

Administered By:

First Name \_\_\_\_\_  
Last Name \_\_\_\_\_  
Credentials \_\_\_\_\_

Client: _____	Site: _____
DOB: _____ / _____ / _____ dd           mm           yyyy	

**Standardized Test Results**  
**IHP Language Development Outcome Measures**

Tool #

Model of Service Delivery (HCD-ISCIS Intervention Code)

IHP   
PSL

HCD-ISCIS Intervention Codes			
IHP		PSL	
American Sign Language	<b>ASL</b>	Caregiver Consultation	<b>CC</b>
Auditory-Verbal Based Therapy	<b>AVT</b>	Group Treatment – Mediator	<b>GM</b>
Communication Assessment	<b>CA</b>	Group Treatment – SLP	<b>GT</b>
French Sign Language	<b>FSL</b>	Home Programming	<b>HP</b>
		Individual Treatment – Mediator	<b>IM</b>
		Individual Treatment - SLP	<b>IT</b>
		Monitoring	<b>M</b>
		Parent Training	<b>PT</b>

How much do you think your child has changed? Question #9 Functional Communication Questionnaire

- A little (1)
- Some (3)
- A lot (5)

**Preschool Language Scale – Fifth Edition (PLS-5)**

Date test completed \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
                                  dd           mm           yyyy

	Score		C.A.	A.A.
Auditory Comprehension	Raw Score	GSV:		
	Percentile Rank			
Expressive Communication	Raw Score	GSV:		
	Percentile Rank			

**Informant**

- Mother                      Hearing age \_\_\_\_\_
- Father                        Therapy age \_\_\_\_\_
- Other                         (the length of time that the child has been receiving direct therapy services)

Please note all IH clients with a PHL are required to have an assessment completed every 6 months. If you are unable to complete the assessment, please identify the reason.

Date of next assessment: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
                                  dd           mm           yyyy

**The Rossetti Infant-Toddler Language Scale RI-TLS**

Date test completed \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
dd mm yyyy

C.A.	H.A.	A.S.I.A.	Interaction Attachment	Pragmatics	Gesture	Play	Language Comprehension	Language Expression

Please note all IH clients with a PHL are required to have an assessment completed every 6 months. If you are unable to complete the assessment, please identify the reason.

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Date of next assessment: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
dd mm yyyy

**MacArthur-Bates Communicative Development Inventories (CDIs)**

Date test completed \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
dd mm yyyy

C.A.	H.A.	A.S.I.A.	Gestures		Words				Phrase	
			TGU		WU		WP		PU	
			#	%	#	%	#	%	#	%

Please note all IH clients with a PHL are required to have an assessment completed every 6 months. If you are unable to complete the assessment, please identify the reason.

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Date of next assessment: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
dd mm yyyy

**CA** - Chronological Age

**AA** - Adjusted Age

**HA** - Hearing Age

(the length of time that the child has been wearing his/her hearing aids and/or cochlear implants. For example, a 3 year-old child has a hearing age of 1 day when his/her hearing aids and/or cochlear implants are first fit).

**ASIA** – Auditory Skills Intervention Age

**TGU** – Total Gestures Used

**WU** – Number of Words Understood

**WP** - Number of Words Produced

**PU** - Number of Phrases Understood

(The length of time that the child has been receiving auditory-verbal therapy services. For example, if the child has been attending auditory-verbal therapy sessions for 7 months, then the child has an auditory-verbal age of 7 months).