Report Writing for Speech–Language Pathologists and Audiologists

SECOND EDITION

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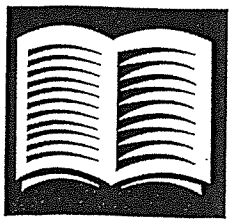
Clinical Reports



CHAPTER 2

Regardless of the professional work setting of the speech–language pathologist or audiologist (medical, public school, private practice, or community clinic), often the only communication medium reflecting a professional practice is in written reports. This may be somewhat unsettling to those who purposely chose a profession with a primary emphasis on oral communication or to those who labor at writing.

Many judge a clinician's professional/clinical competency based on written reports. Meitus (1983) feels that other "professionals will come to know and establish confidence in a clinician, in part, on the basis of what is committed to paper," and failure to write adequate reports diminishes "clinical effectiveness" (p. 290). Even minor errors in grammar and spelling may cause the reader to question the accuracy of the reported results, impressions, and recommendations (W. O. Haynes & Pindzola, 1998). R. King and Berger (1971) point out that "the efficiency of a clinic, school or agency can be evaluated by the thoroughness or lack of adequate reporting by its staff" (p. 113).

Standards for Reporting

Record keeping and the types of reports necessary to maintain a professional practice are specified in the standards (effective January 1, 1994) for Professional Service Programs Accreditation (ASHA, 1999f). The following indicators are the standards for maintaining client files:

- The program has a record keeping system for describing clinical activities, including communication about the client to and from other professionals, institutions, and programs.
- All records are organized with a consistent format and are legible, dated, and appropriately signed.
- Dated authorizations by the responsible individual (client, parent, guardian) are obtained for reports made to other professionals, institutions, and programs.
- Clinical reports contain information about the rationale, consistent with current knowledge about the disorder area, on which the clinical decision is based.
- In support of evaluation decisions regarding the diagnosis, impressions and recommendations, information about the tests and procedures used and the nature of the observations by the examiner and by other specialists are included. Consideration of the client's functional needs and cultural/linguistic environment should also be considered and included when appropriate.
- For treatment decisions, the nature of treatment procedures used and descriptions of obtained results are included based on the client's changing needs.
- Treatment plans include the type of services, frequency of the delivery of the services, and the probable duration of the speech–language pathology and audiology services without guaranteeing results.
- Clinical reports are disseminated within a specified time to appropriate persons and agencies.
- Policies and procedures for recording all clinical activities are evident.
- Screening activities are documented; hearing screening or a referral for an audiologic evaluation is included in all speech–language evaluations.
- Case records contain at least the following information:

  Client identification data

  Referral source and reason for the referral

  Pertinent information about the client such as medical records, psychological reports, educational tests, observations, and so forth.

  Name of speech–language pathologist or audiologist responsible for the evaluation

  Evaluation report(s) containing history information, summary of the examination results, and impressions and recommendations including a prognostic statement

ciples of writing. Additional resources for learning about the writing process are available (Bates & Kromas, 1993; Berke, 1995; Blum, 1984; Elbow, 1998; Hegde, 1998; Kramer, Mead, & Leggett, 1995; Strunk & White, 1999; E. H. Weiss, 1990).

Principles of Writing

According to Knepflar (1978), it is "important that a system of report writing be developed whereby reports are concise, complete, well organized, and above all, honest" (p. 118). The information from the evaluation and interview is of limited value until it has been integrated in a clear, precise, efficient, and orderly format (Emerick & Haynes, 1986). W. O. Haynes and Pindzola (1998) add that a report should be made "alive" so that those who read it have a clear understanding of what occurred during the evaluation. This requires that notes recording all behaviors, impressions, and occurrences during the evaluation be taken quickly before the memory of the examiner fades. Most clinicians follow a busy daily schedule and see numerous clients. One cannot depend on memory to keep them all straight by the end of a busy day. Video and audio recordings are helpful aids to accurate reporting. Some agencies include in each file a photograph of the client.

To write a clear, concise, complete, well-organized, efficient, honest, and "alive" report, a clinician must study and practice language usage, report composition and form, and appropriate writing style. Basic rules for report writing are provided in Table 2.1 (Knepflar, 1976). Following these rules facilitates the development of a clear, understandable, accurate, grammatically correct, and succinctly written communication. Read through the examples of violations of the rules in Table 2.1 and rewrite them following the basic rules for effective writing.

The use of appropriate terminology is important to the accurate transmission of information. Table 2.2 provides appropriate and commonly used terms to identify the person receiving services, procedures used, professional completing the evaluation, and communication problems, as well as terms with a professional tone that identify or describe history information, observations, findings, procedures, and recommendations.

Being familiar with current terminology can be a professional challenge. Terminology changes over time. So-called buzzwords or politically correct terms tend to go in and out of style. Therefore, it is important to know the current preferred terminology of the populations served. Most important, the writer should keep the "person" foremost in the language (American Psychological Association [APA], 1994; Knepflar, 1976). Table 2.3 provides a summary of preferred terminology for reference to a client presenting problems other than or in addition to speech and language.

Diagnostic terminology tends to change. For example, attention deficit disorder would have been described as "distractible, hyperactive behaviors" in the 1960s. The use of preferred terminology for reporting a client's diagnosis is imperative. Neidecker and Blosser (1993) remind the writer to avoid emotionally charged words and phrases, which tend to promote hostility, guilt, fear, or suspicion in the reader. See Tables 2.3 and 2.4 for preferred terminology in reporting a client's diagnosis and describing observed behavior. Then rewrite the sentences in Worksheet 1.

The stated diagnosis when third-party payments are involved must conform to the terms used for speech, hearing, and language disorders in the *International Classification of Diseases–Ninth Edition* (ICD–9) (U.S. Department of Health and Human Services, 1994) and by ASHA (1997b, 1997c). Conditions are described by ICD–9 codes. Procedures are described by the Current Procedural Terminology (CPT) codes used for billing speech–language pathology and audiology services to Medicare, Medicaid, and private insurers. Reimbursement may depend upon the use of terminology for diagnosis. The clinician may not necessarily feel certain terms are most appropriate, but may need to use them nonetheless because that language is preferred by insurance carriers. In addition, coding for reimbursement can be confusing because the same regulations are interpreted differently by various programs, states, or insurance providers (Iskowitz, 1999). ICD–9 classifications that commonly pertain to speech, hearing, and language disorders are listed in Table 2.5. Procedure codes for speech–language pathology and audiology are found in ASHA publications (ASHA, 1997b, 1997c).

The composition and form of a report determine the way it reads. Ideally a report follows an orderly sequence in which the reader is guided through each major element and its supporting information. The report form or format determines the report writing style. Clinicians tend to develop a preferred report format and style; however, the agency or setting in which one works may adopt a uniform format developed to accommodate the limitations in writing time and secretarial support within the agency as well as the varied purposes of the reports. The report format used in hospitals is generally very different from that of speech–language–hearing clinics or schools. Most agencies develop a standard format for arranging the specific sections of their reports to assure continuity. Most clinicians adapt to the format provided in the work setting and continue to use a personal style of writing within that format.

Students in university training programs traditionally have not been taught to write the types of reports they will need to produce in varied off-campus practicum sites because of time constraints in the university curriculum and the tendency for reporting formats in medical, clinical, and school sites to be in a constant state of revision. Changes in federal and state laws and in medical reimbursement requirements are major reasons for modifying reporting practices in the various professional settings outside the university. In fact, increased productivity standards in rehabilitation settings have created frustration among speech–language pathologists because they have limited time to write abbreviated, quickly dashed-off reports and progress notes because this time is not "billable" (Hoolsema,

Table 2.2
Commonly Used Terms in Report Writing

Terms Referring to the Person Receiving Services

client, patient, child, youngster, student, the child's first name, Mr. or Ms. followed by surname

Terms Designating Clinical Activity Completed

treatment, remediation, intervention, speech rehabilitation, assessment, examination, testing, appraisal

Terms Referring to the Person Providing the Services

the (this) clinician, the (this) speech–language pathologist or therapist, the (this) examiner

Terms Identifying the Problems with Communication

Parameters Involved	*Identifying Terminology*
speech	abnormality
communication	anomaly
articulation	defect
language	deviancy
voice	deviation
rhythm	difficulty
fluency	disorder
hearing	dysfunction, impairment, problem

Professional Terms that Identify or Describe

ability, abilities
administer, administered
appear, appears, appeared
baseline
behavior, behaviors
carry over
causal
characteristics
conduct, conducted
congenital
contingent
criterion
data
demonstrate, demonstrates, demonstrated
determine, determines, determined
etiology, etiologies, etiological
evidence, evidenced
feedback
generalize, generalizes, generalized
goal, goals
impression, impressions
improve, improves, improved
increase, increases, increased
indicate, indicates, indicated
informant, informants
judgment
nature
objective, objectives
observation
occur, occurs, occurred
onset
outlook
parameter
perform, performs, performed
performance
produce, produces, produced
production
progressive
project, projects, projected
reinforcement
report, reports, reported
respond, responds, responded
response
reveal, reveals, revealed
skill, skills
state, states, stated
status
symptom, symptoms
symptomatology
target behavior, behaviors
task, tasks
terminate, terminated
unremarkable
utterance, utterances
verbalize, verbalizes, verbalized
verbalization, verbalizations

Note. From "The Agony of Report Writing: A New Look at an Old Problem," by W. Haynes and D. Hartman, 1975, *Journal of the National Student Speech Hearing Association, 1*. Copyright 1975 by *Asha*. Reprinted with permission.

Table 2.4
Positive Terminology for Describing Behavior

Negative	Positive
laziness	can perform better when motivated
troublemaker	disturbs the class
uncooperative	needs to learn to work with others
cheats	depends on others' work
stupid	needs help
below average	is performing at own level
dirty	poor self-care habits
uninterested	complacent
must	should
stubborn	strong-willed
insolent	outspoken
liar	tends to stretch the truth
wastes time	needs to make better use of time
sloppy	needs to do neater work
failed	did not meet the requirements
nasty	has difficulty getting along with others
time and again	usually
poor work	work below usual standards
clumsy	awkward motor movements
profane	uses unacceptable language
selfish	needs to share more with others
rude	inconsiderate of feelings of others
bashful	shy; reserved
showoff	tries to get attention

Note. From *School Programs in Speech–Language: Organization and Management*, by E. Neidecker and J. Blosser, 1993, Needham Heights, MA: Allyn & Bacon. Copyright 1993 by Allyn & Bacon. Reprinted with permission.

Effect is a verb meaning to cause, make, achieve, execute, or bring about. If you can substitute the words in parentheses below and preserve the desired meaning of the sentence, then the word *effect* or *effects* is probably appropriate.

- Example: The use of easy onset phonation *effects* (*causes, makes, achieves, executes, brings about*) a positive change in phonatory quality.

The word *effect* can also be used as a noun conveying the outcome, result, or conclusion. If you can substitute the words in parentheses below and preserve the desired meaning of the sentence, then the word *effect* is probably appropriate.

- Example: A positive *effect* (*outcome, result, conclusion*) of treatment is improved social skills.

For practice using these terms, complete the exercises on Worksheet 2.

Amount and *Number*

Amount is a noun that refers to quantity, sum, whole, mass, or total.

- Example: The *amount* and extent of vagus nerve involvement described in the medical report explain the primary etiology for the client's voice disorder.

Number is a noun that refers to units that can be counted.

- Example: The *number* of correct responses increases when the words are modeled by the examiner.

The word *number* can also be used as a verb meaning enumerate, list, count, tally, compute, figure, or calculate.

- Example: The client will *number* the correct responses listed in his notebook and graph the totals at the end of each week.

For practice using these terms, complete Worksheet 3.

Anxious and *Eager*

Anxious refers to a state of distress, concern, apprehension, nervousness, or fear.

- Example: Ms. Hermosillo seems *anxious* about her child's readiness for first grade.

Eager is used to express desire, zeal, and enthusiasm.

- Example: The child is *eager* to complete all activities.

Worksheet 4 provides practice using these terms.

Can and *May*

Can implies the ability to do something.

- Example: Mrs. Moreno *can* effectively swallow thickened liquids.

May implies permission or degree of probability.

- Example: The client's swallowing difficulties *may* be related to the following factors.

For practice using these terms, complete Worksheet 5.

(text continues on p. 18)

Worksheet 1 *(Continued)*

9. Mary's laziness contributes to her poor work in the academic setting.

10. Ricardo appeared uninterested and somewhat bashful during the evaluation.

11. Bryan is a troublemaker and cheats in class.

12. Grace was defective at birth with a cleft palate, has been spoiled and tends to be selfish and rude.

13. Don is clumsy, does sloppy work, uses profanity in class, and is a really big showoff.

14. Time and again, Kay fails examinations administered in class.

15. Insolent and stubborn, Bobby Joe refuses to cooperate in the clinical setting.

Table 2.5 *(Continued)*

749.20	Cleft Lip and Palate; Unspecified	780.4	Dizziness and Giddiness
749.21	Cleft Lip and Palate; Unilateral Complete	780.5	Sleep Disturbances
749.22	Cleft Lip and Palate; Unilateral Incomplete	781	Symptoms Involving Nervous and Musculoskeletal Systems
749.23	Cleft Lip and Palate; Bilateral Complete	781.0	Abnormal Involuntary Movements
749.24	Cleft Lip and Palate; Bilateral Incomplete	781.1	Disturbances of Sensation of Smell and Taste
749.25	Other Combinations	781.2	Abnormality of Gait
750.0	Ankyloglossia	781.3	Lack of Coordination
750.10	Anomaly of Tongue; Unspecified	783.3	Feeding Problems (Elderly/Infants)
750.11	Aglossia	783.4	Failure to Thrive
750.12	Congenital Adhesions of Tongue	784.0	Headache
750.13	Fissure of Tongue	784.1	Throat Pain
750.15	Macroglossia	784.2	Swelling, Mass or Lump in Head/Neck
750.16	Microglossia	784.3	Aphasia (excludes developmental aphasia)
779.3	Feeding Disturbance (In Newborn)	784.4	Voice Disturbances; Unspecified
780.00	Alteration of Consciousness	784.41	Aphonia
780.01	Coma	784.5	Other Speech Disturbance (Dysarthria, Dysphasia; Slurred Speech)
780.02	Transient Alteration of Awareness	784.6	Other Symbolic Dysfunction; Unspecified
780.03	Persistent Vegetative State	784.61	Alexia and Dyslexia
780.09	Other (drowsiness, semicoma, unconsciousness, somnolence (sleepiness), stupor)	784.69	Other (Acalculia, Agnosia, Agraphia, Apraxia)
780.1	Hallucinations	786	Dyspnea and Respiratory Abnormalities
780.2	Syncope and Collapse (blackout, fainting, presyncope)	786.1	Congenital Laryngeal Stridor
780.3	Convulsions	787.2	Dysphagia

Note. From *International Classification of Diseases–Ninth Edition*, by U.S. Department of Health and Human Services, 1994, Washington, DC: Public Health Services and Health Care Financing Administration.

Table 2.6
Guidelines for Composing Readable Reports

1. Use simple vocabulary and natural sentence structure. Limit sentence length to 18 words or less and paragraph length to 125 words or less.
2. Delete the words *that*, *by*, *which*, *who*, and *whom*, then reconstruct the sentence without them.
3. Choose short words over long ones.
4. Write in the active voice when possible.
5. Remove qualifying adjectives such as *very*, *quite*, *much*, *rather*, *somewhat*, and *approximately*.
6. Nouns ending in *ion* should be changed to verbs. For example, "Her verbalizations were short" would be changed to, "She verbalized in short utterances."
7. Vary the length and type of sentences.
8. Make revisions, then read the report aloud while judging whether the report would make sense to others having only the report in front of them.
9. Revise further with the objectives of making the complex more simple and the unfamiliar more familiar.

Note. From "Editor's Notebook: Texas Talk," by R. Reece, 1982, *Minnesota Medicine*, *65*(12). Copyright 1982 by Minnesota Medicine. Reprinted with permission.

Worksheet 2

Use of *Affect* and *Effect*

Mark a plus (+) if the sentence is correct, a minus (−) if it is incorrect.

____ Johnny's attitude effects his performance.

____ The use of visual cues effects increased stimulability in correct articulator placement for production of lingua-alveolar consonants.

____ The parents feel that Mildred's friends negatively affect her self-image as a speaker.

____ Phyllis reports her mother's suggestions for improving fluency had a beneficial affect.

____ The positive affects of reading to preschool-aged children on their speech and language development are documented by research.

Choose the correct form of *affect* or *effect* in these sentences.

1. Myrna's regular practice sessions using reduced rate and an easy relaxed approach (affects/effects) improved fluency in conversational speech.
2. John's (affect/effect) during the fluency-enhancing exercise was flat and emotionless.
3. Feared speaking situations negatively (affect/effect) John's fluency.
4. Phonological treatment generally has a positive (affect/effect) on speech intelligibility.
5. A change in Jacob's home environment appeared to have a positive (affect/effect).
6. Joe Bubba's weak performance on the *Test of Language Development–Primary: Third Edition* appeared to be (affected/effected) by short attention and behavioral difficulties.
7. Gary's motivation to increase his fluency skills should have a positive (affect/effect) on the prognosis for his speech improvement.
8. (Affected/Effected) by the presence of her mother, Elsie was frequently distracted while taking the *Test of Language Development–Primary: Third Edition*.
9. Tom's improved fluency appears to be (affected/effected) primarily by his use of rate control and voluntary stuttering.
10. Loud sound (affects/effects) in movie theaters cause Marjorie to cry and cover her ears.

Worksheet 4

Use of *Anxious* and *Eager*

Select *anxious* or *eager* as the appropriate word to complete each of these sentences.

1. Ms. Goldman was _____ to have her child enrolled in speech and language treatment.
2. Ms. Bernstein guardedly and _____ly reported the details of her son's previous history of emotional problems.
3. Mr. Rodriguez indicated that he is _____ to begin a treatment program designed to help him cope with his stuttering.
4. Carole _____ly completed the activities and resisted leaving the room when the session was over.
5. Although she entered the clinical setting _____ly, Sophia appeared to relax and enjoy the fluency-enhancing activities as she developed confidence.
6. Ginger's mother appeared _____ when the potential benefits of enrolling the child in preschool were presented.
7. At the end of the session, Mr. Reagan appeared tired and nervous. He _____ly waited for his wife to pick him up.
8. Carlos was not _____ to complete any of the formal tests administered.
9. Despite her lack of attention and refusal to complete most activities presented, Olivia _____ly completed all of the receptive items needed to reach a ceiling score on the *Preschool Language Scale.*
10. Ms. Jackson reported that Andrew's eye–hand coordination is regressing. She is _____ to enroll him in physical therapy.
11. Mr. Hymel responds best to treatment during early afternoon sessions. During morning sessions he tends to be impatient and _____ about a variety of factors that he finds worrisome.
12. Grace appears _____ to enroll in treatment but seems _____ about the possibility of being assigned a male clinician.
13. The child's grandmother is _____ about our recommendation for the child's velopharyngeal function to be assessed by a craniofacial team. She is _____ly attempting to convince the child's parents to ignore the recommendation and seek a second opinion.
14. It appears that Janie's prognosis for improvement with treatment is good based on her cooperation in the clinical setting and Ms. Littlebear's expressed _____ness to be actively involved in the treatment process.
15. Mr. Nickel was _____ to finish the session early.

information. Other words that can be used to reduce overuse of these words include *indicated, remarked, observed, asserted, said, described, revealed, related, disclosed, added,* and *noted.*

Adequate and *adequately* and *reported* and *reportedly* are often repeated in the examination findings section of a report. Other options might include the words *sufficient* or *sufficiently; enough; competent* or *competently; appropriate* or *appropriately; acceptable* or *acceptably; satisfactory* or *satisfactorily; ample; effectual* or *effectually.*

For practice, review a diagnostic report (either from your files or in the samples provided in this book) and note the words that are used to convey *adequate* performance in the examination and the *report* of information in the history. List them, then list alternative word choices.

Redundancy and Wordiness

Following are examples of redundancy (and thus wordiness) in phrasing and ideas. Identify a word (either a new word or one of the words included in the wordy phrase) that could substitute for each phrase. Worksheet 6 provides practice in editing wordy phrases.

Wordy Phrase	Revision
may possibly	may
might possibly	might
small in size	small
normal and no complications	normal
prior or previous history	prior history
absolutely essential	essential
future plans	plans
various different	different
spell out in detail	describe
qualified expert	expert
advanced planning	preparation
each and every	each; every
at this point in time	currently
certainly inappropriate	inappropriate
totally involved	involved
successfully produced	produced
the true fact	the fact
several different types	several types; different types
as of yet	(omit entirely)
far and above	exceed; surpass

One simple rule facilitates clarity: When a single word will effectively convey the intended meaning, use it. Of course there are exceptions. The intent of the clinician and the language in common professional use must also be considered. Table 2.7 provides examples of simple words that can be substituted for more complex ones.

Transition

Transitional phrases facilitate the smooth flow of sentences and paragraphs. There is a tendency to overuse certain transitional phrases and connectives. Table 2.8 provides some alternatives for transitions that lend variety and decrease repetition.

Of course, sometimes simple, overused words are replaced with more complex or longer words. However, in the interest of creating a readable report, it is sometimes advisable to sacrifice simplicity for smooth transition. Review a diagnostic report and note where transitional phrases and words could be placed for variety and ease of reading.

Use of Pronouns

If the writer has mentioned more than one person before using a pronoun to refer to one of them, confusion is certain to result. Sometimes pronouns are placed too far from the noun they relate to, causing the pronoun to drift. In any case, the noun should be restated.

In the following example, clarity suffers because of pronoun misuse and wordiness.

> ▶ **History:** Ms. Garcia described her pregnancy with Dawn as being normal with no complicating factors. However, one week following her birth, Ms. Garcia had occasion to be hospitalized due to a uterine infection. She was cared for by her father during this particular time.

The example might be rewritten as follows:

> ▶ **History:** Ms. Garcia's pregnancy with Dawn was unremarkable. One week following her birth, Dawn was cared for by her father while Ms. Garcia was hospitalized for a uterine infection.

During editing, the writer might decide that Dawn's caretaker during her mother's hospitalization was not relevant and delete reference to it.

There is disagreement about the use of personal pronouns in report writing. W. O. Haynes and Pindzola (1998) believe that personal pronouns should be avoided; in other words that "it is preferable to keep the 'I' out of it" because an impersonal writing style minimizes "the writer's verbal idiosyncrasies" and also tends to facilitate objectivity (p. 411). They recommend that reference be made to the "examiner" or the "clinician" to maintain a more impersonal style. Knepflar (1976), on the other hand, maintains that personal pronouns should be used when they are the natural way to make a clear statement, and that to avoid using personal pronouns can give the impression

Table 2.7
Word Pairs: Simple and Complex

Simple	Complex
advanced	sophisticated, progressive
after	following, beyond
answer	reply, respond
begin or start	commence, initiate, originate
do	accomplish, achieve, execute, perform, effect, complete
end	terminate, finish, complete, conclude, discontinue
enough	sufficient, plenty, adequate, ample, abundant
expect	anticipate, await, foresee, envision, require, assume
find	locate, detect, discover, recover, retrieve, determine
get	acquire, obtain, secure, procure
happen or occur	transpire, ensue, take place
help	assist, serve, facilitate, improve
hopeful	optimistic, encouraging, promising
keep	retain, reserve, maintain
know	realize, comprehend, discern, understand, perceive
later	subsequently, afterward, consequently, following
live	reside, dwell
met	encountered
more	greater
much	substantial, abundant, ample, considerable
new	sophisticated, innovative, inventive, current
on	upon
say	remark, state, articulate, speak, express, relate, declare
seem	appear
send	transmit, direct, refer, route, relay
show	demonstrate, exhibit, reveal, display, perform, present
so	thus
try	endeavor, attempt, undertake, venture
use	operate, manipulate, utilize, employ, expend, consume

that the writer is not willing to take responsibility. Somewhere between these views, Peterson and Marquardt (1994) indicated that an impersonal and relatively formal tone should be maintained in reporting, although personal pronouns should be used when they are the most appropriate way to make a clear statement.

Avoiding personal pronouns promotes use of the passive style of sentence construction. Some believe that active sentence construction should be used whenever possible, while passive forms should be avoided (APA, 1994; Meitus, 1983). Thus, the writer must decide whether to use personal pronouns in report writing. The purpose and recipients of the report, along with the usual style preferred by the agency, will influence the writer's decision. Most important, the writer should be consistent in the use of personal pronouns and active or passive voice within sections of a single report.

Style: Common Errors

Style is improved by consistency in voice and tense and in spelling, punctuation, sentence structure, and expression of numbers. Use of folksy or cute phrasing quickly reduces the level of professionalism conveyed by the report. Following are exercises to provide the clinician with practice in editing reports to improve style.

Consistency in Voice and Tense

Active voice is more direct and livelier to read. Passive voice is justified if the actor is less important than what is acted upon. Consistent use of the past tense usually is appropriate in the history section of a report. However, consistent use of the present tense is appropriate when describing the performance at the time of the assessment along with the impressions and recommendations.

- **History example:** It is reported by Ms. Espinoza that Albert's speech and language development is slower than that of his older brother.
- **Edited version:** Ms. Espinoza reported that Albert's speech and language development was slower than that of his older brother.
- **Examination example:** Debra's receptive language abilities were revealed by her performance at the 3-year, 6-month level on the *OWLS Listening Comprehension Scale*.
- **Edited version:** Debra's performance on the *OWLS Listening Comprehension Scale* places her at the 3½ year level in receptive language.
- **Impressions example:** Marcie was diagnosed as being a severe stutterer characterized by struggle behaviors, part-word repetitions, and whole-word repetitions. I think her prognosis for improvement with treatment is good because she has a positive attitude and can modify her speech.

- **Edited version:** Marcie presents a severe stuttering disorder characterized by struggle behaviors and part- and whole-word repetitions. Prognosis for improvement with treatment appears good based on her positive attitude and ability to modify her speech with instruction.

- **Recommendations example:** I recommend that Ms. Pisell's larynx be evaluated by an otolaryngologist before she begins vocal health instruction.

- **Edited version:** Ms. Pisell should be seen by an otolaryngologist for a laryngeal examination. Based on the results of that evaluation, she may be a good candidate for vocal health instruction.

Elimination of Folksy or Colloquial Phrasing

The writer should weigh carefully whether to use the words *rather, very, little, pretty,* and *some*. Usually they can be deleted. Phrases like *bored to death, pretty cooperative, very tired, way past, not too long ago, pretty well, rather anxious, a little feverish,* and *some candy* (as reinforcers) are examples of folksy or colloquial phrases that have been included in diagnostic reports. Every writer must maintain vigilance in editing such phrases from reports and other professional correspondence.

Consistency in Spelling

Some words have two accepted spellings (e.g., *cuing* or *cueing*). One selected spelling must be used consistently throughout the report.

Proofreading carefully for typographical errors is essential. Some editors read the text backwards to locate misspelled words. A spell checking feature on word processing software is helpful, but one must remember that if *two* is spelled *to* or *too*, the spell check will not pick it up because all those words are spelled correctly. Reading the text aloud, proofreading by peers or supervisors dedicated to protecting confidentiality, and setting the report aside for 24 hours and then rereading it are other strategies some find helpful in locating errors.

Some adjectives may be used differently depending on *–ic* or *–ical* endings. The American Medical Association Press (Fishbein, 1950) has adopted a list of preferred endings. See Table 2.9 for a list of adjectives that appear most often in the reports of speech–language pathologists and audiologists.

Consistency with Numbers

Numbers one through nine should be written out as words unless the number is a unit of measure, such as a time, date, age, page number, percentage, unit of money, test score, or score on a scale. Numbers 10 and above should be expressed as figures. If a number lower than10 appears in the same sentence for comparison with a number 10 or above, then it is expressed as a figure. The following are sentences that need editing for number use:

- **Example:** Judy walked at nine months, said her first word at eighteen months, and appropriately used two-word phrases at 2 years.

- **Edited version:** Judy walked at 9 months, said her first word at 18 months, and appropriately used two-word phrases at 2 years. (The edited version shows consistent use of figures to designate age.)

- **Example:** On the *Assessment of Phonological Processes–Revised,* Sergio omitted syllables five percent of the possible occurrences, reduced consonant sequences 55 percent of the possible occurrences, omitted prevocalic consonant singletons five percent of the possible occurrences, produced no stridents or liquid [l] and [r] phonemes, and produced velar obstruents fifty-nine percent of the possible occurrences and glides thirty percent of the possible occurrences.

- **Edited version:** Sergio's responses to the *Assessment of Phonological Processes–Revised* provides a phonological analysis of his production of 50 selected words. Of the possible number of occurrences on the assessment, Sergio's percentage of usage of the phonological processes is as follows: Omission of Syllables (5%); Reduction of Consonant Sequences (55%); Omission of Prevocalic Consonant Singletons (5%); Production of Velar Obstruents (59%); and Production of Glides (30%). Sergio produced no strident or liquid [l] or [r] patterns. (All percentages are in figures.)

Consistency in Punctuation

Writers often find quotations and phrases within parentheses difficult to punctuate. Confusion usually lies in placement of punctuation inside or outside quotation marks or parentheses. Commas and periods are placed inside quotation marks unless a parenthetical reference is included. Parentheses enclose matter apart from the main thought.

- **Example without parentheses:** Jasper's speech is characterized by the use of structurally incomplete utterances that convey complete thoughts. Following is a short segment of the sample: "Boy go no bye bye." "We see doggie." "I no see bear." "We like nice doggie."

- Example with parentheses: Javier responded to pictures with one-word utterances (e.g., "Mommy," "baby," "kitty," and "door").

Parentheses are used to provide explanatory information. The punctuation is enclosed by the parentheses if the statement is complete. (A complete sentence is completely enclosed by parentheses.) The punctuation follows the closing parenthesis if the parenthetical word or phrase lies within the statement (including the end of the sentence). Parentheses are confusing (even for the most experienced writer).

Parallel Sentence Structure

Parallel sentence structure is often lacking in the recommendations section of a report.

- Example of poor parallel structure: *Recommendations*—Jeanie should be enrolled in voice treatment emphasizing the following:
  1. To improve her vocal habits;
  2. Provide information on the relationship between vocal habits and the condition of the vocal folds; and
  3. She will become more informed on the anatomy and physiology of the vocal mechanism.

- Edited version: *Recommendations*—Jeanie should be enrolled in voice treatment with objectives focused on her
  1. heightened awareness of the relationship between vocal fold condition and vocal habits;
  2. expanded understanding of basic anatomy and physiology of the vocal mechanism; and
  3. increased use of good vocal habits.

There are several other options for rewriting these recommendations using parallel structure. How would you have rewritten the section?

Writing style is individual. The task is to use precise words to convey intended meaning, avoid ambiguity, and present ideas in statements that are orderly, economical, and smooth. For some, writing is a pleasant challenge. For others who are long in ideas and short in patience, writing is tiresome, difficult, and irksome. In the clinical setting, those who dislike writing may delay report writing, placing the program out of compliance with quality-assurance criteria required for program accreditation. Programs accredited by the Professional Services Board (ASHA, 1999f) must have evidence that their policies ensure timely preparation and dissemination of reports.

Writing Reports

Planning, Preparing, and Writing the First Draft

Clinicians often procrastinate in starting a diagnostic report. Reports are easiest to write just after seeing the client. Table 2.10 outlines the steps in the diagnostic report writing process. In practice, time constraints demand skipping some of the steps, often at the expense of thoroughness in that relevant information may be omitted. For some clients omitted information may be negligible, but for others (such as clients with swallowing difficulties, progressive neurological diseases, seizure-related behaviors, etc.) omitted information could result in serious consequences. Beginning report writers should develop their skills by following all the steps in the report writing process.

It is best to begin with an outline. An outline provides a plan for the report, helps ensure clarity and consistency, breaks the report into manageable units, and helps the writer see the sequence of the report from beginning to end (Bates & Kromas, 1993; Heineman & Willis, 1988; Markman, Markman, & Waddell, 1994; Theriault, 1971). Flower (1984) cautions that an outline should be adapted in accordance with the specific purposes of each report, the setting in which it is used, and the intended readers.

Once the outline is complete, the writer begins by putting the information on paper as quickly as possible; the preliminary draft is completely written before any rewriting begins. W. O. Haynes and Pindzola (1998) suggest that when the writer meets barriers, it is best to jump over them and continue with the rest of the report. The blank spots can be completed later. Necessary revisions can also be made later. It may be helpful to make notes in the margins regarding problem areas that need to be addressed. Writers who are skillful at word processing save time during the writing and revision phases of completing a report.

It is sometimes appropriate to complete specific units of the report and assemble them later. If team members of several disciplines are contributing to the report, some of the material may need to be rearranged before the draft is completed. The integrated diagnostic report is discussed later in this chapter.

When writing a clinical report, it is essential to "emphasize new information; avoid overquantification; emphasize conclusions and recommendations rather than raw data; offer recommendations, not prescriptions; and write for a specific readership" (Flower, 1984, p. 111).

Darley (1978a) emphasizes the importance of never reporting information that is critical of other professionals or agencies, or of reporting information that has been revealed in confidence.

Quotations can be informative to readers of clinical and research reports. If it is necessary to quote a parent's or client's own words, enclose them in quotation marks. Indicate omitted words by ellipses (. . .). If words must be added, enclose

Report Format

Nation and Aram (1977) believe that "clinical report writing should follow . . . the steps of the diagnostic process" (p. 330). According to Pannbacker (1975), a diagnostic report should be organized for easy retrieval of information. It also should reflect accuracy, completeness, clearness, conciseness, and prompt preparation (W. O. Haynes & Pindzola, 1998).

Using a standard format has several advantages: (a) it requires less time to write the report; (b) it helps ensure that all staff report similar information; and (c) it helps facilitate retrieval of information (Flower, 1984). Use of a standard format also may help new clinicians become familiar with the information contained in diagnostic reports. In some instances, it may be possible to use an abbreviated format designed for specific program needs.

According to Knepflar (1978), a weakness of some reports is that they provide information only about the major problems, and say nothing about other aspects of communication. If information is reported about each aspect of communication, the report serves as a baseline measure. It also helps to ensure that important information is not omitted.

Use of Sample Reports

There are many ways to learn to write reports. According to Meitus (1983), one way to learn report writing is to "read many samples of reports written by experienced professionals" (p. 297). It is helpful to have sample reports available for students, who can read the good reports and practice rewriting the poor ones.

The style and format of the report vary based on the specific purpose of the report, the setting in which the clinician works, the referral source, and the policies of particular facilities regarding report writing (Nation & Aram, 1977). Knepflar (1976) described several approaches to "tailor" reports to the needs of specific readers. Hanson (1979) indicated that if the report is carefully planned and written, it may provide necessary information for several reviewers.

Several sample reports representing different types and formats are provided in the appendixes. Complete reports on all disorders and all possible combinations are not reproduced because of space limitations. Other examples of reports and case studies are in texts readily available to speech–language pathologists (Blischak & Ho, 2000; Dalston, 1983; Dworkin & Hartman, 1988; Dworkin & Meleca, 1997; Hegde & Davis, 1995; Helm-Estabrooks & Aten, 1989; Lund & Duchan, 1988; Meitus, 1983; Middleton & Pannbacker, 1997; R. Miller & Groher, 1990; Nation & Aram, 1977; Shipley & McAfee, 1992; Stemple, 1993). Writers should review sample reports from a variety of other sources, including the facility in which they work.

The reevaluation report is written somewhat differently from the initial evaluation report. The date of previous evaluations should always be indicated in the reevaluation report, along with a brief discussion of initial evaluation findings and recommendations. History information should be updated at the time of the reevaluation. An example of a letter that may be used to request additional information from another agency or professional is provided in Chapter 4, Figure 4.2.

Current test results should be compared to the results of previous evaluations. Impressions and recommendations are based on all available information. The procedures for reevaluation are of particular interest to school speech–language pathologists, who must provide annual reviews of student progress.

The final step in the diagnostic report process is follow-up. The clinician must assure all paperwork and recordkeeping have been completed. Follow-up may be needed to determine whether the intended recipients received the report, whether the receiver understood or had questions about the contents, and whether the client has been seen for additional testing or is receiving treatment (W. O. Haynes & Pindzola, 1998). To avoid confusion, a letter like the one in Chapter 4, Figure 4.1, might accompany a report sent to the individual or facility that referred the client.

Types of Reports

A variety of diagnostic report formats have been utilized. It may be appropriate to use a general format, keeping in mind that reports vary based on the facility requirements and the intended receivers. Figure 2.1 provides an example of a standard (traditional) diagnostic report format that may be adapted to meet a variety of needs. A worksheet for following this format is provided in Figure 2.2. Sample standard reports are provided in Appendix A.

Facility-Based Formats

The Problem Oriented Medical Report (POMR) or Problem Oriented Report (POR) was originally designed for medicine but has been adopted for use by other health-care professionals, including speech–language pathologists. The POR system is based on a problem-solving process. It consists of (a) the database, (b) problem list, (c) plans, and (d) follow-up notes.

The database is a comprehensive compilation of initial information about an individual and the services received. It includes data about the individual's history, present problems, present life situation, results of previous speech–language evaluations, treatment notes, reports from other professionals or facilities, and correspondence (Bouchard & Shane, 1977; L. Kent & Chabon, 1980; Kettenbach, 1990; Peterson & Marquardt, 1994). Problems are identified, listed, and numbered. The resulting list serves as a table of contents and includes initial plans for treatment as well as a rationale for further evaluation (when appropriate), treatment plans, and client and family education.

Sample Report Format Worksheet

Date: _____

Name: _____ Birthdate: _____ Chronological Age: _____

Parent(s): _____

Address: _____

Telephone: _____ Date of Evaluation: _____

File Number: _____

Speech and Language Evaluation

Statement of the Problem: _____

_____

History: _____

_____

Examination: _____

_____

Impressions: _____

_____

_____

Recommendations: _____

_____

_____

Signature(s) (Include Name, Title, ASHA Certification and State License)

_____

_____

_____

Figure 2.2. Worksheet for traditional or general report format.

Treatment plans should include long-term and short-term goals as well as statements about prognosis, and should specify the amount, frequency, and direction of treatment (ASHA, 1999f). The plans may be presented in outline or narrative form.

Client records should indicate when treatment plans were discussed with the client and family, and when conferences were held with other professionals to discuss treatment. Recommendations from the conferences should be included. Discharge recommendations and follow-up referral recommendations made to the client also should be noted in the client's record. According to ASHA's Professional Services Board (1999f), treatment reports should contain (a) the time period covered by the report, (b) the number and length of sessions, (c) the diagnostic summary, (d) the summary of the treatment plan, (e) the summary of the client's responses to the treatment plan, (f) the current client status, (g) the conclusions and recommendations, and (h) the signature and title of the qualified speech–language pathologist or audiologist who is responsible for the service.

Information about treatment is included in the POMR/POR and SOAP formats. Cornett and Chabon (1988) described a flowchart format for treatment plans. The flowchart provides in a table format the objectives written in behavioral terms, procedures or techniques including the reinforcement method used to achieve each objective, and a written record of the results including stimulus items and the client's responses. Tonkovich (1989) described a format for using ASHA's Functional Communication Measures (FCM) in diagnostic reporting and treatment planning. The FCM format (a) improves time efficiency and cost effectiveness; (b) eliminates unnecessary details in reporting; (c) establishes uniformity in data collection and diagnostic nomenclature; (d) facilitates computer generation of reports; and (e) enables monitoring of quality assurance outcome indicators (Frattali & Lynch, 1989; Larkins, 1987). Nova Care (1989) also developed a format for functional outcome. The reporting of functional outcome is further discussed in Chapter 3. Examples of treatment plans are provided in Appendix D.

Individualized Education Programs (IEPs)

The Education for All Handicapped Children Act of 1975 (EHA) addresses education for children from 3 to 21 years of age. The Education of the Handicapped Act Amendments of 1986 (P.L. 99-457) ensured services for preschool children and created a comprehensive program for infants and toddlers (0–3 years) with disabilities. In 1990, EHA was renamed the Individuals with Disabilities Education Act (IDEA) (P.L. 101-476). Referred to as Part H, The Infant and Toddlers with Disabilities program, IDEA was amended again in 1991 to P.L. 102-119 (Myers-Jennings, 2000). These children must be identified, assessed, and educated in the most appropriate environment for each child's specific needs and abilities. The document that summarizes and correlates all of this information is termed an Individualized Education Program (IEP).

The IEP is a child-centered plan developed by the child's teachers, school administrators, remedial specialists, and parents. W. O. Haynes and Pindzola (1998) state that the IEP should respond to very specific questions: (a) What is the problem? (b) Where is the child functioning now? (c) Who will do what with the child and how often? (d) When and how is progress to be measured? Cornett and Chabon (1988) provide a checklist to assess and document the appropriateness of the IEP relative to legal requirements (includes all information required by law), relevance (objectives appropriate for student's diagnosis), manageability (reasonable criteria for time allotted to treatment), and clarity (comprehendible terminology and readily understandable outcome criteria).

Current practices provide that speech–language services be provided in a collaborative style in more inclusive educational settings such as classrooms. In addition, the treatment objectives are combined with the educational curriculum to make treatment objectives more relevant and functional to the child's daily living. In addition, the child's progress must be regularly reported. Reports must provide a description of the child's current level of performance along with a list of measurable annual treatment goals. Progress reports must be sent as often as indicators of educational progress are sent to parents of nondisabled children. Thus, progress reports are sent with report cards at the end of every reporting period. These regulations are required by the Individuals with Disabilities Education Act (IDEA) (U.S. Department of Education, 1999).

The specific format varies among school districts or state education agencies and it can range from simple to complex. Many school districts have simplified the procedure by using computer-generated formats that retain individuality of assessment and treatment plans but are more efficient than handwritten forms (Krueger, 1985). Nelson (1988) provides detailed individualized speech and language intervention programs for infants, children, and adolescents presenting a variety of disorders that are in accordance with EHA. Samples of IEPs are provided in Appendix E.

Some school-based speech–language pathologists also prepares the Individualized Family Service Plan (IFSP). The IFSP involves the assessment of the family as well as the child or student. Included in the IFSP report are (a) the child's current levels of development, such as cognitive, motor, speech, language, hearing, self-help, social, and behavioral; (b) the strengths and needs of the family in facilitating the child's development; (c) the expected outcomes for the child and the family; (d) the criteria and timelines for measuring progress; (e) the services needed to meet the needs of the child and family including their type and frequency; (f) the date treatment will begin and an estimated time period for the duration

- Summary of treatment plan
- Number and length of treatment sessions
- Expected date for termination of service
- Discharge plan(s) including recommendations for whatever continued services and follow-ups are needed (Cornet & Chabon, 1988; Flower, 1984; Hegde & Davis, 1988; Kittenback, 1990)

Discharge reports should begin with a concise history of relevant services prior to the initiation of current treatment services (Flower, 1984). Next, the report should include speech, language, and hearing problems at the beginning of treatment. Finally, there should be specific discharge plans. If the problem-oriented medical record format is used, a discharge plan should be developed for each problem listed (Bouchard & Shane, 1977). Discharge reports usually should be sent to the original referral source, so the need for further services can be determined. Specific forms for discharge planning and follow-up can be found in Cornet and Chabon (1988).

Summary

Well-written evaluation reports are essential to speech–language pathology and audiology. Information gained from the evaluation is of little value until it has been documented in some usable form. In order to achieve a well written report, the clinician should follow the rules of writing through careful study of appropriate language usage, composition, form, and style.

Familiarity with the report writing process is essential to executing a well-written report. Steps involved in this process include planning, preparing, and writing the first draft; revising and refining the draft; and proofreading the final copy. Knowledge of a standard report format and study of sample reports are helpful in building report writing skills. The report process does not end with the signing of the initial report; follow-up and review are ongoing tasks and include reevaluation reports and a tracking process to assure that all paperwork has been completed within prescribed timelines.

There are several types of clinical reports: the traditional or standard report, Problem Oriented Medical Reports or Problem Oriented Reports, SOAP format, integrated diagnostic reports, treatment plans and reports, Individualized Education Programs, and progress reports. The format for reports is generally dictated by the work site. Regardless of format, all reports should provide objective and subjective data about assessment and treatment. Attention to clinical reports is important because they form the foundation for clinical services and establish the professional reputation of the clinician.

Exercises

1. In a brief essay, identify and describe the kinds of professional writing that you expect to do. To whom will you be writing (colleagues, supervisors, clients, etc.)?

2. Why should simple, straightforward language be used when writing a diagnostic report?

3. Why are written reports essential to effective clinical practice?

4. Identify major barriers to effective report writing.