

Initial Evaluation

Patient Name	:	Alston Rebello	Emirates ID	:	784-1991-2906159-3
File No	:	17	DOB	:	1996-06-20
Nationality	:	Indian	Date	:	2024-02-01
Gender	:	Male	Doctor's Name	:	Doctor Vision

Siblings : d Informant: d Date of Evaluation 1/11/2024 12:00:00 AM

Medical Diagnosis: d Presenting Symptoms: d HEARING STATUS: d

<input checked="" type="checkbox"/> Normal	<input checked="" type="checkbox"/> Middle ear effusion	<input checked="" type="checkbox"/> Sensory-neural hearing loss	<input checked="" type="checkbox"/> Conductive hearing loss
Devices/Aids	<input checked="" type="checkbox"/> Nil	<input checked="" type="checkbox"/> Hearing Aid	<input checked="" type="checkbox"/> Cochlear Implant
			<input checked="" type="checkbox"/> FM System

Last Hearing Test: d

OPME

Overall	d
Teeth	dd
Lips	d
Tongue	d
Jaw	d
S/H Palate	d
Cheeks	

SWALLOWING

History of aspiration	<input checked="" type="radio"/> Yes	<input type="radio"/> No
Current eating or drinking difficulties	<input checked="" type="radio"/> Yes	<input type="radio"/> No
Dysphagia	<input checked="" type="radio"/> Yes	<input type="radio"/> No

SPEECH:

<input type="checkbox"/> Verbal		<input type="checkbox"/> Non Verbal	
SPEECH:	SPEECH:	SPEECH:	SPEECH:

Sign here, only if all of your questions have been answered to your satisfaction	
PATIENT	DOCTOR
	<div></div>
Patient Name Alston Rebello Date 2024-02-01 22:15	Doctor Name Doctor Vision - Speech Therapy (DHA101) Date 2024-02-01 22:15

