

## SIHO Speech Therapy Treatment Plan for Certification

Patient Name: _____	Date: _____	
Member ID# _____	Evaluation Date: _____	
Facility: _____	Therapist: _____	
Ordering Doctor: _____	Age: _____	Developmental Age: _____
Date of Injury/Trauma/Surgery: _____	# Visits Used To Date: _____	

**Background Information: (Include Diagnosis and ICD 9 Code)**

**Functional Limitations:**

**Short Term Goals (One Month):**

**Treatment Plan:** If treatment involves casts, splints or assistive devices please indicate.

**Frequency and Duration:**

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

\_\_\_\_\_  
Date