SPEECH-LANGUAGE EVALUATION

Name: P.E.
D.O.B.: XX/XX/XXXX
D.O.E.: 12/10/2021
Clinicians: Angela Johnson, Laura Morini, Kathryn Ballerini
Referred By:

Caregivers: J.E.
MR#:
Age: 79
Language in Home: English
1st Language: English
2nd Language: N/A

REASON FOR REFERRAL:
P.E. is a 79-year-old male who was referred to Boston Children's Health Physicians for a speech and language evaluation and was brought in to the clinic by his wife.

BACKGROUND HISTORY:
The patient background history was obtained from the patient's wife, J.E., through interview and completion of initial paperwork.

Medical History

P.E sustained a right hemisphere frontal lobe ischemic cerebrovascular accident (CVA) in July 2021 and has a history of dementia. The client has a history of bowel obstruction and frequently undergoes scopes of his gastrointestinal tract to remove any blockages. The most recent scope resulted in sepsis and hospitalization. Soon after hospitalization the client incurred the CVA, resulting in aphasia. He attends PT once per week and OT twice per week.

The client had back fusion surgery in 2018 and attended physical therapy for pain management post-op. He also had cataracts removed in 2019.

P.E. is currently on a soft food diet and is able to feed himself with no difficulty. The client also has a history of reflux with a resulting cough and his hearing was reported to be within normal limits.

The client is currently being treated for edema of the right hand and wrist and he wears a brace to reduce swelling.

Speech-Language History

P.E. is a monolingual English speaker. He received speech therapy home care 2 times a week for 3 weeks following discharge from the hospital and services were discontinues 3 months ago. The client's wife reports minimal progress from previous services.

Current concerns include word finding difficulty, lack of verbal communication, and slow processing.

Social History

The client lives at home with his wife. There was no mention of a social life and the client's family does not visit frequently because they find it hard to see P.E. in this condition. The client previously worked as a chef and a security guard, but has been retired since 2018.

CLINICAL OBSERVATIONS:

Physical Features

The patient's wife reports that he can now walk short distances; however, he uses a wheelchair whenever he is out of the house.

Overall Behavior

The client appeared to be in good spirits and was willing to work with the clinicians. He was observed to hold attention to tasks even if he found them to be difficult and signaled for cues or repetition when needed. P.E. displayed some frustration with more difficult tasks, but was very responsive in the clinical environment. The client's interaction with his wife appeared to be positive in nature and he was cooperative when given directions.

The results appear to reflect the client's current level of function. The behaviors seen in the evaluation collaborated with what the client's wife reported he was like at home.

SUMMARY OF LANGUAGE AND SPEECH ABILITIES:

Formal Testing: (put each test in a separate table)

Name of Standardized Test

No formal testing was performed.

Informal Testing:

The client's wife was interviewed in order to gather background history, as well as information in regards to current level of function. The *Boston Diagnostic Aphasia Examination* was used in a non-standardized was to elicit verbal and non-verbal communication from the client.

Language Comprehension:

P.E. presented with a severely disordered language comprehension in relation to functional needs. This was assessed informally using the *Boston Diagnostic Aphasia Examination* to elicit demonstration of language comprehension, as well as clinical observations.

Auditory Processing Abilities

The client was presented with the word comprehension section of the *Boston Diagnostic Aphasia Examination* and scored 11.5 out of a possible 16 points. When needed P.E. used non-verbal cues to request repetition from the clinician. He also looked to his wife when he was unsure of an answer. The client was observed to verbalize two of the answers (ant and T). P.E. was also presented with the commands section of the *Boston Diagnostic*

Aphasia Examination, which he could not complete. He did demonstrate understanding of the first stimuli and looked at the ceiling when prompted to point to it.

Semantics

Semantics was not assessed.

Morphology and Syntax

Morphology and syntax were not assessed.

Discourse:

Discourse was not assessed

Language Production:

The patient presents with a severe language delay in relation to functional needs. This was assessed informally using the *Boston Diagnostic Aphasia Examination* to elicit language production, as well as clinical observations.

Semantics

The client was observed to produce a few short verbalizations, paraphasias and phrases. The most notable phrase produced was "I don't know". P.E. was also observed to perseverate on previously mentioned stimuli. For example, after correctly verbalizing the letter T, he later repeated the letter as an answer to several questions.

Morphology and Syntax

P.E. was observed to produce some phonemic paraphasias, as well as perseverations of the first phoneme in a word. For example, when asked to identify the color green, the client produced "g" repeatedly.

Pragmatics

The patient was observed as a passive participant in conversation. He appeared to understand the turn-taking aspect of conversation and picked up on non-verbal cues enough to know when it was his turn to speak in the conversation. He was also observed

Discourse

Discourse was not assessed.

Reading and Writing Abilities: (if assessed)

P.E. demonstrates a severe delay in reading and writing abilities in relation to daily needs.

Reading

Reading was not assessed.

Writing

P.E. did not complete the writing activity presented. The client was observed to hover above the page when attempting to write and only made pen to paper contact long enough to write half of the letter "p".

Articulation/Phonological Abilities:

Articulation and phonology were not assessed.

Fluency/Rate:
Fluency and rate were not assessed.

Voice:
Voice was not assessed.

ORAL PERIPHERAL EXAMINATION:
Anatomical – A formal assessment of the client's anatomy was not done. The client's facial symmetry appeared to be within normal limits. All other structures were not assessed.
Physiological – A formal assessment of the patient's physiological status was not conducted. However, the client's articulators appeared to function within normal limits based on the limited language produced.

IMPRESSIONS:
P.E. is a 79-year-old male who incurred a right hemisphere frontal lobe ischemic CVA and has a history of cognitive impairments secondary to dementia.
P.E. presents with severely disordered speech and language, consistent with that of global aphasia. The client was not observed to produce many speech sounds, he had a delay in comprehension and had difficulties when it came to word finding. On the aphasia severity scale presented in the *Boston Diagnostic Aphasia Examination* he is best represented by a score of 0, indicating he has no useable speech. P.E. was, however, observed to have some auditory comprehension, which is not consistent with this score of 0 on the aphasia severity scale. Considering the client's current level of functioning, he would most likely benefit from speech therapy, both individual and group, as well as potentially an augmentative and alternative communication device.

RECOMMENDATIONS:
1. Speech therapy 1-2 times per week for individual sessions at Boston Children's Health Physicians outpatient clinic.
2. P.E. should attend group therapy for adults with aphasia once a week at Boston Children's Health Physicians outpatient clinic.

Evaluated By:

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