

Pediatric SLP evaluation report outline

Original initial / re-evaluation write-up fields; the SLP selects the assessment.

therapycrm.io

1. Question, priorities and context

Initial / re-evaluation	Prior report / plan version
Reason / referral question and child-family priorities	
Relevant intake reference / history source / date	
Languages / dialects / modes / partners / settings	
Interpreter or other contributor role; access needs	
Domains selected by SLP; areas not assessed	
Record the question, sources and unknowns. This outline supplies no test items, diagnostic decisions or prescribed service frequency.	

2. Assessment evidence ledger

Methods / approved source record references

Procedural changes / access / response supports / validity limits

Observed evidence and source

Method / context	Unit / count / denominator	Supports / modifications	Source / date / limits

Functional strengths / participation description

Information still needed; conflicting or reported findings

State whether a sample is in words, sounds, opportunities or utterances. Do not assume one language or context represents all communication.

3. SLP reasoning, discussion and review

SLP interpretation linked to recorded evidence

Limits / unassessed areas / comparison with prior report

Child-family discussion, questions and understanding

Clinician-selected next steps and responsible person

Review date / sharing scope / current plan reference

Author / credentials / signature / date under clinic process

A progress update is not automatically a re-evaluation. Any score interpretation, diagnosis and plan decision remains with the evaluating SLP.