CMSF Documentation Examples

Pt found to have Guillain Barre

The patient currently presents with evidence of a moderate dysarthria characterized by reduced vocal loudness, reduced phonatory efficiency, reduced breath support for speech, breathy vocal quality, hypernasality w/ nasal emission during production of oral phonemes, imprecise articulation most notable for velar consonants (k, g) and alveolar pressure consonants (s, z), and restricted prosodic variation. These deficits are suggestive of LMN involvement (CN X, phrenic nerve) with ataxic components. Additionally, speech/voice appeared to deteriorate over the course of extended speech (e.g., passage reading). Dysarthria negatively impacts speech intelligibility, naturalness, and efficiency.

Speech deficits observed are suggestive of a neurologic process. Fatigue of the speech system w/ decline in functioning during extended speech is most commonly associated with demyelinating conditions, but may also be driven largely by respiratory involvement. Currently, medical w/u is in process for differential diagnosis. Differential diagnosis includes Guillain-Barré syndrome, and speech deficits would correlate with this disease process.

Visualization of the vocal folds by ENT is encouraged given today's findings. Additionally, while oropharyngeal swallow function appeared grossly intact this visit, a fiberoptic endoscopic evaluation of swallowing (FEES) is indicated to rule out silent aspiration and evaluate functioning of the laryngeal and pharyngeal structures given the concern for disruption to the vagus nerve.

Bilingual patient with Bell's palsy

The patient currently presents with left-sided facial weakness (CN VII) suspicious for Bell's palsy given the absence of imaging findings. All other cranial nerves intact. Facial weakness is having a subtle impact on speech function, resulting in a mild LMN dysarthria characterized by mild articulatory imprecision of labial consonants and slowed rate of speech. As a result, the patient exhibits mildly reduced efficiency of speech but is still an effective communicator. Her speech appears to be fully intelligible based on conversational success with a Spanish-English interpreter. No evidence of cognitive-linguistic deficits. Per pt and daughter, speech has improved compared to prior care date. Facial nerve deficit does not appear to have a negative impact on feeding / swallowing at this time. There are currently no clinical signs concerning for UMN lesion.

Patient with basal ganglia CVA

The patient presents with evidence of a hypokinetic dysarthria characterized by reduced phonatory efficiency / coordination, reduced vocal loudness, restricted prosodic variation, and subtle articulatory imprecision in connected speech. Deficits impact speech intelligibility, naturalness, and efficiency. Speech deficits are consistent with the site of lesion location. Language and cognition appear to be grossly intact / baseline.

Patient with suspected hemorrhagic cerebellar CVA (based on CT, unable to obtain MRI)

The patient currently presents with mild-moderate dysarthria characterized by atypical speech prosody and irregular articulatory breakdowns (i.e., errors are not produced on specific phonemes consistently). Non-speech clinical characteristics observed include dysmetria (e.g, undershooting movement when reaching for cup of water) and nystagmus. No clinical evidence this date of neuromuscular weakness, spasticity, or aberrant muscle tone. Overall, deficits observed are consistent with impaired motor coordination and are suspicious for cerebellar lesion. As a result of her dysarthria, the patient experiences mildly reduced intelligibility and moderately reduced efficiency / naturalness in connected speech.