents of the children attending the kindergarten.

Dress code:

Preschools require neat casual clothing, but often on the casual side, as a clinician may end up anywhere from an office to the sandpit! They also require neat shoes, preferably with closed toes, but this can vary.

How to access file notes:

Files will often be in the possession of the clinician in charge of therapy intervention. However, each Preschool facility will have its own specific information regarding each child, and this can be obtained from the teacher in charge. Files should never leave the facility.

Case load:

It is not common for a single kindergarten to have a full time Speech Pathologist or other allied health workers on staff. Therefore, these professionals will often visit several Preschool facilities regularly to form their caseload. A Speech Pathologist will often spend one day in each facility, completing assessments, therapy intervention and referrals where necessary. It is not uncommon for a Speech Pathologist to give parents informational counselling and recommendations regarding schooling options.

The case load is primarily speech and language therapy for preschoolers; however, during assessments it is important to be aware of possible fluency and/or voice disorders, as well as other more specific disorders, for example, ADHD.

Other information relevant to this facility:

It is common for these clinics to have a relaxed environment, and there are times when the Preschool facility's routine needs to have precedence over the clinician's therapy intervention. Each individual Preschool facility is different and will have its own routine. The challenge is for the clinician to fit into these routines, as children learn best and are most comfortable when they are in their own specific routines.

Education - In schools

Hierarchy:

Department of Education and Training has several offices around Victoria. Each office is responsible for a particular area (much in the way different councils are responsible for each municipality). Within each office there are a range of allied health professionals including Speech Pathologists, Social Workers, Guidance Officers and Visiting Teachers (who work with hearing or vision impaired student as well as children with health issues or those living with disabilities). There is no universal structure or hierarchy of professionals between the offices. Each office generally operates independently apart from providing a network for resources and ideas. DE&T Speech Pathologists work in a number of schools within their area. They will often set work to be carried out by an aide in between visits.

Dress code:

The dress code differs slightly between schools, however generally clinicians are required to dress in a neat manner – suits are not necessary, however no denim.

How to access files:

Files are generally located in the Speech Pathology office, however can vary between schools. Ask your supervisor at the commencement of your placement.

Case load:

DE&T Speech Pathologists work with school aged children within the school environment. Speech Pathologists can work with students individually, as well as with teachers and other school staff within the classroom. Where possible, parents are involved in sessions and follow-up activities. Speech Pathologists can work on the following areas:

- Oral Language (expression) as well as Comprehension
 - Articulation and Phonological Awareness
 - Reading, written language and spelling
 - Fluency
 - Voice
 - AAC
 - Saliva control
 - Eating assistance
- } Not as common as the above but particularly seen when working with children with disabilities

Other information relevant to this facility:

Services Provided by Speech Pathologists:

- Assessment and regular therapy as well as classroom intervention
- Consultation with teachers, parents, families and other educational personnel.
- School/class/home programs
- Training of teachers/parents/aides/volunteers as facilitators of programs
- Provision of materials and resource information
- In-service programs for teachers and/or parents on specific topics (e.g. cued articulation)
- Involvement in program support groups
- Group and intensive programs
- Some Speech Pathologists are contracted as an SSO.

Community health

Hierarchy:

In many Community Health Centres there is a structure which encourages a multidisciplinary team approach. One such structure uses teams within a centre. For example, a centre may have four teams- a Rural Allied Health Team, a Community Health Team, a Community Services Team and an Alcohol and Drug team – each with a slightly different service and client criteria. Each of these teams will consist of at least one person from each profession that is relevant to its services. For example, the Rural Allied Health Team services the remote clients that require their services but cannot come to the centre (ie. The allied health professionals make home visits). In such a team there may be a Speech Pathologist, a Podiatrist, an Occupational Therapist, a Continence Nurse, a Physiotherapist and a Dietician. One of these clinicians may be nominated to be the leader or there may be an external leader. This group will usually meet once a week to discuss patients and progress.

Next in the hierarchy is the Director of Health and Community Services. This person will manage each of the four teams below them. Above this person is the Chief Executive Officer who also manages the Corporate and Office staff. Finally, the Board of Management is at the top of the hierarchy.

Dress code:

The dress code differs slightly between centres, however generally clinicians are required to dress in a neat manner – suits are not necessary, however no denim. Many centres also have a closed-shoe policy.

How to access file notes:

Due to the multidisciplinary nature of these centres, there will generally be a ‘library’ area which will contain the files. Often, you will be required to ask for the file in advance or you will have to fill in a form indicating which files are currently in your possession so that others who may need the file know where it is.

Case load:

The case load will differ according to which population you are assigned to. Community health centres generally take clients who have not yet started school, or who have left school. Depending on the size of the facility, there may be more than one Speech Pathologist, in which case, the case load may be divided between clinicians so that each clinician specialises in one area. This division may also be funding based.

Drugs that affect speech and swallowing

There are many occasions when it is useful to know what the effects of certain medications are to a client's speech and swallowing abilities. You may be asked by clients or their family members whether there are any effects on speech or swallowing for the medications that they are taking. You are not expected to know this information off hand, and it would be appropriate to consult one or more of the references below to give accurate information to the client and their family.

The list of references below is not comprehensive, and there may be additional references that you come across that you find helpful. Please share any additional references with your classmates as they are invaluable resources.

Books:

MIMS Australia. (Ed.) (2002). MIMS Annual. Sydney: MediMedia Australia Pty Ltd.

Located in the La Trobe University Library is an annual publication called MIMS. This publication is produced for those in medical and allied health professions, and therefore lists much more information about the drug than just the effects on communication and swallowing.

This book allows you to search for a particular drug with a proprietary name, a generic name, pharmacological action desired, indication to be treated, therapy area, and manufacturer.

This book provides information about the drug regarding its composition, description, actions, pharmacology, indications, contraindications, warnings, precautions, use in pregnancy, use in lactation, use in children, interactions, adverse reactions, dosage and administration, overdose, presentation, storage, poisons schedule and reference.

Coleman, Y. (2005). Drug-nutrient interactions favourite fifty. Hawthorn: Nutrition Consultants Australia

"Drug-Nutrient Interactions Favourite Fifty" is a small publication produced for medical and health care professionals with 50 of the most-asked-for drugs taken from "Drug Nutrient Interactions The Manual".

The book provides information about a particular drugs generic and pharmaceutical name, the nutrients affected, adverse reactions, biochemical factors and nutritional care.

Vogel, D. & Carter, J.E. (1995). The effects of drugs on communication disorders. San Diego: Singular Publishing Group.

Below is the reference for a fantastic book that is located in the La Trobe University Library. It is divided into several areas including speech and voice specific neurologic disorders, language specific neurologic disorders, disorders of cognition, psychiatric disorders, idiopathic speech and voice specific disorders.

The book provides information about specific diseases and their common pharmacologic treatments (ie. the drugs used) and the desired and undesired effects of these drugs. You may alternatively look up the index and find information about the chosen drug without it being used for treatment of a particular disease.

The book also includes terms related to medical conditions and management, several abbreviations and definitions of terms associated with medical management and a brief overview of neuroscience and neuropharmacology.

Vogel, D., Carter, J.E. & Carter, P.B. (2000). The effects of drugs on communication disorders. (2nd ed.). San Diego: Singular Publishing Group.

There is an updated version of this book which is much larger and contains information regarding several more drugs that affect speech and swallowing. This book is not currently available in the La Trobe University Library, but your supervising clinician may have it in the resource area of your clinic.

Internet Sites:

The link below is a page on the National Centre for Voice and Speech website. It provides a short list of frequently prescribed medications and their effects on voice and speech.

www.ncvs.org/ncvs/info/vocol/rx.html

You can also go to www.google.com.au and enter the medicine name onto the search engine. This will bring up quite a lot of information about the drug, so you may have to sift through to find the specific effects (if any) that the particular drug has on speech and swallowing.

Some Speech Pathology Assessments

The following are some assessment tools tests that you may see during clinical placements. Not all tests used are mentioned on this list. Where possible, a call number for the Bundoora campus library has been provided.

Assessment for Phonological Awareness and Reading (APAR)

Iacono, T. & Cupples, L. (2000). Assessment for Phonological Awareness and Reading. Victoria: Centre for Developmental Disability and Health; New South Wales: Department of Linguistics, Macquarie University.

Available online at <http://www.elr.com.au/apar>

Assesses phonological awareness and reading skills in adults and children. It assesses listening comprehension using the Peabody Picture Vocabulary Test. It covers real words, non-words, written sentences, blends and phoneme counting.

Boston Diagnostic Aphasia Examination (BDAE)

Goodglass, H., Kaplan, E. & Baressi, B. (2001). The assessment of aphasia and related disorders. (3rd ed.) Philadelphia: Lippincott Williams & Wilkins.

LTU (Bundoora) Library call number: [616.8552 A8462 2001](#)

This test assesses the possible communication impairments associated with aphasia and can be used to effectively locate areas of difficulty. It is comprised of 27 subtests targeting auditory comprehension, expressive language, understanding of written language and writing.

The Boston Naming Test can be used in conjunction with the BDAE or as a separate assessment for anomia (word finding difficulties).

Clinical Evaluation of Language Fundamentals 4 (CELF-4)

Semel, E., Wiig, E. & Secord, H. (2003). Clinical Evaluation of Language Fundamentals. (4th ed.) New York: The Psychological Corporation; San Antonio: Harcourt Brace & Co.

LTU (Bundoora) Library call number: [618.92855075 W662c 2003](#)

This assessment is a standardised test for children aged between 5-21 years. It contains a number of subtests covering both expressive and receptive language. A preschool version is also available (CELF-P) for use with children aged between 3-6;11 years. Each subtest focuses on different areas of language, for example, linguistic concepts, creating expressive sentences and identifying relationships between words. This test can be completed as a whole or particular subtests can be assessed individually.

Frenchay Dysarthria Assessment

Enderby, P. (1983). San Diego, California: College Hill Press.

LTU (Bundoora) Library call number: [616.855 E56f](#)

This test assesses 11 areas including reflex, respiration, lips, jaw, palate, laryngeal, tongue, intelligibility rate, sensation and associated factors. The results of these separate areas can be totalled to allow comparison between your client's results and those of known dysarthric groups.

Naomi Chivell, Nicole Haspell, Rebecca Hillis, Rebecca Molina, Melissa Warren (2005)

Goldman Fristoe Test of Articulation

Goldman, R. & Fristoe, M. (2000). Goldman Fristoe Test of Articulation. (2nd ed.) Circle Pines: American Guidance Service.

LTU (Bundoora) Library call number: [155.413 G6192 2000](#)

This test provides information about a child's articulation by sampling both spontaneous and imitative sound production. Examinees respond to picture plates and verbal cues from the examiner with single word answers that demonstrate common speech sounds. Additional sections provide further measures of speech production. This test is used to measure articulation of consonant sounds, determine types of misarticulation and compare individual performance to national, gender-differentiated norms.

Preschool Language Scale

Zimmerman, I.L., Steiner, V.G. & Pond, R.E. (2002). Preschool Language Scale. (4th ed.) San Antonio, Texas: The Psychological Corporation.

LTU (Bundoora) Library call number: [372.6 Z74 2002](#)

This assessment is standardized for children from birth to 6 years. It looks at a variety of language based skills in both receptive and expressive language.

Psycholinguistic assessments of language processing in aphasia (PALPA)

Kay, J; Lesser, R; Coldheart, M (1992) Psycholinguistic assessments of language processing in aphasia (PALPA). Lawrence Erlbaum Associates, Sussex

LTU (Bundoora) Library call number: [616.8552075 K23](#)

Text titles: Introduction; Auditory processing; Reading and spelling; Picture and word semantics; Sentence comprehension. Summary Designed to be a resource for speech and language therapists and cognitive and clinical Neuropsychologists who wish to assess language processing skills in people with aphasia.

Renfrew Language Scales

Renfrew, C.E. (1995). Renfrew Language Scales. (4th ed.) Bicester Oxon: Winslow.

LTU (Bundoora) Library call number: [155.413 R411 1997](#)

The Renfrew Language Scales consist of three tests of expressive language. These are:

Action Picture Test- This test assesses responses produced from a simple question about a corresponding picture card. It assesses the information content and grammatical usage of each response and provides the age level the individual is functioning at for both these areas. It is standardized for assessment of children between the ages of 3-8 years.

Word finding vocabulary test- This test is used for children aged between 3-9 years of age. It assesses the child's ability to name 50 line drawings of objects which are arranged in order of difficulty.

Bus story test- This tests assesses the child's information content, sentence length and grammatical usage in consecutive speech by retelling the 'bus' story. It is used for children aged between 3-8 years.

Reynell Developmental Scales III

Edwards, S., Fletcher, Garman, Hughes, Letts, Sinka. (1997). Reynell Developmental Scales III. Windsor: NFER Nelson Health & Social Care. University of Reading ed.
LTU (Bundoorra) Library call number: [153.94 R459 1997](#)

This assessment is divided into two scales, expressive language and comprehension. It is standardized for children aged between 15 months and 7;6 years. This assessment uses toys, puppets and pictures to gain either verbal responses or responses showing a child's comprehension skills.

Sutherland Phonological Awareness Test –Revised (SPAT-R)

Neilson, R. (2003). Sutherland Phonological Awareness Test. Jamberoo, New South Wales: Self Published.
LTU (Bundoorra) Library call number: [618.92855075 N414s 2003](#)

This test assesses phonological awareness skills in 5-8 year old children required for literacy learning in the first few years of school. It assesses rhyming, syllabification, phoneme identification, segmentation and blending, deletion of consonants, non-word reading and non-word spelling.

Test for Auditory Comprehension of Language (TACL)

Carroe-Woolfork, E. (1985). Test for Auditory Comprehension of Language. (3rd ed.) Allen, Texas: DLM Teaching Resources.
LTU (Bundoorra) Library call number: [155.413 T3425 1985](#)

This test assesses receptive spoken vocabulary, grammar and syntax in children aged between 3 - 9;11 years. The test consists of three subtests that assess the child's ability to understand language by pointing to the correct picture.

Test for Reception Of Grammar (TROG)

D.V.M. Bishop. (1982). Test for reception of grammar. Manchester, England: Medical Research Council.
LTU (Bundoorra) Library call number: [616.855075 T342](#)

This test assesses the child's understanding of grammatical contrasts rather than a test of comprehension in everyday situations. It looks specifically at the comprehension of grammatical structures within a sentence.

Test of Narrative Language (TNL)

Gillam, R & Pearson, N.A. (2004). Test of Narrative Language. USA: Super Duper Publications.

This test assesses children's story comprehension and oral narration. The narrative comprehension subtest assesses children's ability to recall and understand information in stories. It also assesses the ability to make inferences about information that was not stated in the stories.

The oral narration subtest assesses children's ability to weave words and sentences into stories that contain characters who engage in goal-directed actions, events and solutions.

This test assesses measures the child's use of proper nouns, action verbs, temporal adverbs and causal verbs within well-formed sentences in script-like stories and fictional stories.

Test of Problem Solving –Expanded (TOPS-E)

Bowers, L., Huisingh, R., Barrett, M., Orman, J. & LoGuidice, C. Test of Problem Solving. Illinois, USA: Linguisystems.

This test assesses problem solving and critical thinking skills in children aged between 6-11 years. It assesses problem solving, determining solutions, drawing solutions, empathizing, predicting outcomes using context cues and vocabulary comprehension.

The Bureau Auditory Comprehension Test

Sydney Health Commission. (1982). The Bureau Auditory Comprehension Test. Sydney, New South Wales: Sydney Health Commission of NSW.

LTU (Bundoorra) Library call number: [155.413 B952](#)

It assesses a child's ability to follow one step instructions specifically targeting spatial concepts, the function attributes of objects and other linguistic concepts.

The Fisher Atkin Articulation Survey

Atkin, N. & Fisher, J. (1996). The Fisher Atkin Articulation Survey. (3rd ed.) Parkville, Victoria: Royal Children's Hospital Speech Pathology Department.

LTU (Bundoorra) Library call number: [618.92855075 A873ar 1996](#)

This test assesses the ability to correctly produce speech sounds in single words. It assesses all 24 consonant sounds and consonant blends.

Western Aphasia Battery

Kertesz, A. (1982). Western Aphasia Battery. New York: Grune & Stratton.

LTU (Bundoorra) Library call number: [616.8552 W527](#)

This test assesses spontaneous speech, comprehension, repetition and naming, reading, writing, apraxia and construction. Scores for these subtests are combined to yield an aphasia and a cortical quotient. The client may be classified according to aphasia type based on oral language subtest scores using the taxonomic table provided.

Some Useful Resources

- <http://www.myhq.com/public/g/b/gbennell/>
This website is a fantastic resource. It contains over 200 links which have been sorted into specific areas of Speech Pathology, for example, dysphagia, audiology, phonology, aphasia, as well as general links.
- <http://www.latrobe.edu.au/hcs/hcs/students/studentshowcase.htm>
The La Trobe University Human Communication Sciences Student Showcase where some previous Speech Pathology students' work and resources are displayed.
- <http://www.linguisystems.com>
This is an American website with many great resources that you can purchase. These resources are primarily for use with paediatric clients primary school and high school clients. There are also some free demo pages available to download.
- <http://www.blacksheep-epress.com>
This is a UK site that sells some excellent resources. Go to the 'freebies' section for some free example therapy pages.
- <http://www.dotolearn.com>
This is a website which provides access to board maker pictures.
- <http://www.preschoolprintables.com>
Some fun activity ideas to use in clinic and some great rewards.
- <http://www.superduperinc.com>
Super Duper Publications produces educational material for the Speech & Language market.
- <http://www.herring.org/speech.html>
This website contains a list of links to a variety of resources, including therapy ideas, activities and information for clinicians and parents.

- <http://www.listen-up.org/edu/speech.htm> and
<http://www.listen-up.org/oral/language.htm>

These websites contain a list of links to other Speech Pathology websites, with information for both clinicians and parents.

- <http://www.brainstormed.com.au/index.htm>

Online store supplying Speech Pathology resources from a variety of different areas.

- http://members.tripod.com/Caroline_Bowen/slp-eureka.htm

Caroline Bowen is a Speech Pathologist who has created this website full of different therapy ideas and activities across a variety of areas within Speech Pathology.

- <http://www.lib.uiowa.edu/hardin/md/speech.html>

This website contains information about different conditions a Speech Pathologist may work with and includes pictures. Links to different Speech Pathology links are also provided.

- <http://www.geocities.com/speechlanguage/links/>

Contains a list of links to specific conditions and Speech Pathology areas as well as information about different facilities clinicians can work in [note: USA site]

- <http://www.mnsu.edu/comdis/kuster2/sptherapy.html>

This site provides a list of links to specific therapy activities and ideas as well as links to interactive websites, for example, to help aid reading, etc.

- <http://home.comcast.net/~speechguide/sample.html>

This website contains a list of links which have been sorted into specific areas of Speech Pathology including pragmatics, language, fluency and AAC.

Appendix 1 - Case History Questions

The following is not a comprehensive list and you will need to include or exclude questions which are specific to your client and clinical placement. You will also need to confirm the required format with your supervisor. There are provided as an example and somewhere to start.

Generic Case History Questions

Client name:

Date of assessment:

UR no.:

Date of report:

Birth date:

Clinician (student and supervising):

Address:

Referral from:

Background information:

- What would the client like to achieve in the session?
- What are the client's/caregiver's expectations of the service?
- Have they seen a Speech Pathologist previously?
- Have they seen any other professionals? If so, why?
- Client's general health
- What is the client's profession?

Description of problem and impact on client:

- What is the client or client's caregiver's perception of the problem?
- When did the disorder begin?
- Has it gotten either better or worse since then?
- What impact does the difficulty have on the client/?
- How has the problem been managed so far?
- Are there any similar communication problems within the family?

Specific to Paediatrics

Family History

- Parents Names/ Occupation
- Siblings
- Speech/Language delays in family
- Other delays

Educational

- Kinder/School currently attending

Birth Details:

- What was the pregnancy like?
 - Full term
 - Birth weight
 - Illnesses
 - Complications (full term, type of birth)
 - Condition of baby:

Developmental History:

- Motor
 - Sat at age...
 - Crawled at age...
 - Walked at age...
 - Fine motor skills
 - Toilet training
 - Sleeping? Good/bad?
 - Did these differ significantly from other siblings in the family?
- Speech
 - Vocalisation/ babbling (varied?)
 - Talked at age...
 - First word/ sentence. Give examples.
 - Vocabulary
 - Use of 2-3 word phrases. Give examples.
 - Response to instructions (verbal and non-verbal)
- Feeding
 - Feeding problems/ Bottle or breast-fed?
 - Suckling difficulties
 - Swallowing
 - Eating habits?

Medical:

- Middle ear infections
- Hearing tests
- Vision
- Fevers
- Medications/ hospitalisations
- Major childhood illnesses

Social Interactions

- With siblings / family members
- Friends/ with out the presence of parents
- Personality/ Behaviour/ Knowledge of social rules
- What sort of things does the child like to do?

Education

- How is he going at kinder?
- Has teacher mentioned his speech problem to you?
- Concentration/ ability to follow instructions
- Relation to other children

Specific to voice

- What are the client's expectations from the clinic?
- How does the client's perceive their voice? Are they happy with their voice?
- What do they think caused the voice problem?
- Does the severity of the problem vary though the day?
- Has client had previous voice therapy?
- How does the client use their voice during the day? At the weekend?
- How does the client describe their personality? Outgoing/Quiet? Extrovert/Introvert?...
- Does the client live/work in a noisy environment?
- Does the client suffer from reflux? Colds? Sore/tired throats? Respiratory problems?...
- Does the client smoke? Drink alcohol? Coffee? Tea?
- How much water does the client drink each day?
- Does the client's voice have any impact on leisure activities?
- Maximum Phonation time for:
 - /a/
 - /i/
 - /u/
 - /s/
 - /z/
 - /m/
- Evaluate pitch variability
- Evaluate loudness variability
- Count to 10 at:
 - Comfort level
 - Maximum loudness without shouting
 - Minimum loudness without whispering
- Evaluate use of falling, level, and rising tones
(Produce /la:/ stepwise up and down the scale to reach maximum and minimum pitch ranges)
- Voice quality
 - Rough
 - Breathy
 - Strain
 - Glottal fry
 - Phonation breaks
 - Pitch breaks
 - Tremor
 - Falsetto
- Pitch – High/ low/monotone
- Loudness – Loud/soft/monoloud
- Resonance – nasal...?
- Pitch and voice quality of cough, laugh, and vocalised pauses
- Posture – for voicing
- External muscle strain
- Larynx height and tongue position
- Mouth opening – lip spreading/rounding

Specific to Dysphoric Voice (ie. Transsexual Voice)

- Establish client's preferred name and correspondence name
- Establish the client's stage in their gender reassignment
- What other health professionals are they seeing?
- Has the client tried to alter their voice at all?
- How has the client's family and friends reacted to their decision regarding their gender reassignment?
- Language behaviour
 - Interrupting
 - Tag questions
 - Gesture (more feminine)
 - Eye contact (more feminine)
 - Facial expression (eg. nodding, smiling, lip rounding, eyebrow and jaw movements, touching during conversation and minimal responses (for encouragement, eg. uhuh...) more feminine)
 - Phonetic structure – articulation (Eg. dropping the end sounds from words)
 - Prosody – Intonation
- Non-verbal behaviours
 - Laugh (soft/loud)
 - Cough (soft/harsh)
 - Sneeze (soft/harsh)
 - Etc...
- Body posture (more feminine)
 - Legs together or crossed
 - Light/airy hand gestures
 - Play with hair, jewellery...
 - Face conversation partner
 - Use good eye contact
 - Stand upright rather than slouched

Specific to Fluency

- Confirm stuttering/determine severity
- How representative is their fluency today compared to other days?
- Does their family have a history of stuttering?
- Establish a hierarchy of communication situations. (Where do they have most problems with fluency?)
- What previous treatment has the client had?
- What did they feel about that therapy?
- Why are they coming for therapy now/what's their motivation for therapy?
- What are their goals/expectations for therapy?
- Conduct rating including the number of ss% and secondary behaviours.

Specific to Dysphagia

- Do you ever have any difficulties chewing/swallowing your food or drinks?
- Does food ever “go down the wrong way”?
- What happens when food/fluid goes down the wrong way?
- Do you ever have episodes of coughing/choking on food or drinks?
- General description of difficulties
- Does your food ever require special preparation before eating (eg. Cut into small pieces)?
- Do you avoid certain foods that you have difficulties with?
- Any history of recurring chest infections or pneumonia?
- Has your weight recently changed?
- Have you noticed a change in the time it takes you to eat a meal?

Oral stage

- Do you have your own teeth?
- Does food/saliva ever dribble from your mouth?
- Do certain foods get stuck in your mouth?
- Do you have difficulties chewing certain foods.
- Does food or drink ever come out your nose?
- Do you find it hard to use cutlery or drink from a cup?

Pharyngeal stage

- Can you sometimes feel food stuck in your throat?
- Do you sometimes need to swallow multiple times to get the food down?
- Do you ever need to wash food down with a drink?
- Is your voice ever gurgly after you have had something to eat/drink?
- Do you ever cough after swallowing?
- Do you ever choke when eating?

Oesophageal stage

- Do you ever wake up with a sour/bad taste in your mouth?
- Does it sometimes feel that food/drink comes back up your throat after eating?

Specific to Neurological Disorders

- Tell me why you are here/What happened?
- Have you previously been hospitalised? If yes, when and why?

Questions for alertness:

- Do you know who you are?
- Do you know where you are?
- Do you know how you got here?
- Do you know what month it is?

- Do you wear glasses? If so, when do you wear them?
- Do you have a hearing aid? If so, do you wear it all day?
- Do you have dentures/false teeth? If so, where are they?

- Do you know who I am?
- Do you know what I'm doing here?

- When did your symptoms first occur?
- Have you had any previous difficulties with your eating or drinking or talking?
- How would you rate your speech today from a scale from 1 – 10 (bad – good)?
- How does your eating and talking differ from before you came here?
- What is the highest level of education you achieved?

Appendix 2 – Example Session Plan

Long Term Goals

- XXX will demonstrate age appropriate articulation in all contexts
- XXX will demonstrate age appropriate expressive language in all contexts
- XXX will demonstrate age appropriate receptive language in all contexts

Short Term Goals

- XXX will follow verbal one and two stage commands relating to the direct environment to 90% accuracy in all settings
- XXX will accurately produce the /k/ and /g/ sounds in all word positions in spontaneous speech to 90% criterion in all settings
- XXX will demonstrate appropriate use of auxiliary verbs in the present tense to 90% accuracy in all settings
- XXX will demonstrate appropriate use of the regular past tense grammatical morpheme to 90% accuracy in all settings

Sessional Goal One

XXX will accurately use regular past tense verbs to complete a carrier phrases (S+V-ed) to 90% criterion within the clinic setting

Rationale

According to Brown's order of acquisition of the 14 grammatical morphemes, the past regular grammatical morpheme is acquired at approximately 4 years. As XXX is XXX years old, age appropriate receptive language skills must include understanding of this grammatical morpheme

Procedure

Intro: "We're going to play a game where we have to make some sentences. It's a bit like what we did yesterday. We're going to make sentences about what people did yesterday. Remember, when we're talking about what they did yesterday, we have to put an extra sound on the end. It's an /ed/ sound. Let me show you. This man is waiting. Yesterday he wait...ed. waited. Can you hear that extra sound on the end of wait? Wait...ed. Can I hear you say that word? Waited." Go through various examples and have XXX produce the past tense verbs after a model. Visual cues will also be used (cued artic and words written on cards with the 'ed' separated. The 'ed' will be joined with the rest of the word as XXX is required to say the verb.

Go through various verbs giving XXX a carrier phrase to complete with the regular past tense verb. For each verb, XXX will be given a piece of the bowling game.

Initially, verbs requiring a /t/ or /d/ sound on the end to create the past tense will be used to assist XXX to consolidate this grammatical structure. Words that require an /ed/ sound will then be introduced

XXX will be provided with consistent informative verbal praise and reinforcement for attempts and accurate responses.

Contingency

Up:

- Remove visual cues. XXX will be required to complete the carrier phrase without visual prompts.
- XXX will be required to produce a sentence containing the target verb. This will be elicited by providing prompting and modeling to use the sentence 'yesterday, he/she.....' Visual cues will be used to assist XXX in remembering the words.

Down:

- Verbal prompting (Are you remembering to put the extra sound on the end? The /ed/ sound?).
- Visual Cues: (Cued artic for final sound)
- Visual cues (word written on cards with the past regular morpheme separated from the rest of the word)
- Modeling. (Yesterday the man jumped. What did he do yesterday? He

Sessional Goal Two:

- XXX will produce /k/ and /g/ in word initial position at the paragraph level to 90% criterion within the clinic setting

Rationale

According to Grunwell (1987), the phonological process of fronting is generally suppressed by 3;6. As XXX is currently 6, he must be able to produce the back sounds /k/ and /g/ for his articulation to be age appropriate.

XXX has demonstrated the ability to produce /k/ and /g/ in isolation, CV syllables, single words, two word phrases and sentences

Production of sounds in paragraphs is the next stage up from phrases in the hierarchy of stages for learning sounds.

Procedure

Prior to commencing this activity, XXX will be given a game to play with to break up the two activities.

Intro: "Do you remember the sounds that we've been working on? We're going to read a book with our /k/ and /g/ words."

XXX will be given a small picture book with a short story (three sentences) containing /k/ words. He will be told the story as he reads along with the book. He will then be required to read the book back using accurate /k/ sounds. This will be repeated with /g/ words. At the end of reading the book, XXX will be given a turn of the 'bean game'

XXX will be provided with consistent verbal reinforcement and praise for attempts and accurate productions. He will be provided with informative feed back (e.g. excellent. I heard a really good /g/ sound at the start of that word) approximately every 5 responses and for self-correcting (e.g. I heard you say the wrong sound in that word but you noticed and fixed it up so that it was the right sound. Well done, you can have two turns for that!).

Contingency

Up: * XXX will be required to repeat the activity with a mixture of /k/ and /g/ words
* XXX will be given a longer story/book to re-read

Down:

- Verbal prompting (can you say that again?)
- Visual Cues (cues articulation)
- Verbal prompting (Did you remember to use your special sounds)
- verbal prompting (did you remember your /k/ sound? Did you keep the front of your tongue down?)
- Modeling (cow) and cued artic
- Modeling with target sound emphasised
- Modeling with target sound segmented

Sessional Goal Three:

- XXX will produce the /k/ and /g/ sounds in the word medial position in Adj+N phrases to 90% criterion within the clinic setting.

Rationale:

According to Grunwell (1987), the phonological process of fronting is generally suppressed by 3;6. As XXX is 6 years old, he must be able to produce the back sounds /k/ and /g/, for articulation to be age appropriate.

XXX has achieved criterion for production of /k/ and /g/ in the word medial position of single words.

Production of sounds at phrase level is the next level up in the hierarchy of stages for learning sounds.

Procedure:

Intro: We're going to play a game with our /k/ and /g/ sounds in the middle of words. We're also going to say two words together. Let me show you (with visual cues). 'Yellow bucket'. Now you have a try.

Play a 'board game'. /k/ and /g/ cards will be placed in a row and used as game squares. Take it in turns to roll the dice and move along the number of cards rolled. For each card

XXX will be required to produce the word in an adj+N phrase elicited with adjective cards.

XXX will be provided with consistent verbal reinforcement and praise for attempts and accurate productions. He will be provided with informative feedback (e.g. excellent. I heard a really good /g/ sound at the start of that word) approximately every 5 responses and for self-correcting (e.g. I heard you say the wrong sound in that word but you noticed and fixed it up so that it was the right sound. Well done, you can have two turns for that!)

Contingency:

Up: XXX will be required to create a sentence using the /k/ and /g/ words. He will be given a carrier phrase to use: I've got a.....

Down:

- Verbal prompting (can you say that again?)
- Visual Cues (cues articulation)
- Verbal prompting (Did you remember to use your special sounds)
- verbal prompting (did you remember your /k/ sound? Did you keep the front of your tongue down?)
- Modeling (market) and cued artic
- Modeling with target sound emphasised
- Modeling with target sound segmented

Appendix 3 – Oral Peripheral Examination

This Oral Peripheral Examination is a comprehensive list of different areas that may be reviewed. Many clients may not need all these areas assessed. In this case, please simply use the questions that you need.

Clients Name:

Address:

Telephone:

Date of Birth:

Sex:

UR number:

Pre-Assessment

Hearing/Visual Impairment

Reported swallow difficulties/Weight loss? _____

Presentation

SOOB

SIB

RIB

Cooperative

Uncooperative

Unmotivated

Weak

Anxious/agitated/confused

Alertness/Attention

Alert, attentive

Fluctuating

Easily fatigued

Unrousable

Posture

Supported

Unsupported

Leaning to left/right

Unable to support head/trunk

Physical limitations _____

Other variables

O2 mask in situ

Nasal prongs

NP airway

Trachea _____

Auditory Comprehension

No/min response to speech/commands

Yes/No questions

Follows simple commands/general conversation

Follows complex commands/functional

Verbal Response

Dysarthria

Dysphasia

Dyspraxia

Dysphonia

No/minimum response

Few words, automatic/spontaneous speech

Occasional sentences, may/may not be appropriate

Functional

Naomi Chivell, Nicole Haspell, Rebecca Hillis, Rebecca Molina, Melissa Warren (2005)

Current nutritional status

- Nil orally
 Alternative IV NG/J tube G/J tube
 Oral intake _____

Respiratory System

- At rest NAD Clavicular
 Thoracic Diaphragmatic
 Selective oral/nasal breathing

- Cough Effective Ineffective
 Moist Dry

- During speech NAD
 Speaking on residual air
 Vocalisation on inspiration
 Incoordination

Chest Condition

- Clear
 Regular suctioning
 Infected (upper airway secretions)
 Pneumonia
 Previous chest condition

CLINICAL EXAMINATION**Dentition**

- Teeth Present Absent
 Good condition Poor condition

- Dentures Upper Lower
 Full Partial
 Fit correctly?

Sensation

- Left mandible Right mandible
 Left cheek Right cheek
 Left forehead Right forehead

Facial (VII)

Symmetry _____

Raise eyebrows NAD Reduced range
Eyelid closure NAD Reduced range
Smile NAD Reduced range
Purse lips NAD Reduced range
Suck in cheeks NAD Reduced range

Drooling Present Absent
 Poor lip seal? Left Right

Puff out cheeks for 10 seconds
 NAD Nasal escape

Press on puffed out cheeks
 NAD Weak

Jaw (V)

Normal occlusion Retracted mandible Prognathic mandible
 Minimal opening Extended opening

5 reps of lateral movements
Impaired range? Left Right

Lateral movement against resistance
Left? Weak Strong
Right? Weak Strong

Lingual (XII)

At rest: NAD Tremor
 Fasciculation
 Spastic/bunched Flaccid
Atrophy? Left Right

Mucosa NAD Dry
 Red Pale

5 protrusions NAD Impaired range Impaired rate
Protrusion against resistance Weak Strong

5 lateral movements NAD Impaired rate
Impaired range? Left Right
Against paddle? Strong Weak

Tongue elevation NAD Impaired range
Tongue depression NAD Impaired range

5 elevations/depressions NAD Impaired range
Impaired rate

Symmetry at rest _____
Symmetry on protrusion _____

Palatopharyngeal/Soft Palate (IX, X & XI)

- Voluntary cough
- Report of involuntary cough
- Voluntary swallow

Palate symmetry?
Deviation Right Left
Tremor Left Right

Uvula symmetry? _____
Pooling? Present Absent

Phonation (X)

- Voice quality:
- NAD Wet Tremor
 - Harsh Breathy Stridor
 - Strained/strangled Monoloud Monopitch
 - Pitch breaks

Articulation tasks

15 secs of /a/ Time: _____ secs

5 repetitions of /a/ NAD
Impaired elevation? Left Right

5 repetitions of *may pay*
 NAD Hypernasal Hyponasal

5 repetitions of /p t k/ NAD
 Reduced rate Incoordination

Alternate pucker/smile (“oo-ee”) x 5
 NAD Reduced rate
Reduced range? → Left Right

5 repetitions of /k/ NAD Reduced rate Incoordination

5 repetitions of /t/ NAD Reduced rate Incoordination

5 repetitions of /p/ NAD Reduced rate Incoordination

5 repetitions of *ka la* NAD Reduced rate Incoordination

GIVE FEEDBACK TO THE PATIENT REGARDING RESULTS AND PREDICTIONS

Abbreviations used

NAD – No abnormality detected

RIB – Resting in bed

SIB – Sitting in bed

SOOB – Sitting out of bed

NG/J tube – Naso-gastric/Jejunum tube (enteral feeding)

G/J tube – Gastric/Jejunum tube (enteral feeding)

Appendix 4 – Example Handover Report

INTENSIVE TREATMENT PROGRAM REPORT

Student Name:	xxx	Sex:	xxx
Date of Birth:	xxx	Age:	xxx
School:	xxx	Teacher:	xxx
Date of Program:	xxx	Date of Report:	xxx

Brief History:

XXX is a 5-year-old boy in Prep in 2005. XXX XXX, Speech-Language Pathologist at XXX Primary School, referred him for therapy after prep screenings indicated articulation difficulties.

Further testing showed XXX has difficulties with various phonological processes including final consonant deletion and backing.

Treatment Program:

XXX attended xxx xxx-minute sessions during school hours. He attended therapy in a 1:1 format as well in a group setting with one of his peers.

Goal 1:

XXX will reduce his use of final consonant deletion at carrier phrase level by 60% with prompting but without modelling.

Rationale:

At the beginning of this therapy block, XXX's speech was unintelligible. His teacher reported difficulties understanding what he was telling her, even after numerous repetitions. Testing indicated that XXX has not suppressed the use of the phonological process of final consonant deletion at word level and in connected speech. Subjective observation of XXX's speech showed that final consonant deletion is the largest disruptor to XXX's intelligibility. Therapy will begin at this level with stress on the final consonant. XXX shows an aptitude and willingness during therapy sessions and he should progress to carrier phrase level.

Procedure:

Extensive use of modelling, repetition, and cueing (including hand clapping) were used to help XXX add the final consonant to his words. A series of board games, colouring-in activities and group games were used to help XXX practice adding the final consonant to a word. Most of these activities involved using minimal pairs to demonstrate the importance of adding the final consonant.

Prep students at xxxx use cued articulation in the classroom to help them learn to recognise the sounds attached to letters when learning to read so this was also used during therapy.

XXX enjoys playing games with cards, particularly 'snap' and 'go fish'. These games were regularly played during therapy, using final consonant deletion cards. Initially, XXX was required to say the picture on the card (eg. Ca-t) and as therapy progressed, XXX was required to give more information before he could put down his card (eg. I have a ca-t). In all activities, the final consonant was exaggerated.

Results:

XXX can produce the final consonant of words at a carrier phrase level to a 90% criterion. XXX has begun working on suppressing his final consonant deletion at a sentence level however is still having difficulties at this level at this time. XXX will occasionally become confused if the target word is at the start of the carrier phrase and will add the final consonant to the end of the sentence.

Goal 2:

XXX will slow down his speech if asked to repeat himself to a 50% criterion.

Rationale:

XXX's intelligibility improves slightly if he slows down his rate of speech. XXX is an excited boy who enjoys expressing his ideas. When he becomes excited however, his rate of speech increases, which reduces his intelligibility further. XXX becomes very frustrated when he realises that people cannot understand him and will yell any repetitions.

Procedure:

XXX was given an elastic band, which he will wear around his wrist. XXX responds well to tactile cues so will benefit from this exercise. He is aware that if you stretch an elastic band too far that it will snap. It was demonstrated to XXX that when he talks too fast, the elastic band stretches to keep up so he has to talk slower to allow the elastic band to return to its normal size. In the initial sessions for this goal, the elastic band was held to show him what would happen and as therapy progressed, XXX began to wear the elastic band on his wrist. If he was talking too quickly, his elastic band would be pointed to as a cue, then stretched if he continued to talk too quickly.

Results:

XXX will slow down his speech when asked to repeat himself to an 80% criterion. With further prompting, XXX will slow down his speech for the remaining 20% of responses. This has significantly reduced XXX's frustration during conversations, and has increased his intelligibility by 50% when assessed subjectively.

Summary:

XXX is a competitive boy who enjoys playing games. He is particularly enjoys playing 'snap' and 'go fish' (eg. with final consonant deletion cards). XXX also enjoys drawing on the whiteboard. He tries his hardest throughout the session, however will become frustrated when he realises that people cannot understand him. This frustration has notably reduced since therapy commenced as XXX now has strategies to use when people cannot understand him. XXX has learnt that people understand him more when he talks slower and if his conversation partner still does not understand him, XXX has begun to rephrase what he is saying.

OR

XXX will attempt to evade working during the session and has difficulties sitting still in his chair. This behaviour improves if he is given a set number of tasks to complete or if he can see the end of the activity. For example, XXX has a stamp chart, which he has to fill each session before he is allowed to go back to class. Each 'snap' or correct answer will earn him a stamp.

XXX feels comfortable when given rules to follow – eg. Talk quietly in the classroom.

XXX is competitive boy who enjoys winning games.

Recommendations:

Following this therapy program, the following recommendations have been identified:

0. XXX requires further therapy targeting his use of final consonant deletion.
1. XXX would benefit from therapy targeting his remaining articulation errors.
2. XXX should sit at the front of the classroom when on the mat to help him see better in class.

XXXX XXXX
XXX year Speech-Language Pathologist
La Trobe University

XXXXXX XXXXX
Speech-Language Pathologist
Supervisor

Appendix 5 – Example Dysphagia Report

SPEECH PATHOLOGY REPORT

Date:

NAME:

DOB:

ADDRESS:

CONTACT DETAILS: Tel.

MAIN CARER:

RELATIONSHIP:

ADDRESS:

CONTACT DETAILS:

DOCTOR:

ADDRESS:

CONTACT DETAILS:

CASE MANAGER:

ORGANISATION:

ADDRESS:

CONTACT DETAILS:

BACKGROUND INFORMATION:

Mrs XXX is a XXX year-old lady living alone, but with family support nearby. She was referred by the XXX with concerns regarding her swallowing and voice.

A joint session was conducted on XXX with the centre's dietician. XXX's daughter, XXX, her son-in-law and a home care attendant were also present.

Mrs XXX reports that she has had a variety of illnesses during her life including polio, pleurisy, rheumatic fever, repeated tonsillitis and ear infections. It is suspected that she has had epilepsy in the past.

She was diagnosed with hiatus hernia 2 – 3 years ago and also has post-polio syndrome, arthritis and brittle bones. She has been prescribed cortisone for her arthritis and takes nitro-dur to prevent angina. She is currently waiting for her prescription of cortisone to run out before having her flu immunisation. She is currently using eye-drops to treat ongoing conjunctivitis. Her blood pressure also requires monitoring.

There is a strong family history of diabetes, thyroid problems and goitre.

Mrs XXX reported allergies to paint, thinners, nail polish – particularly the fumes. She also reported insomnia and will usually “get up around 1am”

Mrs XXX has eliminated foods from diet which affect reflux or which she has difficulties with (including capsicum, rice, lettuce, baby corn, crumble, hard vegetables, spices, hard meat, mustard, sauce, pepper). She does not always eat breakfast.

XXX, home carer, is to prepare meals for Mrs XXX, with only 2 frozen meals on wheels to be delivered each week.

EATING/SWALLOWING ASSESSMENT:

Mrs XXX was assessed using a bulbar examination and dysphagia assessment. She was observed eating her usual lunch meal, delivered by Wheels on Meals. Diet consists of a soft normal consistency, with the exception of shaved silverside which required cutting into small pieces.

Mrs XXX reported that she currently has a cold, however has no history of chest infections. Mrs XXX reported that she may fatigue during a meal and will not finish. XXX reported a decrease in weight and a decreased amount of food eaten; however, her food intake has increased in the recent past.

- **Oral preparatory stage:** Mrs XXX displayed difficulties with this phase, specifically difficulties transporting the food to her mouth due to her arthritic hands. Because of this, she does not always eat breakfast. She uses a modified a knife and fork.
- **Oral phase:** Moderate-severe oral dysphagia present. Mrs XXX reported difficulties chewing and swallowing her food and drink, particularly if eating/drinking quickly. She also reported that food will “slip down her throat before she is ready”. An increased oral transit time was observed. Mrs XXX reported altered taste and smell sensations.
Mrs XXX has worn upper dentures since her teeth were removed during illness 52 years ago; however she no longer has fitting lower dentures. She has ulcers in her mouth decreasing the comfort of her upper dentures and reports that her dentures are rough in some areas. She also reported that she wears her upper dentures ‘most often’ during meals however food gets caught underneath them, requiring clearing after each meal.
It was observed that Mrs XXX is a mouth breather, with reported difficulties breathing through her nose. This resulted in Mrs XXX breathing through her mouth when chewing. Mrs XXX occasionally talks with her mouth full and will take large mouthfuls. XXX reported that her mother will often burp after a meal.
- **Pharyngeal stage:** A swallow was not triggered when food “slipped down her throat,” increasing the risk of aspiration/penetration.
- **Oesophageal stage:** Mrs XXX reported that food may “get stuck at the throat” and the upper or lower oesophagus. This feeling may last for several hours.

Cranial Nerve Assessment – reported fluctuations in ability

CN V – mandibular musculature

Mrs XXX demonstrated normal occlusion of the jaw. She demonstrated the ability to open her mouth against resistance, however could not make lateral jaw movements. She reported ‘neuralgic’ pain between her temporal-mandibular joint and her chin.

CN VII – facial musculature

Mrs XXX has normal sensation on most of her face however sensation was less sensitive around her left cheek. Mrs XXX demonstrated an ability to produce all movements asked, however had difficulties producing sequential movements. Mrs XXX reported occasional drooling. On a task involving alternate puckers/smiles, Mrs XXX used intense concentration, had a decreased rate of speed and displayed some oral groping/searching. Mrs. XXX produced 9 repetitions of the sound /p/ during one breath, with the sound produced softly and with no voice.

CN IX & X – palatopharyngeal musculature

On phonation of ‘ah’, the uvula showed a deviation to the left. Right palate function appeared to be within normal limits however the left palate had reduced movement. Mrs XXX produced 17 repetitions of /k/ within one breath.

Mrs XXX can produce a weak voluntary cough. She reported that the effectiveness of her cough fluctuates.

CN XII – tongue musculature

Observation of the tongue at rest showed no abnormalities. Mrs XXX displayed some difficulties when depressing her tongue, with the body of her tongue remaining stationary with the tip curling up.

Mrs XXX protruded her tongue against resistance without difficulties and displayed the ability to elevate her tongue, lick her lips and make lateral movements, however all movements had a reduced rate of speed. Mrs XXX produced 20 repetitions of the sound /t/ during one breath.

Articulation System

Mrs XXX displayed difficulties with diadochokinesis (repetition of /p t k/). She needed to use intense concentration and displayed some oral groping on the /p/. Rate of production was decreased.

Summary:

The bulbar examination highlighted a variety of difficulties covering each of the cranial nerves assessed. Mrs XXX demonstrated difficulties with sequential movements and displayed some oral groping, suggesting a dyspraxic element.

Recommendations:

- Facial exercises to assist with sequential movements and rate of movement
-

COMMUNICATION ASSESSMENT

Voice Assessment

Mrs XXX reports that it is “quite an effort to talk” and that her voice will disappear if she has a cold. Mrs XXX reported that she can feel tension in her larynx. She also reported an inability to breath through her nose. It should be noted that her daughter reported similar difficulties. It was observed during the swallow assessment that Mrs XXX has a small larynx.

Mrs XXX’s speech was not formally assessed, however the following was noted:

- **Respiratory function:** Mrs XXX occasionally became breathless during the session and reported an inability to breath through her nose. Mrs XXX became breathless occasionally during the session, requiring a short break to regain her breath. Breathing patterns during speech appeared within normal limits. Testing indicated reduced ability in prolonging the sounds, including /a/ (3 secs), /s/ (3 secs), /z/ (2 secs).

- **Phonation:** It was observed that Mrs XXX's voice has an abnormally high pitch and a very strained quality. She also has decreased volume. She had a decreased range when gliding up and was unable to glide down. Mrs XXX displayed a decreased range of pitch.
- **Articulation:** Within normal limits
- **Resonance:** No concerns
- **Intelligibility:** Mrs XXX has decreased intelligibility due to the pitch, quality and volume of her voice.

Summary:

Mrs XXX demonstrated difficulties with her voice, including decreased volume, reduced range, an abnormally high pitch and a very strained quality. She also became breathless after conversations.

Recommendations:

- Home visit to further investigate issues surrounding her voice

-

RECOMMENDATIONS:

A referral via GP to - radiography for a videofluoroscopy or barium swallow

- ENT for voice and swallow assessments

A referral to a dentist re: ill-fitting dentures

FOLLOW-UP:

- Home visit to explore more thoroughly issues relating to Mrs XXX's voice difficulties

-

(your name)
Speech Pathology Student
X year La Trobe University

(supervisor's name)
Speech Pathologist
(Agency)

Appendix 6 - Mealtime Assessment Report

Name:

Date of birth:

Age:

Home address:

Day service:

Supervising Speech Pathologist:

Date of report:

Background Information:

XXX began at Yooralla Day Service on xxx after attending XXXX Special Development School. It was therefore requested that a meal-time assessment be conducted.

The assessment was conducted over two lunch time periods at the bowling alley. XXX was also asked questions regarding meal-times

XXX uses a motorised wheelchair for mobility. The wheelchair is fitted with a tray from which she consumes her meals

Observations:

Drinking

XXX drank a regular cold drink from a regular cup without handles. She used both hands to support the cup as she brought it to her mouth.

XXX was observed to have good lip seal of cup and did not display any spillage. XXX took single sips of drinks with breaks of a few seconds between each sip. XXX did not demonstrate any coughing or any behaviour to suggest that the drink had gone down the wrong way.

Eating

XXX was observed eating a sandwich chopped in half with spread on it, an apple chopped into small pieces and potato chips. She was also observed eating potato wedges with sour-cream. XXX used her hands to eat all foods.

XXX was observed using a tearing motion to break the sandwich. The tearing of food, rather than precise biting, meant that XXX occasionally tore off large pieces of sandwich. She was able to effectively chew the large pieces until they were small enough to handle. XXX demonstrated a slow yet effective chewing motion and swallowed 2-3 times for each mouthful.

XXX requested for her apple to be cut into small bite sized pieces. She was able to effectively chew and swallow these although her chewing motion was slow. This suggests that XXX is currently able to manage foods of a harder consistency.

XXX required help to open her chip packet. Again, her chewing motion was slow, however, she was able to chew and swallow the chips without any difficulties, suggesting that she is currently able to manage “crumbly” foods such as biscuits and toast.

XXX required no assistance with the potato wedges. She was able to effectively chew and swallow them. Again, her chewing motion was slow.

For all foods observed, there was no evidence of aspiration (food going down the wrong way).

Summary

XXX presents with a mild eating difficulty at the oral level. She requires some modifications to her food to maximise swallowing safety and make chewing easier for her. These modifications are outlined below

Recommendations

- **Drinking:** Cup should be half filled only to avoid spillage.
- **Eating:** XXX’s foods should be cut into bite sized pieces which she can transfer to her mouth with her hands.
- **Equipment:** XXX requires no special equipment for eating or drinking. She does not use cutlery.
- Should XXX demonstrate an increase in coughing, chest infections or any further difficulties with her eating or drinking, further input from a Speech Pathologist is recommended.

(your name)
Student Speech Pathologist

(supervisor’s name)
Supervising Speech Pathologist

Appendix 7 – Speech and Language Assessment

Summary Report

DATE:

NAME:

UR number:

D.O.B:

CHRONOLOGICAL AGE:

ADDRESS:

TELEPHONE:

PARENTS:

BACKGROUND INFORMATION

XXX is a XXX year old child who attends XXX. XXX was referred for Speech Pathology after XXX screening indicated the need for further assessment for speech and language difficulties.

She is in Grade XXX and has XXX siblings. English is the only language spoken in the home environment. XXX has a younger brother, xxx, who is 19 months of age. It was reported that xxx walked at 14 months and was joining words at around 2-2 ½ years. XXX's mother was unable to recall the age when she began using single words. XXX has a history of problems with severe reflux. She is reportedly fussy at times with certain foods and is allergic to cow's milk.

XXX's mother first noticed XXX's stutter around the age of 2- 2 ½ years when she was beginning to put together two word utterances. They reported that the stutter gradually became more noticeable and has continued for the past 2 years. During this time XXX's speech became fluent for a period of approximately 3 months while attending therapy with xxx in a xxx practice. XXX's stutter has returned and has been apparent for the past 3-4 months.

XXX's mother stated that the severity of XXX's stutter has been constant, and that her speech doesn't fluctuate during the day or when she is tired.

XXX's mother reported that her daughter's stutter is not consistently more severe in any specific situation. XXX is reported to be aware of her stutter and her mother stated that she sometimes becomes frustrated when she is trying to speak and is having difficulty. XXX will occasionally put on voices when her stutter is more severe.

There is a family history of stuttering as XXX's paternal grandfather is reported to have a stutter and her maternal uncle has also been reported to have stuttered.

• **TEST CONDITIONS AND BEHAVIORS:**

Testing was conducted at XXX using the standard procedures as outlined in the test manuals. Conditions throughout testing were considered to be adequate with minimal distractions in the environment, a good rapport established and adequate eye contact was maintained. In general, XXX appeared cooperative during testing and appeared to attempt to respond appropriately. XXX was able to understand and respond appropriately to all commands given to her. Overall, the examiner felt that the results of this test were a valid estimate of current functioning abilities in this area. XXX did not wear glasses or hearing aids during testing.

XXX was assessed by XXX XXX, XXX year Speech Pathology student at XXX.

- **HEARING**

XXX responded inconsistently and consequently did not pass the hearing screening. During the screening, it was noted that XXX had a very quiet voice. A letter has been sent home including a request that XXX sees an Audiologist. XXX was taken to a doctor who diagnosed a middle ear infection. This is currently being treated. However, no known audiological examination has since been conducted.

- **VISION**

No vision assessments have been noted. This is not a concern at the present time.

- **GROSS AND FINE MOTOR SKILLS**

XXX can walk without difficulties, however it should be noted that XXX occasionally assumes peculiar stances (eg. Sitting crooked with her head on a large angle with arms bent). Her fine motor skills have been assessed subjectively with no difficulties identified.

- **ORAL PERIPHERAL EXAMINATION**

No oral peripheral examination was conducted and it is not deemed necessary at this time.

- **COMMUNICATION ASSESSMENTS**

The following assessments were used to assess XXX's communication:

- 1) Test of Auditory Comprehension of Language 3rd Ed. (TACL-3)
- 2) Test of Language Development – Primary (TOLD-P:3)
- 3) Fisher-Atkin Test of Articulation

- **Test of Auditory Comprehension of Language – Primary 3rd Ed.**

This test assesses the client's auditory comprehension skills.

The TACL-3 has 3 sub-tests

- 1) Vocabulary (V)
- 2) Grammatical Morphemes (GM)
- 3) Elaborated Phrases and Sentences (EPS).

The V subtest assesses the client's ability to correctly point to a picture that correlates to a word given orally (eg. Cutting). The client has three pictures to choose from. In this subtest, XXX scored a quotient of 70, which places her in the 'poor' category for this area. This correlates to an age-equivalent of less than 3 years old.

The GM subtest assesses the client's ability to correctly point to a picture that correlates to a sentence of varying complexity given orally (eg. The girl is jumping). The client has three pictures to choose from. On the GM subtest, XXX scored a quotient of 90, placing her in the 'average' category, though on the lowest cusp. This correlates to an age-equivalent of 4;0 years, 1 year less than her chronological age.

The EPS subtest assesses the client's auditory comprehension of elaborated phrases and sentences (eg. The cat has no eyes, the little bird is eating). The client shows their comprehension by pointing to a picture, which correlates to the orally given sentence. The client has three pictures to choose from. On the EPS subtest, XXX scored a quotient of 85, placing her in the 'below average' category. This corresponds to an age-equivalent of 3;9 years, 1;1 year less than her chronological age.

The scores from all three subtests are correlated to give standard scores. These scores are tallied giving a total test quotient, indicating the clients overall auditory comprehension competence. XXX's total test quotient was 76, indicating poor auditory comprehension skills (the mean quotient is 100). This places XXX approximately 1.5 standard deviations below the mean, indicating below average functioning relative to individuals of the same age.

• **Test of Language Development –Primary 3rd Ed.**

The Test of Language Development – Primary was administered to assess XXX's expressive and receptive language. The first six subtests were administered.

The TOLD-P:3 is designed to be used with children aged between 4 and 8 years old. This test is designed to measure a child's ability to word meanings, understand relationships between words, give simple definitions, understand sentences, imitate spoken sentences, and complete sentences. Overall performance on this test is indicated by a composite score called the Spoken Language Quotient, which reflects the child's listening, organizing, speaking, vocabulary, and grammar skills.

The Picture Vocabulary subtest assesses the child's ability to hear a spoken word then point to a corresponding picture. There are three different pictures for the child to choose from.

The Relational vocabulary subtest assesses the child's ability to find the relationship between two different objects (eg. A kite and a bird = they fly).

The oral vocabulary subtest assesses the child's ability to describe an object (eg. What's bird? = it flies, its an animal, it has feathers).

Expressive	Standard score	Percentile
Picture Vocabulary	7	16
Relational Vocabulary	10	37
Oral Vocabulary	9	37

The grammatic understanding subtest assesses the child's ability to understand a sentence and then point to a picture that corresponds to that sentence.

The sentence imitation subtest assesses the child's ability to listen to a sentence and then repeat the sentence back to the examiner without missing any of the words, although root endings may be dropped.

The grammatic completion subtest requires the child complete the last word of a sentence (eg. John is a boy and Bill is a boy. They are both ____ (boys)).

Receptive	Standard score	Percentile
Grammatic understanding	8	25
Sentence imitation	7	16
Grammatic completion	7	16

The scores of the individual subtests can be combined differently to produce 6 different composite scores.

The Spoken Language Composite is derived from the sum of the standard scores of all six subtests and measures overall language abilities is the sum of all the subtest standard scores, giving XXX a quotient of 86 for Spoken Language (mean = 100). The resulting quotient of 86 on the Spoken Language Composite falls 1 standard deviation below the mean and indicates borderline average functioning relative to individuals of the same age.

The Listening Composite is the sum of the picture vocabulary and grammatic understanding subtests. XXX scored a quotient of 85, which falls 1 standard deviation below the mean and indicates borderline average functioning relative to individuals of the same age.

The Organising Composite is the sum of the relational vocabulary and sentence imitation subtests. XXX scored a quotient of 91, which falls 0.66 standard deviations below the mean, indicating average functioning relative to individuals of the same age.

The Speaking Composite is the sum of the oral vocabulary and grammatic completion subtests. XXX scored a quotient of 88, which falls 0.8 standard deviations below the mean. This indicates borderline average functioning relative to individuals of the same age.

The Semantics Composite is the sum of the picture vocabulary, relational vocabulary and oral vocabulary subtests. XXX scored a quotient of 91, which falls 0.66 standard deviations below the mean, indicating average functioning relative to individuals of the same age.

The Syntax Composite is the sum of the grammatic understanding, sentence imitation and grammatic completion subtests. XXX scored a quotient of 83, which falls 1.1 standard deviations below the mean, indicating below average functioning relative to individuals of the same age.

Composite	SS sum	Quotient	Percentile
Spoken Language	48	86	18
Listening	15	85	16
Organising	17	91	27
Speaking	16	88	21
Semantics	26	91	27
Syntax	22	83	13

• **ARTICULATION AND PHONOLOGY**

XXX's articulation was assessed at word level using the Fisher-Atkin Articulation survey.

Errors that were found at word level are as follows:

Substitutions

- Fronting: th → f (thumb/fumb, teeth/teef)
: ŋ → n (finger/fin ger, ring/rin)
- Devoicing: z → s (zip/sip, scizzors/scissors, keyz/keys)
: dz → ʃ (bridge/brish)
- Stopping: v → b (vacuum/bacuum, glove/glub)
: th → d (feather/feader)

The phonological processes of fronting and stopping are normally suppressed prior to the age of 4;6. Since XXX is 5;0 at this time, this is not a major concern.

It has been observed that XXX speaks with a soft voice, particularly in unfamiliar situations. This is likely to have contributed to the devoicing that was noted during this assessment so it is not considered a major concern at this point in time

• **PRAGMATICS**

XXX's pragmatic skills were assessed subjectively with no problems identified, however, XXX did show a shy and withdrawn personality.

• **VOICE**

XXX has not been formally assessed in this area, however it has been noted during a hearing screen that XXX has a very quiet voice.

• **FLUENCY**

Measures of XXX's speech were taken within the clinic. XXX stuttered on 1.7% of 629 syllables. XXX mainly used short simple sentences during this sample time and as such this was not a clear indication of his fluency levels. It is anticipated that XXX's speech may be less fluent in a more naturalistic speech when longer sentences are used. XXX's stutter was characterised by inconsistent sound repetitions and prolongations. XXX's mother reported that fluency levels within the clinic were not representative of levels at home on a fluent day/time but that her stutter was very apparent and quite severe at other times. Further measures will be taken in the clinic in future sessions to establish a true baseline rate.

• **COGNITION**

Due to family history, concerns were raised regarding XXX's cognitive abilities so she was referred to XXX's Guidance Officer, XXX XXX for testing. Testing is still incomplete at this time however initial results indicate that XXX's cognitive skills are below average. See separate report for full details.

SUMMARY and RECOMMENDATIONS

Language testing placed XXX one standard deviation below the mean for syntax and listening skills. This should be monitored however there are no major concerns at this time.

XXX also showed some phonological process errors, which need to be monitored. These processes should have been suppressed by this time, however given that there is only a 6-month gap and her intelligibility is not affected, this will not be addressed at this time.

XXX will benefit from the standard language and vocabulary stimulation that occurs in the classroom and general exposure to language. XXX will also benefit from an increase in confidence and facilitation of positive social skills.

As XXX is aware of and shows signs of being distressed about her stutter, and the fact that the stutter has been constant over a period of 2 years, it is recommended that XXX receive speech therapy targeting this area. Therapy sessions have been scheduled to commence on a weekly basis from XXX. Therapy will be based using the Lidcombe Programme of Stuttering Intervention. The aim of this intervention is to promote fluent speech in all situations while maintaining and developing a child's confidence in speaking. It requires regular attendance at therapy sessions with a designated parent that will be able to conduct therapy tasks outside of the clinical setting. Once XXX's fluency increases he will be placed on a maintenance programme, involving a number of brief assessments that occur less frequently during a designated period to ensure fluent speech is maintained.

The following are recommended to increase XXX's speech and language abilities:

1. Encourage XXX to extend his sentences by incorporating more detailed information into them. This can be done by asking detailed questions about objects or events that are nearby. Make sure this is not done while practicing fluency.
2. Give a correct model of any word that XXX is unable to produce a sound correctly instead of correcting his speech. This is to give XXX additional exposure to the correct sound as he may be having difficulty hearing some sounds.
3. Again, make sure this is not done when practicing fluency as corrections are required when stutters are produced and XXX may become confused.
4. XXX should be re-screened at the end of 2005 to monitor her speech and language skills.

Therapy targeting fluency will commence on a weekly basis from xx/xx/xxxx. If XXX's parents or those working with XXX would like to discuss this report or XXX's skills further they should not hesitate in contacting xxx on xxx.

Based on the results, the following suggestions are recommended:

XXX XXX
XXX year student
Bachelor of Speech-Language Pathology
La Trobe University

XXX XXX
Speech-Language Pathologist
Supervisor

Appendix 8 – Intensive Fluency Progress Report

PROGRESS REPORT- SESSION 1:

Name:

UR:

Student Speech Pathologists: XXX XXX & XXX XXX

Speech Pathologist: XXX XXX

Date of Session: XXX

XXX attended the first follow-up session with his mother. Although XXX appeared tired he remained focused and cooperative throughout all tasks presented by the student clinicians.

- **Base rate at commencement of session:**

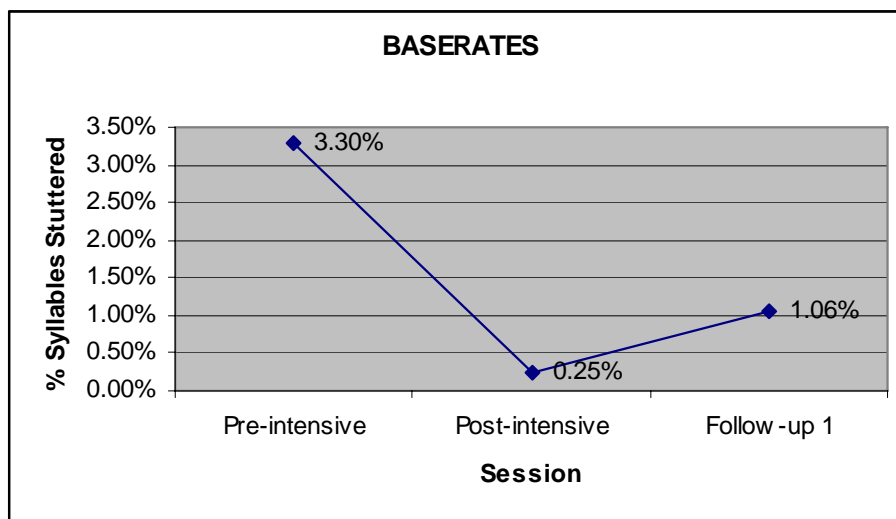
The following information was calculated during a three minute conversation with XXX:

Syllables per minute: 189

Number of stutters: 6

% syllables stuttered: 1.06%

The graph below indicates today's base rate in comparison to the pre and post-intensive recordings.



XXX found it difficult to use smooth speech consistently throughout the conversation. Whilst there was some linking, XXX commented that he was unsure how to do a gentle onset properly. XXX's stutters involved quick repetitions occurring at the beginning of a phrase or sentence, but there were also 1-2 single word repetitions (e.g., where where or I I) and target blocks on /w/ and /h/, as well a phrasal repetition (e.g., because we had because we had). On several occasions when XXX stuttered the student Speech Pathologists had to remind him to stop himself immediately if he could. At times during the

session XXX's mother found it very difficult to understand why he was stuttering after the completion of the intensive week.

- **Home practice:**

XXX had recorded three telephone conversations during the week. Two were to his father whilst the remaining telephone conversation was with a friend. Together XXX and the student Speech Pathologists listened to, and briefly discussed, a sample of one of the conversations between him and his father. After listening to the sample XXX was able to determine that he needed to use smooth speech more consistently. XXX also detected stutters in this sample which were predominantly sound and single word repetitions as well as target blocks. XXX mentioned that he finds it hard to use the technique when talking to his father. This difficulty is documented in his hierarchy of speech situations and will be focused on in future follow-up sessions. XXX did not complete several other home practice tasks which he found difficult to include amongst his daily routine. The student Speech Pathologists and XXX discussed ways to modify these home practice activities so that they will be more manageable.

Home practice tape: Telephone conversations:

Task:	Syllables per minute:	Number of stutters:	% Syllables stuttered:
3 ½ minute conversation with Dad	179	9	1.4%
3 ½ minute conversation with friend	174	8	1.3%
2 minute conversation with Dad	200	12	3%

- **Smooth speech practice:**

2. A conversation with XXX at the commencement of the session indicated that he would like to practice how to do gentle onsets. Therefore, several tasks were completed instructing XXX how to use this aspect of the technique. The student Speech Pathologists began by modelling single words from a list of twenty asking XXX to repeat each word using a gentle onset. Initially XXX required several attempts on each word; however as the list progressed XXX was able to consistently produce a gentle onset. XXX then read twenty phrases without receiving a prior model. XXX was able to read fifteen using a gentle onset, and for the remaining five where XXX did not initially use a gentle onset a single model was provided before he was successful. XXX then read several paragraphs from an article in a magazine requiring only a few reminders about the use of gentle onsets.

3. XXX is completing a school project next week in the city. The project involves surveying people about several major tourist attractions in Melbourne. XXX had asked during the intensive if he would be able to practice reading the details he has to tell each survey participant. XXX began by reading from a prepared paragraph that provides survey participants with his name, school and information regarding survey content. He firstly read at 160 syllables per minute (spm) and over four attempts increased this to his comfort rate of 190 spm. XXX consistently used gentle onsets and required only a few reminders to link his words. XXX maintained appropriate eye contact and sufficient speaking volume throughout the task.

- **Home Practice for the next follow-up session:**

Home practice activities for the following week were discussed with XXX. It was decided that XXX would complete one 5-10 minute conversation each morning before going to school as well as have one face-to-face conversation each evening. XXX was asked to tape several of these conversations and bring them next session. Additionally, XXX is going to complete three telephone tasks that the student Speech Pathologists outlined, but was given the option of altering or expanding upon these tasks depending on what he feels he needs to practice most. The student Speech Pathologists and XXX finished the session discussing strategies to assist in the consistent use of smooth speech throughout the day, e.g., written reminders placed around the house, a special bracelet, or a sticker on his school diary.

Next session: XXX.

XXX XXX

(Student Speech Pathologist)

XXX XXX

(Student Speech Pathologist)

XXX XXX

(Speech Pathologist)

Appendix 9- Fluency Review Report

La Trobe Fluency Clinic Review Day (add date)

Name: XXX XXX

UR:

DOB:

Age:

Gender: Female

Review Date:

Student Speech Pathologist: XXX XXX

Supervising Speech Pathologist: XXX XXX

Background

XXX lives in XXX with her family. She has recently completed a masters degree in Psychology and is currently employed in this area at XXXX. This is XXX's 10th review day having completed her first review day in XXXX.

XXX completes a range of tasks on a daily basis to maintain her smooth speech techniques. These include:

- 15 minute daily conversation to her husband in the morning
- 15 minute monologue daily to herself in the morning
- Telephone calls throughout the week to automated telephone competitions
- Car practice in the morning: XXX will complete a monologue of her clients for the day if she feels she needs further practice for her speech
- Weekly conversations either via the telephone or in person to her speech buddy. XXX reported to the clinician that she has not spoken to her speech buddy for approximately 5 weeks due to a recent holiday commitments. XXX reported that her and her speech buddy would be resuming weekly practice in the near future.

XXX reports these home practice tasks are still completed and are helpful to her use of smooth speech techniques. XXX further reported that for the last six weeks she has been taking the medication Olanzapine for her stuttering and has reported a positive change in her speech.

XXX reports that she finds the review days extremely helpful to brush up on her speech techniques. XXX reported that she would like to practise her techniques, especially with words beginning with /s/ at this particular review day. It was decided that the focus of the day would be individual practice with some transfer tasks if time permitted.

Baserate:

A Baserate of XXX's speech was taken at the beginning of the session, a 10 minute conversation between XXX and another review day participant.

10 minute conversation

947 syllables

189spm

26ss

2.7% syllables stuttered.

Hierarchy of Difficult Situations

The following hierarchy was completed during the review day. The situations are listed below from one being the most difficult situation to six the least difficult.

3. Going for an interview (including the phone call for the position description)
4. Phone calls in particular to her extended family
5. Giving presentations/ speaking to a group
6. Giving specific information for example telephone numbers/ spelling her name
7. Speaking to her kids
8. Speaking to her husband

Discussion

XXX's main focus for the day was to practise using her techniques individually. XXX and the clinician therefore decided to move through the program slowly practising every speech level multiple times. XXX was able to maintain good rate and fluent speech with use of her techniques with speeds of 60spm. It was decided that an extra level of tasks (at a rate of 90-100spm) be added to the program before XXX attempted 120spm. XXX maintained fluent speech through these tasks with some stutters evident in conversation at this level. At increased speeds it was observed that XXX had increased length of her sentences causing her to run out of breath towards the end of the sentence and stutter. XXX was encouraged to reduce the length of her sentences and increase her linking of words and reduce her stutters in these sentences.

XXX was given the opportunity to practise her speech during two conversations with other participants in the program. The first conversation was at 120 spm where XXX maintained her use of technique through the conversation. During this conversation it was noted that her sentences were occasionally too long and she seemed like she was running low on breath, causing her to stutter. Again XXX was encouraged to shorten her sentences by taking extra pauses to reduce the stutters present in her speech.

The second conversation XXX participated in was at a speed of 150spm. XXX's use of smooth speech techniques was improved from the preceding conversation. XXX used shorter sentences and reduced the number of stutters in her speech during this conversation.

XXX only reached the beginning of 150spm at the review day because a speech sample with no stutters was more difficult to obtain at the higher speeds.

Recommendations

XXX has an excellent home practice format this includes the following tasks:

- 15 minute daily conversation to her husband in the morning
- 15 minute monologue daily to herself in the morning
- Telephone calls throughout the week to automated telephone competitions
- Car practice in the morning: XXX will complete a monologue of her clients for the day if she feels she needs further practice for her speech
- Weekly conversations either via the telephone or in person to her speech buddy. XXX reported to the clinician that she has not spoken to her speech buddy for approximately 5 weeks due to a recent holiday commitments.

It was discussed at the end of the session that XXX will soon have to go through the interviewing process for employment including telephone calls for position descriptions and one to one interviews. XXX and the clinician discussed a number of ideas where XXX will be able to facilitate practice into her daily routine to prepare her for these interviews. Practice included ideas such as:

- Giving her husband a list of question that an interviewer might ask XXX. XXX's husband would ask her some of these questions randomly while eating dinner or watching T.V. to prepare her for the material she may be asked during the interview.
- For telephone conversations where XXX must ring to obtain a position description of the job in question, XXX commented that practicing a telephone call before she has to make it increases her anxiety of this task. It was discussed that XXX try calling the automated telephone competitions before making the position description conversation to practice her smooth speech before the conversation.

XXX has a good structure of home practice to maintain her smooth speech techniques. It is recommended that she continues to attend review days also.

XXX XXX

XXX XXX

Student Speech Pathologist

Speech Pathologist

Appendix 10 – Camperdown Program Report (Fluency)

LA TROBE UNIVERSITY FLUENCY CLINIC Camperdown Program Summary Report

Name:
Date-of-Birth:
U.R. number:
Date of last session:
Student Clinician:
Supervising Clinician:

Background Information:

X is a 30-year-old male who contacted the La Trobe Fluency Clinic with concerns regarding his fluency. He subsequently participated in the Camperdown Program at La Trobe University between xx.xx.xxxx and xx.xx.xxxx.

X lives at home with his mother, father, and four younger siblings. Both his youngest brother and his father have a history of stuttering. The family speaks English at home. X is currently employed as a _____ where he has worked for the last 3 years.

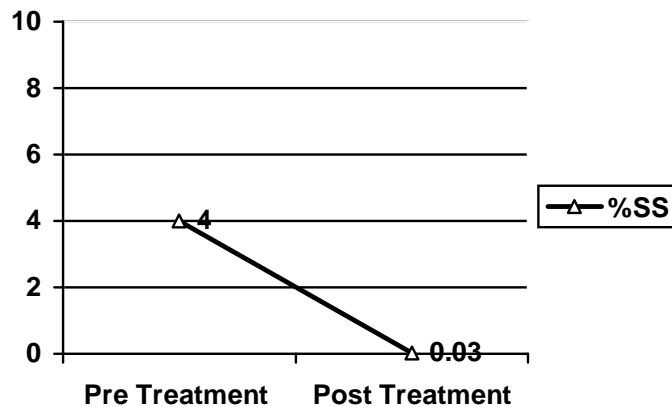
X has previously attended four therapy sessions with a private Speech Pathologist but reported no improvement in his fluency. X reported a history of depression related to his stuttering, but has reported that he no longer has any significant health problems and is no longer on any medication.

X stated that he is now an outgoing individual who loves to socialize and meet new people.

Base Rates

	Speech sample	Total number of syllables	Syllables per minute	Total syllables stuttered	Percentage of syllables stuttered	Severity rating	Naturalness rating
Pre treatment	10 Minute conversation						
Post treatment	10 Minute conversation						

X's Base Rate Pre and Post Treatment



Primary Stuttering Behaviours

- Sound repetitions eg. C...c...can
- Sound prolongations eg. S___tutter
- Syllable repetitions eg. I... I... I would like to..., and...and...and
- Phrase repetitions eg. Last week I...last week I...

Secondary Stuttering Behaviours

- Blinking
- Reduced eye-contact
- Reduced volume
- Excessive use of fillers eg. Umm...
- Increased tension

Summary of Treatment Progress

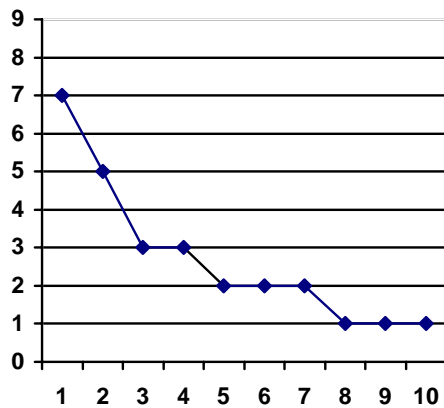
X is a participant in the research trial of the Camperdown Program at La Trobe University Fluency Clinic. X attended weekly therapy for ten sessions (2 hours each) between x and x. The treatment schedule consisted of two individual teaching sessions, a group practice day and seven individual problem solving sessions. During the sessions X was required to assign his speech both a severity and naturalness rating between 1 and 9 and to discuss his fluency during his homework tasks.

In the first session X was introduced to the Prolonged Speech Exemplar and was required to imitate it as closely as possible. He was required to compare his own speech to that of the Exemplar. X used terms such as 'joining', 'linking', 'slower' and 'stretching out the sounds' to describe the features of Prolonged Speech. He initially had difficulty approximating the Exemplar and demonstrated some syllabic speech.

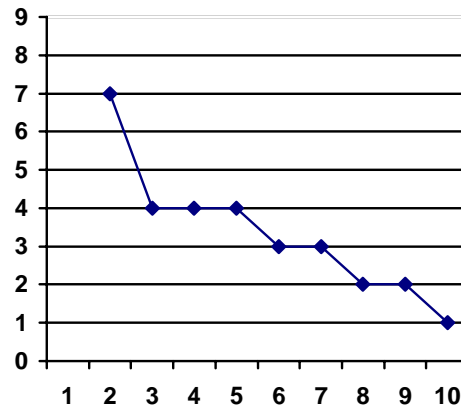
During the program X progressed from a severity rating of 7 to a rating of 1 (one representing no stuttering and 9 representing severe stuttering). The naturalness scale

of 1-9 (1 representing normal speech and 9 representing the exemplar's Prolonged Speech at 60 spm) was introduced in week 2 of the program and implemented in week 3. X was able to maintain a severity rating of 1 whilst experimenting with his naturalness. When implementing prolonged speech, X progressed from a naturalness rating of 9 (when imitating the exemplar) to a consistent rating of 1 to 2.

**Weekly SEV ratings in clinic
(As rated by clinicians)**



**Weekly NAT Ratings in clinic
(As rated by clinicians)**



These graphs outline the severity and naturalness rating scores given to X's overall speech each week during the treatment sessions.

Transfer and maintenance of technique

X practised the prolonged speech technique in a range of settings including: one-to-one conversations, monologues, group discussions and an oral presentation before a large group of unfamiliar people.

X adopted the prolonged speech technique easily within the clinical setting but reported difficulty transferring the technique to everyday tasks. He stated his use of the technique had increased markedly in all settings by the completion of the program. Throughout the program X was able to demonstrate a developing ability to self-monitor and accurately problem-solve difficulties which he encountered. He was also able to devise and implement numerous strategies to assist him in remembering to use his technique, for example, sticky notes on his phone at work, a message on his computer screen saver and placing his watch on the opposite wrist.

X was able to develop appropriate goals and consciously work towards their achievement in multiple settings.

Through appropriate application of the technique, problem solving and use of memory strategies, X was able to gain control over his fluency.

Prognosis

The results obtained from the initial assessment indicated a mild-moderate stutter. X's stuttering behaviours were primarily characterised by single sound repetitions on the initial sound of words, sound prolongations, syllable repetitions and phrase repetitions. X remained strongly motivated, participated actively throughout the program and was able to obtain fluent speech. It is anticipated that X will remain fluent in the future provided he continues to actively apply maintenance strategies practiced during treatment to monitor and control his fluency.

Recommendations

It is recommended that X employ the following strategies to maintain his fluency in the future:

- Continue to achieve a severity rating of 1 and a naturalness rating of 1 to 2.
- Continue to practise technique with the exemplar
- Continue to monitor severity and naturalness and to assign ratings on a daily basis
- Continue to develop graphs detailing severity and naturalness ratings to visually represent fluency achievements and times of disfluency
- Problem solve to determine the reasons for times of disfluency and to address these issues
- Upon completion of the research trial it is recommended X attend fluency review sessions to obtain feedback on his use of technique

If you have any enquiries or concerns regarding the information obtained in the above report, please do not hesitate to contact the clinic reception on 9479 1921.

4TH YEAR SPEECH PATHOLOGY
STUDENTS

SUPERVISING SPEECH PATHOLOGIST

Appendix 11 – Hyperfunctional Voice Report

LA TROBE COMMUNICATION CLINIC

Assessment Report Template (For Hyperfunctional)

Name:
D.O.B.:

U.R No.:

Date of assessment:
Date of report:

Student Speech Pathologist:
Supervising Speech Pathologist:

CASE HISTORY INFORMATION

Source: HCS 22 DVL Manual.

Information to be included:

Referral and self-report of voice problem.

- Referral source (who and when)
- reasons of referral as seen by client
- cause of problem as seen by client
- impact of voice problem as seen by client
- previous episodes of voice problems
- associated symptoms/sensations. e.g. laryngeal tension
- previous ST or strategies employed by client.

Onset

- Who first noticed it and when
- circumstances of onset
- gradual vs. sudden.

Variability

- variability since onset
- circumstances surrounding changes.
- current variations in voice e.g. daily basis, morning vs. night.
- rating of severity today compared with other times.

Voice Use Patterns

- past and present voice use patterns
- current hyperfunctional vocal behaviour
- voice use environment
- singing/voice/acting training

Relevant Medical Factors

- thyroid/endocrine disorders
- medications

Naomi Chivell, Nicole Haspell, Rebecca Hillis, Rebecca Molina, Melissa Warren (2005)

- surgery, trauma or cancer of head/neck/chest
- respiratory tract disorders
- gastric reflux/LPR
- Allergies
- Hearing loss
- Smoking, alcohol, recreational drugs, pollutants,
- dysphagia etc.

Psychosocial and Environmental Factors

- family, work, school and social relationships
- stresses in any of the above
- anxiety, depression
- client description of personality and behavioural characteristics

VOICE EVALUATION RESULTS

A perceptual evaluation of ABC's voice during conversation and phonatory tasks revealed (**quality**) moderate roughness and breathiness. ABC's **pitch** was perceived to be slightly low; **intonation** appropriate; **loudness (conversation and maximal intensity range)** normal; **resonance** normal.

Respiration/posture to be included here if disordered.

Please refer to the Appendix for further details.

Voice analysis using objective measures (CSL) produced the following results:

- a) Standard reading passage
- b) Pitch glides/Scale singing
- c) Prolonged vowel /a/

Observational measures produced the following results

- d) Maximum phonation times for vowel /a/ ; also note type of respiration engaged in
- e) S/Z Ratios
- f) Additional information could include glottal closure on cough or hard glottal attack if relevant.
- g) Resonance: Nasality sampling if relevant

DISCUSSION

RECOMMENDATIONS

Appendix 12 - Dysphoric Voice Report

LA TROBE COMMUNICATION CLINIC

Name:
D.O.B.:

U.R No.:

Date of assessment:
Date of report:

Student Speech Pathologist:
Supervising Speech Pathologist:

CASE HISTORY INFORMATION

Source: HCS 22 DVL Manual.

Information to be included:

Referral and Description of Voice

- Referral source (who and when)
- reasons of referral as seen by client
- cause of problem as seen by client
- impact of voice problem as seen by client
- previous episodes of voice problems
- associated symptoms/sensations. e.g. laryngeal tension
- previous ST or strategies employed by client.

Onset (if there is a problem)

- Who first noticed it and when
- circumstances of onset
- gradual vs. sudden.

Variability (if there is a problem)

- variability since onset
- circumstances surrounding changes.
- current variations in voice e.g. daily basis, morning vs night.
- rating of severity today compared with other times.

Voice Use Patterns

- past and present voice use patterns
- current hyperfunctional vocal behaviour
- voice use environment
- singing/voice/acting training

Relevant Medical Factors

- **hormone therapy etc.**
- thyroid/endocrine disorders
- medications
- surgery, trauma or cancer of head/neck/chest
- respiratory tract disorders
- gastric reflux/LPR
- Allergies
- Hearing loss
- Smoking, alcohol, recreational drugs, pollutants,

Psychosocial and Environmental Factors

- family, work, school and social relationships
- stresses in any of the above
- anxiety, depression
- client description of personality and behavioural characteristics

VOICE EVALUATION RESULTS

A perceptual evaluation of X's voice during conversation and phonatory tasks revealed a moderately low pitch for a feminine speaker...

Voice analysis using objective measures (CSL) produced the following results:

- h) Standard reading passage**
- i) Pitch glides/Scale singing**
- j) Prolonged vowel /a/**

Observational measures produced the following results

- k) Maximum phonation times for vowel /a/ ; also note type of respiration engaged in**
- l) S/Z Ratios**
- m) Additional information could include glottal closure on cough or hard glottal attack if relevant.**
- n) Resonance: Nasality sampling if relevant**
- o) Oral vs. Chest resonance**

Communicative Behaviours

Communicative behaviours were assessed informally during the session.

Prosody

X demonstrated good use of prosody during spontaneous speech

Language Behaviour (articulation, rate and vocab)

Language behaviours that are generally perceived as being more feminine communicative behaviours were informally assessed during the session. Sarah is still developing many of the typical female syntactical or semantic patterns, such as hypercorrect grammar, tag questions, confirmation words, and polite requests (Kline, 1978).

Nonverbal Behaviour

These include

Posture: e.g. Feet placed together

Vocal behaviour: e.g. feminine/masculine cough, laugh etc...

Gesture:

Eye-contact:

Facial expression:

Pragmatics:

DISCUSSION

RECOMMENDATIONS

- 1.
- 2.
- 3.

Speech Pathology student

Speech Pathologist