Speech Language Therapy Self Assessment

Directions

Please circle a value for each question to provide us and the interested facilities with an assessment of your clinical experience. These values confirm your strengths within your specialty and assist the facility in the selection process of the healthcare professionals.

Frequency	Experience
1 Observed Only or Never Done	1 No Experience
2 Rarely Done (<6 times/year)	2 Some Experience (Requires Assistance)
3 Occasionally Done (1-2 times/month)	3 Experienced (Performs without Assistance)
4 Frequently Done (daily or weekly)	4 Very Experienced (Performs Well)

Print Name　　　　SS#　　　　Date

General Skills	Frequency	Experience
Patient/Family Teaching	1 2 3 4	1 2 3 4
Patients in Isolation	1 2 3 4	1 2 3 4
Patients in Restraints	1 2 3 4	1 2 3 4
Electronic Documentation	1 2 3 4	1 2 3 4

Patient Populations	Frequency	Experience
TIA	1 2 3 4	1 2 3 4
Learning Disabilities	1 2 3 4	1 2 3 4
Progressive Neurologic Disease	1 2 3 4	1 2 3 4
Traumatic Brain Injury	1 2 3 4	1 2 3 4
Hearing Impaired	1 2 3 4	1 2 3 4
Trachs/ Ventilators	1 2 3 4	1 2 3 4
Pediatrics/ School Age	1 2 3 4	1 2 3 4
Geriatrics	1 2 3 4	1 2 3 4
Voice/ Laryngectomy	1 2 3 4	1 2 3 4

Assessment Tools	Frequency	Experience
Porch Index of Communicative Abilities	1 2 3 4	1 2 3 4
Minnesota Test for Differential Diagnosis of Aphasia	1 2 3 4	1 2 3 4
Boston Diagnostic Aphasia Examination	1 2 3 4	1 2 3 4
Boston Assessment of Severe Aphasia	1 2 3 4	1 2 3 4
Ross Information Processing Assessment- Geriatric	1 2 3 4	1 2 3 4
Western Aphasia Battery	1 2 3 4	1 2 3 4
Rehab Institute of Chicago Evaluation of Communication	1 2 3 4	1 2 3 4
Reading Comprehension Battery for Aphasia	1 2 3 4	1 2 3 4
Bedside Swallow Evaluation	1 2 3 4	1 2 3 4
Modified Barium Swallow Study	1 2 3 4	1 2 3 4
Fiber Endoscopic Evaluation Study (F.E.E.S.)	1 2 3 4	1 2 3 4
Cervical Auscultation	1 2 3 4	1 2 3 4
Pure Tone Screening	1 2 3 4	1 2 3 4
Augmentative Devices	1 2 3 4	1 2 3 4
Blue Dye Test	1 2 3 4	1 2 3 4
Informal Testing	1 2 3 4	1 2 3 4

©2006 Cross Country Healthcare, Inc.

Initials ________

Frequency	Experience
1 Observed Only or Never Done	1 No Experience
2 Rarely Done (<6 times/year)	2 Some Experience (Requires Assistance)
3 Occasionally Done (1-2 times/month)	3 Experienced (Performs without Assistance)
4 Frequently Done (daily or weekly)	4 Very Experienced (Performs Well)

Types of Disorders	Frequency				Experience			
Aphasia	1	2	3	4	1	2	3	4
Apraxia	1	2	3	4	1	2	3	4
Dysarthria	1	2	3	4	1	2	3	4
Hearing Loss	1	2	3	4	1	2	3	4
Dysphagia	1	2	3	4	1	2	3	4
Autism	1	2	3	4	1	2	3	4
Learning Disabilities	1	2	3	4	1	2	3	4
Dementia/ Alzheimers	1	2	3	4	1	2	3	4
Cleft Palate	1	2	3	4	1	2	3	4
Fluency	1	2	3	4	1	2	3	4
Traumatic Brain Injury	1	2	3	4	1	2	3	4
CVA/stroke	1	2	3	4	1	2	3	4
Other (specify)	1	2	3	4	1	2	3	4

Treatment	Frequency				Experience			
Individual	1	2	3	4	1	2	3	4
Group	1	2	3	4	1	2	3	4
Co-Treatment	1	2	3	4	1	2	3	4
Community Re-entry	1	2	3	4	1	2	3	4
Augmentative Devices	1	2	3	4	1	2	3	4
Vital Stimulation	1	2	3	4	1	2	3	4
Cognitive Training	1	2	3	4	1	2	3	4
Safety Awareness	1	2	3	4	1	2	3	4
Dysphagia	1	2	3	4	1	2	3	4
Total Communication	1	2	3	4	1	2	3	4
Computer	1	2	3	4	1	2	3	4
Behavior Modification	1	2	3	4	1	2	3	4
Other (specify)	1	2	3	4	1	2	3	4

Regulations	Frequency				Experience			
Omnibus Budget Reconciliation Act	1	2	3	4	1	2	3	4
Act	1	2	3	4	1	2	3	4
Medicare	1	2	3	4	1	2	3	4
Medi-Cal	1	2	3	4	1	2	3	4
FIMS	1	2	3	4	1	2	3	4
RUG Levels	1	2	3	4	1	2	3	4

©2006 Cross Country Healthcare, Inc.

Initials ________

Frequency	Experience
1 Observed Only or Never Done	1 No Experience
2 Rarely Done (<6 times/year)	2 Some Experience (Requires Assistance)
3 Occasionally Done (1-2 times/month)	3 Experienced (Performs without Assistance)
4 Frequently Done (daily or weekly)	4 Very Experienced (Performs Well)

Settings	Frequency	Experience
Acute Care	1 2 3 4	1 2 3 4
Inpatient Acute Rehab	1 2 3 4	1 2 3 4
Day Treatment Center	1 2 3 4	1 2 3 4
Skilled Nursing Facility	1 2 3 4	1 2 3 4
Home Health	1 2 3 4	1 2 3 4
Outpatient	1 2 3 4	1 2 3 4
Early Intervention	1 2 3 4	1 2 3 4
Pediatrics/School Age	1 2 3 4	1 2 3 4
Private Practice	1 2 3 4	1 2 3 4
Other	1 2 3 4	1 2 3 4

Please list any additional skills:

1. 2.
3. 4.

Additional Training:

1. 2.
3. 4.

Additional Equipment:

1. 2.
3. 4.

Fax to: 1-888-298-3146

The information on this and all preceeding pages is true and correct.

Signature ________ Date ________

©2006 Cross Country Healthcare, Inc. Rev. 02/06