CSAG 2 SPEECH AUDIT FORM – CLINICAL RECORDS

A1 ID Number _____

A2 Name _____

A2 Date of Birth dd/mm/yy ☐☐/☐☐/☐☐

A3 Hospital Number _____

A4 Today's date ☐☐/☐☐/☐☐

Place for Cleft identification sticker if available

B1 Overall number of SLT treatment sessions in any location (not review/monitoring) between 0 yrs and 5 yr audit appt ☐☐

B2 Please indicate the pattern of SLT service delivery for this child ***(please tick all that apply)***

Monitoring only as per Cleft Care Pathway ☐1

Additional monitoring over and above the cleft care pathway ☐2

Centre SLT treatment sessions ☐3

Link/spoke SLT treatment sessions ☐4

Community SLT sessions ☐5

B3 Availability of SLT

Approximately how long did the child wait for the first treatment session? _____ months

B4 Please indicate SLT management at date of audit recording

Therapy not required as judged prior to audit ☐1

Therapy continuing ☐2

B5 Therapy required but not in therapy- please indicate reason

Declined ☐1 On waiting list ☐2 Not available ☐3

Failed to attend ☐4 Awaiting more therapy eg next block ☐5 Discharged ☐6

B5A Other, please describe _____

B6A Has child been discharged from ongoing therapy? Yes ☐1 No ☐2

B6B If yes, please indicate reason below

Treatment not currently appropriate ☐1 Speech within normal limits ☐2

Unknown ☐3 Notes archived and not available ☐4

B6B1 Other, please describe _____

C1 Method of historical SLT delivery (Please indicate all that apply)

Early Parent information given ☐1 Early intervention prior to 18/12 ☐2
Please define your "Early intervention" in Other below

Weekly > 6 week block, needs driven ☐3 Weekly block model e.g. 6 weeks and then review ☐4

Intensive (Def. Therapy on a daily basis for a week or more/ or a morning and/or afternoon of therapy comprising a number of short sessions / 2 or more treatment sessions in one week) ☐5

C1A Other, please specify _____

C2 Who provided the therapy? (Please indicate all that apply)

Specialist at Centre ☐1 Spoke/link Cleft SLT ☐2
Community SLT ☐3 Assistant e.g. teaching/SLT ☐4

C2A Other, please describe _____

Focus of therapy

C3 Cleft consonant work Yes ☐1 No ☐2
C4 Attention and listening Yes ☐1 No ☐2
C5 Language Yes ☐1 No ☐2

C6 Other, please describe _____

During the 5 year period what of the following factors in your view may have influenced the outcome?

D1 Lack of attendance Yes ☐1 No ☐2
D2 Family unable to support child in therapy Yes ☐1 No ☐2
D3 Illness of child/complex medical /educational factors Yes ☐1 No ☐2
D4 Insufficient treatment sessions available or provided Yes ☐1 No ☐2
D5 Local therapy prioritisation system Yes ☐1 No ☐2
D6 Treatment delivered by non SLT Yes ☐1 No ☐2
D7 Velopharyngeal dysfunction Yes ☐1 No ☐2

D8 Give detail of any points above if you wish _____
_____
_____

D9 History of secondary speech surgery? Yes ☐1 No ☐2

CSAG 2 Speech Audit Form – to be filled in at Audit appointment

E1 Hearing loss –current	Yes ☐	No ☐
E2 Hearing loss – past	Yes ☐	No ☐
E3 Hard palate fistula posterior to incisive foramen	Yes ☐	No ☐
E4 Suspected VPI	Yes ☐	No ☐
E5 Confirmed VPI	Yes ☐	No ☐
E6 History of VPI	Yes ☐	No ☐
E7 English additional language	Yes ☐	No ☐

E8 Please indicate child's first language _____

Thank you for filling this in – please state your

F1 Name: _____

F2 Designation: _____

F3 Email: _____

F4 Contact number: _____

F5 Any additional information that you think would be helpful is most welcome.

_____

_____

_____

_____

Thank you!