

**Attachment C**  
**SIHO Speech Therapy Re-Certification Request**

Patient Name _____	Member ID # _____	Date: _____
Facility _____	Therapist _____	
Diagnosis _____	ICD 9 Code _____	
Date of Injury/Trauma/Surgery _____		
Date of First Visit _____	Total Visits to Date _____	Projected Visits to Complete _____

**Initial Deficiencies (only fill in relevant deficiencies, but be specific):**

- |          |          |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

**Treatment to Date (list in probable order of importance):**

- |          |   |
|----------|---|
| 1. _____ | 4. _____  |
| 2. _____ | 5. _____  |
| 3. _____ | Home Exercise Program: Yes <input type="checkbox"/> No <input type="checkbox"/> |

Brief Description (HEP): \_\_\_\_\_

**Change to Date in Deficiencies (use same as above):** Has progress slowed?: Yes  No

- |          |          |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

**Goals (be specific, but write "none" if none set):**

Patient's \_\_\_\_\_

Practitioner's \_\_\_\_\_

Therapist's \_\_\_\_\_

**Patient Compliance (check box):** Excellent  Adequate  Poor

If poor, in what regards? \_\_\_\_\_

\_\_\_\_\_  
Therapist Signature                      Date

\_\_\_\_\_  
Practitioner Signature                      Date