



**University of Vermont Graduate Writing Center**  
**Communication Sciences and Disorders Clinical Documentation:**  
**Writing a Diagnostic Report**

***Sections of a Diagnostic Report and General Tips***

**Background**

- The background section should be carefully organized to keep similar types of information together.
- Include general information including age, location, school attended, other family members, hobbies, and strengths.
- Describe the client's birth, medical history, and history of speech, language, or other medical services.
- Information should be obtained from the case history report and other supporting documentation gathered before the appointment. Do not include information obtained from the family interview.
- Be specific and note who provided the information.
- Define all abbreviations and technical terminology.

Example #1

*Needs improvement:* "Xx had PE tubes inserted in 20XX.... He began receiving speech therapy in kindergarten."

*Better:* "Xx had Pressure Equalization (PE) tubes inserted in both ears in 20XX according to his primary care physician.... Xx's mother reported that he began receiving speech therapy in kindergarten."

**Non-Standardized Assessments**

- Includes observations, family/client interview, speech/language samples, oral mechanism exam, hearing screening, and any other assessment method that is not standardized.
- Include a brief description of each assessment method and what it measures.
- Be specific!
- Avoid descriptive phrases that may alarm clients/family members or sound stigmatizing (e.g., "abnormal", "deficient") or phrases that are not sufficiently objective.

Example #2

*Needs improvement:* "Xx made several abnormal movements of his lips before performing voluntary movements. However, strength and range of motion were typical."

*Better:* "Xx's lips were observed to tremble before performing voluntary movements such as puckering (i.e., kissing motion) and retracting (i.e., smiling). However, strength and range of motion were within functional limits."

**Client/Family Interview**

- This section summarizes the client/family responses to the questions on your diagnostic planning sheet. Use the responses to build a narrative.

- Because the information should tell a story, it does not have to be in the same order you asked the questions.
- Use direct quotations from the client/family member whenever appropriate. Make sure to use quotation marks for any direct quotes.

### **Standardized Assessments**

- Think of the “assessment” sections as the O of a SOAP note. Only include objective data, not diagnoses or impressions.
- Underline all standardized assessments.
- Include a brief description of each assessment method and what it measures.
- Explain the significance of test scores in relation to the mean and what constitutes the average range.
- Use tables to report test results. Include standard scores, subtest scores, and the expected ranges based on similarly aged clients.
- All normed ranges and values need to be cited both in-text and in a separate References section at the end of the report.

#### Example #3

*Needs improvement:* “Xx’s Standard Score on the GFTA-3 was 70. This means that Xx has a speech sound disorder and should continue to receive therapy.”

*Better:* “Xx’s Standard Score on the GFTA-3 was 70. This score is two standard deviations (i.e., a measure of the amount of variation of a set of values) from the test mean of 100 and below the average range of 85-115.”

### **Summary/interpretations**

- Think of the summary as the A of a SOAP note. What do the data indicate and why?
- The beginning of this section includes reiterating the first sentence in the background section and adding a diagnosis.
- Based on the diagnosis, summarize the data that supports that diagnosis.
- Include information on what may be done to help the client.

#### Example #4

“Xx is a six year and five-month-old male who presents with a phonological disorder. The results of the GFTA-3, family interview, and speech sample all confirm this diagnosis.... Based on today’s evaluation, Xx may benefit from additional speech therapy to increase his intelligibility and improve his phonological awareness.”

### **Prognosis**

- Try not to use overly optimistic or pessimistic terminology:
  - use “guarded” instead of “poor”
  - do not use “excellent” unless you really believe the prognosis is excellent
  - use “good” if you think some progress can be made.

*Note: This format follows the guidelines established by the University of Vermont Eleanor M. Luse Center as described in the Diagnostic Report template found in the CSD clinic manual. Formats may differ depending on the setting and institution. Please ask your off-campus placement supervisors for guidelines and tips specific to your placement.*