How to…write a report

You will be able to read previous reports in the case files and/or on Blackboard. The style of your report will differ depending upon who it is addressed to. In some cases it will be specifically to one person, copied to others; in other cases it will be a general report for everyone involved with the client/patient. Not every piece of information indicated below would be appropriate for every report, see *How to…adapt the style of your report*
Reports are always written on letterhead and have a statement of confidentiality.
Reports are not letters.

General points

1. Always think about your reader – who is the target audience, and give appropriate content and length
2. Be straight forward, objective and keep it simple
3. Report information in an organised way - use headings
4. Only include relevant information - don't clutter the report or make it too long
5. Eliminate all modifiers, phrases and words that do not contribute to meaning
6. If important areas have not been addressed, state this - don't leave the reader to second-guess
7. Support all impressions and inferences with behavioural evidence and differentiate them clearly from objective observations
8. Provide examples where necessary and appropriate
9. Use professional language - do not use slang and colloquial expressions
10. Avoid subjective terms e.g. "he was a nice little boy", "she was very good at the task", "…hopefully, he will improve"
11. Arrange ideas within a sentence and within series of sentences in a logical sequence
12. Use correct and complete names of tests
13. Use correct and complete names of referral and other agencies
14. Use past tense e.g. "Mrs X mother reported that John was having difficulty in school", "he scored 30% on X task"
15. Use the 3rd person - avoid use of "I"
16. Respect the privacy and confidentiality rights of the client/informant i.e. do not disclose information that is not pertinent to the report

17. Avoid qualifications e.g. "it appears that…", "perhaps", "apparently", "it would seem that…"; be decisive
18. Avoid jargon: another SLT is probably the only reader you can anticipate being familiar with our professional jargon
19. Ensure report is error free e.g. grammar, punctuation, typos, tenses
20. Use only one side of the paper

The diagnostic/initial assessment report

1. *Routine/identifying information would include some of the following:*
    - Name
    - Date of birth (DOB)
    - Address
    - Phone number
    - Parents/Spouse/Guardian
    - School attended/Teacher (for children)
    - Date of onset (usually for adults)
    - Name of clinician/Clinic
    - Date of testing/assessment
    - Age at time of testing
    - Gender
    - Medical diagnosis
    - Speech and language diagnosis
    - Associated problems
    - Referral source
    - Date of report

2. *Statement of the Problem:*
    - Reason for referral
    - Referral source

3. *Historical/background information*
    - Case history information
    - Information from referral source/medical notes/speech and language therapy notes/etc (Refer to Case History Taking lecture notes)
    - Brief information about client's status during assessment e.g. who brought them, who else was in the room, level of attention, concentration and co-operation
    - This section should be relatively brief

4. *Assessment results/Clinical observations*
    - Information of tests administered (e.g. names of tests, purpose of test). The first time you use the name of a test write it out in full and give abbreviation in brackets.
    - Test results (including scores, descriptive statistics), how these are presented will depend upon who the report is for
    - Observations
    - Interpretation of results (e.g. how do scores compare to normal/age appropriate performance)
    - Separate headings are often used for different assessment areas, for example,

- Comprehension/ Receptive language (auditory and written)
- Expressive language (spoken and written)
- Articulation/Phonology
- Voice
- Fluency
- Hearing

• Back up all statements with data (present data and then conclude, don't leave a statement without behavioural evidence, e.g. "his speech was immature")

5. *Summary and Conclusions*

• Summary of main observations, including concise statement of key features of communication impairment
• Severity of problem may be commented on
• Perpetuating factors/influences
• Need for intervention and anticipated effectiveness
• Prognostic factors

7. *Recommendations*

• *What happens now?*
• Is intervention indicated? Be guided by client's needs not service constraints
• By whom and when?
• Are other referrals required?
• Specific suggestions where appropriate.
• Outline of intended therapy goals where appropriate.

8. *The last bit*

Your signature, your name and title.
The signature, name and title of your supervisor.
CC. A list of names and addresses of people who the report will be copied to

Review of Therapy/Progress Report/Discharge Summary may include:

• Status at the beginning of therapy
• Long-term goals
• Short-term goals
• Summary of therapy procedures used
• Outcome of therapy

It would always include the identifying information as above