



**INDIAN SPEECH - LANGUAGE AND
HEARING ASSOCIATION**

**NOMENCLATURE OF SPEECH,
LANGUAGE, SWALLOWING,
BALANCE AND HEARING
DISORDERS**

2024

ISHA

**Nomenclature of Speech, Language,
Swallowing, Hearing and Balance
Disorders for Indian Context**



**INDIAN SPEECH-LANGUAGE AND
HEARING ASSOCIATION**

National Association of Speech-Language and
Hearing professionals

Edition: 2024

A Publication of Indian Speech-Language and Hearing Association

Under the title:

Nomenclature of Speech, Language, Swallowing, Hearing and Balance Disorders for Indian Context

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Holidays : Central Government Holidays

Published by : President, ISHA

ISBN No.: 978-81-971692-7-4

FOREWORD

Indian Speech-Language Hearing Association (ISHA) presents the first version of the nomenclature document related to Speech, Language, Swallowing, Hearing and Balance disorders to its members for use in clinics. This may also be used for all other professional practice (insurance, medico-legal cases, etc) requirements. This publication will potentially serve to bring uniformity in use of diagnostic labels, tools for screening & assessment, and reporting formats across India. It is anticipated to result in the evolution of a standard care of practice for assessment.

The document has an introduction detailing the conceptualization, frameworks that were referred, and methodology adopted. Seven other chapters suggest the assessment procedures, diagnostic labels, codes, and the alignment to RPWD 2016. Each chapter provides a comprehensive guide to assessment and reporting format with an example for communication, swallow and hearing disorders that a clinician may come upon in his/her practice. Care has been taken to include published tools in India. It is envisaged that this effort will augur well with the earlier published scope of practice document, and to the forthcoming white papers on standard of practice of Audiology & Speech Language Pathology in India.

Compliments to Prof. R. Rangasayee, and Prof. S.P. Goswami for spearheading the team of contributors to this document. Both of them are well known for their forward thinking and as 'advocates of needful change' in our profession. The other authors include experienced academicians and respected clinicians in our country. Dr. M. B. Priya's work as one of the editors is commendable.

I have had the opportunity to listen and contribute to the discussions throughout the development of this document. I feel extremely delighted, that the current version of the document has taken into account some critical aspects of its implementation in India. In this document, ICCD (Indian Classification of Communication Disorders) is introduced as an addition to ICD classification. ICCD codes have been thoughtfully presented to accommodate a few disorders of communication where ICD codes are not available. Emphasis on ICF and RPWD Act (requirements for disability certification) are other highlights.

The initial efforts of Prof. M. Jayaram (President 2022-23), and subsequent follow up by the next President, Prof. S.P. Goswami (2023-24), has fructified as this first version that is ready for implementation in 2024. I hope that teaching institutes, clinics and clinicians will adopt these into practice and contribute to subsequent versions of ICCD and nomenclature of speech-language, swallowing, hearing and balance disorders in future.

Best Wishes,

Prof. Prakash Boominathan
(President 2024-25)

From the desk of Editors:

A committee was constituted for framing a system of nomenclature in Speech, Language, Swallowing, Hearing and Balance Disorders that can be used in the Indian context.

The objectives of the committee were to recommend uniform nomenclature/ terminologies to be used in India by Speech-Language Pathologists and Audiologists while documenting the clinical findings. The committee delineated the scope of such document to cover areas such as clinical findings, diagnosis, disability certification, labelling, legal purposes, research reports and to undertake clinical reporting. This was document based on certain assessment protocols which are specified against each health condition as deemed required by the directives for implementing statutory provisions and beyond.

Deliberations: The members of the committee expressed their views, need and scope for framing uniform terminology and protocols for the assessment of Speech, Language, Swallowing, Hearing and Balance Disorders in the Indian context. They opined that the use of terminologies and assessment protocols for assessment of speech, language, and swallowing disorders are more heterogeneous compared to hearing disorders. The position statement in the field of Audiology is more robust for labelling as well as for the assessment of various disorders of hearing compared to Speech, Language, Swallowing, Hearing and Balance Disorders. The members further deliberated the importance of having a uniform format for report writing as well as for disability certification of various Speech, Language, Swallowing, Hearing and Balance Disorders.

Process for execution: It was decided to co-opt clinicians working in autonomous/ private set-ups, hospitals or any other clinical set-ups in addition to the existing members of the committee. Several existing frameworks like ICD-10/11, DSM-5, ICF or and nomenclature system of other international speech and hearing associations were referred while formulating the terminologies, assessment protocols and documentation formats. The details as stated in RPWD Act 2016 were adhered to while preparing the document for report writing as well as for certification of various Speech, Language, Swallowing, Hearing and Balance Disorders.

This document has been finalised after taking the opinion of various institutions and private practitioners and professionals. We hope that this document will be a first step to have uniform nomenclature in Speech, Language, Swallowing, Hearing and Balance Disorders for Indian Context.

Editor : Prof. R. Rangasayee, Dr. S. P. Goswami & Dr. Priya M. B.

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Background

The use of terminology for particular Speech, Language, Swallowing, Hearing and Balance Disorders conditions have been extensively debated and documented over the years across the globe. However, till date no guidelines have been stipulated in India. Professional organization (ISHA) has realised the need for the use of uniform terminologies for labelling various Speech, Language, Swallowing, Hearing and Balance Disorders in India. The word terminology refers to the larger concept of the use of terms, classification, nomenclature, taxonomy, clinical systems, and the features of these terms themselves.

Although services for persons with Speech, Language, Swallowing, Hearing and Balance disorders in India existed since 1960s¹, the introduction of first training program was launched in the year 1965¹. Since then, the field of Speech- Language Pathology and Audiology has made considerable progress in the area of clinical services, research, manpower generation and advocacy. Since 1965, several professionals and disciplines such as linguistics, psychology and medicine have influenced and paved way for the growth of Speech- Language Pathology and Audiology².

Professionals learn concepts and terms used in the field during undergraduate, postgraduate and doctoral level programs. The use of terminology shapes professional identity. Specific terminology systems reflect each person's fundamental beliefs about their profession³. Speech-Language Pathologists accept the terms that were current during their training and may not identify these terms as a possible source of any problem or ambiguity⁴. Terminology is also influenced by various social welfare and private insurance systems within countries⁵.

It was emphasized that in the field of disability, different purposes in defining may lead to different definitions⁶. Further they were also of the opinion that there are different requirements of terms within and between clinical, service, legislative and administrative systems, which dictate how words are defined. They also suggested that to improve consistency, one should not search for 'uniform' definitions, as it is accepted that definitions must vary according to different purposes. As an alternative, they believed that a framework which includes common standards for terminology and common language about terms, and which allows common reference points would be a productive tool. Thus, terms themselves vary but are consistently comparable and contrastable according to their parameters and the purposes they serve in a given system.

It was reported that emphasis should be given on the use of terminology systems rather than terms as the former would include the organization of concepts to which a term might be attached to allow comparability and consistency⁷. Further, it was suggested that use of uniform terminology improves accessibility, appropriateness, and consistency in labelling the conditions⁸. Further terminology is

developed based on a conceptual framework at the meta-terminology level which would provide the profession with a tool for analysis to debate and ultimately decide on individual terms within specific contexts. Considering terms at a broad 'meta-terminology' level would mean that local language issues and local context requirements, etc., would be catered to, but the differences and universalities in terms could be explored.

It is for this purpose that the Committee constituted by Indian Speech-Language and Hearing Association has prepared this document on uniform terminology for labelling the various Speech, Language, Swallowing, Hearing and Balance Disorders in the Indian context. The members of this committee reviewed the existing terminologies used by Speech-Language Pathologists and Audiologists in India for labelling various communication disorders. The sources for these terminologies included information from institutions, private practitioners and records seen by the professionals referred from Speech-Language Pathologists and audiologists or other healthcare professionals. It was observed by the members that the use of terminologies and protocols for assessment of speech, language, and swallowing disorders are more heterogeneous compared to hearing disorders in India. The position statement at an international level in the field of Audiology is more robust for labelling as well as for the assessment of various disorders of hearing as compared to speech, language, and swallowing disorders. The members deliberated the importance of having a uniform format for report writing as well as for disability certification of various Speech, Language, Swallowing, Hearing and Balance Disorders.

Several medical conditions result in disorders of Speech, Language, Swallowing, Hearing and Balance. Thus, the field of Speech-Language Pathology and Audiology is not all-inclusive but is exclusive in its identification, assessment, diagnosis, treatment and certification. The International Classification of Diseases (ICD) is a medical classification system given by the World Health Organization. It consists of codes representing various medical conditions. Medical as well as allied health care professionals for labelling various diseases/disorders use these codes, insurance, and billing related to the same at International levels. The most recent revision of ICD is the ICD-10 (WHO, 1999S) while the 11th revision (ICD-11, 2019) is under implementation. In the Indian context, ICD-10 is widely used by professionals such as clinical psychologists. The other classification system, which has moved from a medical to a more biopsychosocial rationale, is the International Classification of Functioning, Disability and Health⁹. This is better equipped to describe the activity and participation of an individual with any health condition. This framework views health from a holistic point of view rather than as a disease or a disorder. Further, the American Speech and Hearing Association, Speech Pathology Australia, American Academy of Audiology and other widely acclaimed organizations/associations have also adapted the use of ICD-10, the DSM-5 and ICF model for labelling various communication disorders. The present committee has taken the basis from ICD-10/11, ICF and DSM-5 to formulate

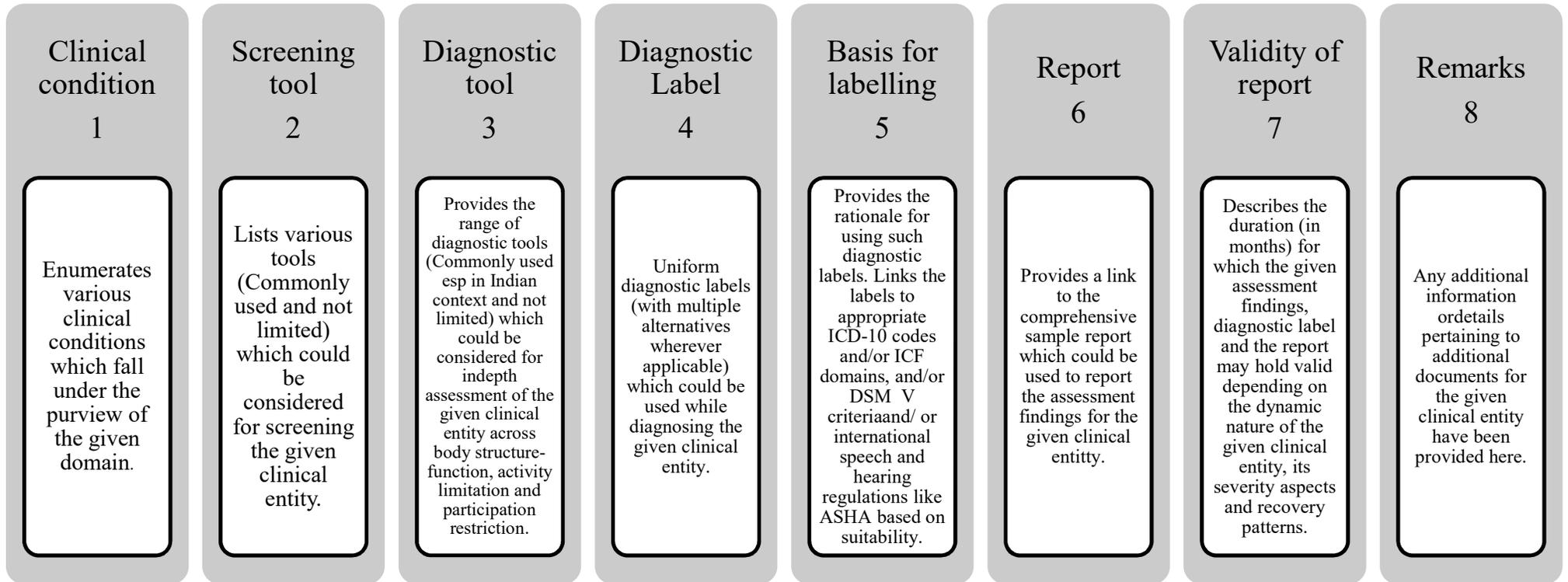
this document. Further, in instances where the ICD 10 and 11 codes were not available for some of the communication disorders, the committee has proposed new codes. The abbreviated code reads as “ICCD” where **I**- Indian, **C**- classification of, **C**- communication **D**- Disorders, followed by nature of the condition (**O**- organic , **F**- functional), disorder (**H**- Hearing, **S** Speech, **L** language and **Sw** Swallowing) and numeric in that order . The numerical value from 01-25 is earmarked for Hearing disorders, while 21-50 for Speech disorders, 51-75 for Language disorders and 75-100 for Swallowing disorders. An illustration for labelling functional Hearing loss as per ICCD would be **ICCD-FH-01**.

It is expected that this document will

- (a) Reflect the preferred terminologies of professionals and the profession at large
- (b) Bring uniformity in terms of labelling the various Speech, Language, Swallowing and Hearing disorders in the Indian context
- (c) Pave the way for better communication across health care professionals
- (d) Help in reimbursement of claims by stakeholders
- (e) Pave the way for considering services of speech-language pathologists and audiologists for insurance purposes.
- (f) Serve as a base in medico-legal cases
- (g) Serve as a complement to the scope of practice document for speech-language pathologists and audiologists
- (h) Reflect the growth and identity of the profession

The protocols for assessment of various Speech, Language, Swallowing, Hearing and Balance disorders have been prepared in line with national and international perspectives. It is recommended that the ICF Rehabilitation Set be used along with condition specific tools (if available) for assessing the activity and participation of all the conditions listed below. This could bring more uniformity to the assessment of activity and participation for all communication disorders. The Figure 1 guides the reader for interpreting various aspects outlined across various clinical domains.

Figure 1: Illustration to guide the readers in interpreting various aspects outlined across various clinical domains.



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Chapter I

Hearing and Balance Disorders

For the purpose of this document, the hearing and balance disorders are classified into: Conductive, Sensory, Neural, Mixed, Auditory Processing Disorders and Vestibular type. The degree of hearing loss is calculated as the average pure tone hearing thresholds of 500Hz, 1000Hz and 2000Hz. Goodman's classification¹ is used to categorize the degree of hearing loss. Threshold should be estimated using modified version of Hughson and Westlake procedure². It is assumed that all assessment are done in standard test conditions with noise levels within the permissible limits as per the adopted standards. However, for the purpose of Hearing Disability Certification, average pure tone hearing thresholds of 500Hz, 1000Hz, 2000Hz and 4000Hz³ to be used. Immittance evaluation is performed with 226 Hz probe tone and ipsilateral and contralateral reflexes are tested for a minimum of two frequencies (500 Hz and 1 kHz). However, in conductive hearing loss without ear discharge it is encouraged to perform Immittance assessment using higher probe frequencies. In case of infants and children where threshold estimation is not feasible through behavioural audiometry, degree of hearing loss should be determined through auditory brainstem responses. Auditory brainstem responses should be assessed using clicks and tone burst. Off late Audiologists are involved in balance functioning assessment. The different tests that are necessary for the assessment of balance functioning in various disorders are provided based on the current available evidences are shown in Table 1. The diagnostic report format for hearing and disorders and a sample report of the same is provided in Annexure I and II. The details for the basis of the diagnostic label and code as well as the other recommendations are given below.

Basis for the label: ICD-10 CM, ASHA – Hearing and Vestibular

Screening for Hearing:

1. AC thresholds at 500Hz, 1000Hz and 2000Hz for adults.
2. AC thresholds at 500Hz, 1000Hz, 2000Hz and Immittance for school aged children.
3. AC thresholds at 500Hz, 1000Hz, 2000Hz and 4000Hz³ for industrial screening.
4. Otoacoustic emissions for neonates and infants.
5. Otoacoustic emissions and automated ABR for neonates and infants with JCIH (2020) risk factors.

For certification purpose: AC thresholds at 500Hz, 1000Hz, 2000Hz and 4000 Hz and a hearing disability certificate as hard of hearing or deaf as per RPWD Act 2016³

Screening for Vestibular: Subjective vestibular evaluation (Case History, Romberg's Test, Tandem gait test)

Assess functional Disability: WHO Disability Assessment Schedule 2.0 (WHODAS 2.0)/ ICF generic set.

Report: Audiogram. (case history, test results for PTA, Immittance Evaluation, Speech audiometry, OAE, ABR, Central auditory processing test, Vestibular assessment, ICF score and hearing disability percentage. Additional space can be allocated in the report for specifying any supplementary tests or information that has to be communicated to the referral source or the concerned.

Validity of the report: Three to six months or as deemed appropriate by the clinician.

It is suggested that the institution/organization/clinic information may be added in the header of the report which may include name, address, contact details, etc.

Table 1- Diagnostic tools, labels, report, validity for Hearing and Balance disorders.

Sl. No	1 Condition	2 Diagnostic tool	3 Diagnostic label & Code
1	Conductive hearing loss, bilateral	Pure Tone Audiometry, Immittance and speech audiometry	Conductive hearing loss H90.0
2	Conductive hearing loss, unilateral with Normal hearing on the contralateral side	Pure Tone Audiometry, Immittance and speech audiometry	Conductive hearing loss H90.1
3	Conductive hearing loss, unspecified Conductive deafness NOS	Pure Tone Audiometry, Immittance and speech audiometry	Conductive hearing loss H90.2
4	Noise effects on inner ear, Acoustic trauma of inner ear, Noise-induced hearing loss of inner ear	Case history Pure tone audiometry, High frequency Audiometry, Speech audiometry , Immittance and OAE	Sensorineural hearing loss (NIHL or acoustic trauma) H83.3
5	Sensorineural hearing loss, bilateral	Case history, Pure tone audiometry, Speech audiometry, Immittance and OAE, ABR for site of lesion test if required	Sensorineural hearing loss H90.3
6	Sensorineural hearing loss, unilateral with Normal hearing on the contralateral side	Case history, Pure tone audiometry, Speech audiometry, Immittance and OAE, ABR for site of lesion test	Sensorineural hearing loss H90.4
7	Mixed conductive and sensorineural hearing loss, bilateral	Case history, Pure tone audiometry, Speech audiometry, Immittance, and OAE	Mixed Hearing Loss H90.6
8	Mixed, conductive and sensorineural hearing loss, Unilateral	Case history, Pure tone audiometry, Speech audiometry, Immittance, Tympanometric width, Gradient, Resonance frequency, OAE	Mixed Hearing Loss H90.7

9	Ototoxic hearing loss	Case history Pure tone audiometry , High frequency audiometry, Speech audiometry, Immittance, OAE	Sensorineural hearing loss H91.0
10	Presbycusis	Case history, Pure tone audiometry , Speech audiometry , Immittance, OAE	Sensorineural hearing loss (Presbycusis) H91.1
11	Sudden idiopathic hearing loss, unspecified ear	Case history, Pure tone audiometry , Speech audiometry , Immittance, OAE and ABR	Sensorineural hearing loss (sudden onset) H91.20
12	Tinnitus	Case history , Pure tone audiometry, Speech audiometry , Immittance, OAE, Tinnitus evaluation – Pitch, loudness, residual inhibition, Tinnitus handicap index, tinnitus functional index	**Variable Normal/Conductive/Mixed/ Sensorineural Hearing loss Mention the severity of tinnitus H93.1
13	Hyperacusis	Case history Pure tone audiometry High-frequency audiometry Immittance, Speech audiometry – Word recognition and loudness discomfort levels	Sensorineural Hearing Loss H93.23
14	Central auditory processing disorder Congenital auditory imperceptions Word deafness	Case history, Pure tone audiometry, Speech Audiometry, Immittance OAE, ABR, Central Auditory processing test to assess each auditory process. -Binaural integration(Dichotic digit test) -Monaural low redundancy tests – Speech in noise test -Temporal processing test (PPT/DPT) -Binaural interaction test (MLD) Cortical auditory evoked potentials (optional)	Normal hearing Central Auditory processing Disorder H93.25
15	Disorders of acoustic nerve	Case History, Pure tone audiometry, Immittance, Speech audiometry, OAE, ABR and other higher order potentials	Sensorineural hearing loss (Retro Cochlear Pathology) Or Auditory neuropathy spectrum disorder H93.3

16	Ménière's disease, Labyrinthine hydrops, Ménière's syndrome or vertigo	Case History, Pure Tone Audiometry, Oto-acoustic emissions, Cervical and Ocular Vestibular Evoked Myogenic Potentials, EcochG, Caloric test.	Normal / Sensorinural Hearing loss H81.0
17	Benign paroxysmal vertigo	Case History, Pure Tone Audiometry, Oto-acoustic emissions, BPPV Positional Maneuver.	BPPV H81.1
18	Vestibular neuronitis	Case History, Pure Tone Audiometry, Auditory Brainstem Response, Cervical and Ocular Vestibular Evoked Myogenic Potentials, Video Head Impulse Test, subjective vestibular evaluation and VNG.	Normal Hearing Vestibular neuronitis H81.2
19	Other peripheral vertigo	Pure Tone Audiometry, Immittance evaluation, Oto-acoustic emissions, Auditory Brainstem Response, Cervical and Ocular Vestibular Evoked Myogenic Potentials, Video Head Impulse Test and Caloric test.	Varies depending on the condition H81.3
20	Vertigo of central origin Central positional nystagmus	Case History, Pure Tone Audiometry, Immittance evaluation, Oto-acoustic emissions, Auditory Brainstem Response, Cervical and Ocular Vestibular Evoked Myogenic Potentials, Video Head Impulse Test, Videonystagmography.	Varies depending on the condition H81.4
21	Vertiginous syndromes in diseases classified elsewhere	Case History, Pure Tone Audiometry, Immittance evaluation, Oto-acoustic emissions, Auditory Brainstem Response, Cervical and Ocular Vestibular Evoked Myogenic Potentials, Video Head Impulse Test, Videonystagmography	Depending on the condition H82
22	Labyrinthitis	Case History, Pure Tone Audiometry, Immittance evaluation, Oto-acoustic emissions, Auditory Brainstem Response, Cervical and Ocular Vestibular Evoked Myogenic Potentials, Subjective vestibular evaluation, Videonystagmography	Sensorineural hearing loss Vestibular Labyrinthitis H83.0
23	Functional Hearing Loss	Case History, Pure Tone Audiometry, Immittance evaluation, Oto-acoustic emissions, Auditory Brainstem Response	Actual degree of hearing loss based on ABR ICCD-FH-01*

* No code prescribed by ICD. The committee has recommended to use this code. ICCD stands for Indian Classification for Communication Disorders. F indicates Functional, H indicates Hearing loss and 01 is the numeric.

Annexure I

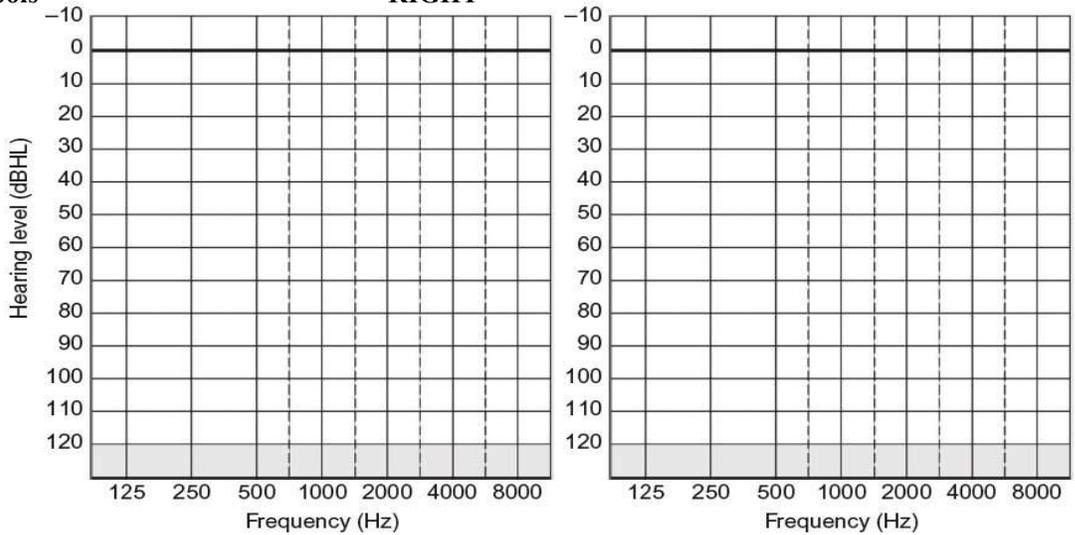
Diagnostic report format for Hearing and Balance Disorders

Name: _____ Case No.: _____ Age: _____
 Gender: _____ Phone no.: _____ Date: _____
 Equipment: _____ Validity of the report: _____

**PURE TONE AUDIOGRAM
RIGHT**

Key to Symbols

MODALITY	RIGHT	BOTH	LEFT
AIR CONDUCTION			
UNMASKED (UM)	○	○	X
MASKED (M)	△	△	□
UM - NO RESPONSE	○	○	X
M - NO RESPONSE	△	△	□
BONE CONDUCTION MASTOID			
UNMASKED	<	>	>
MASKED	[]]
UM - NO RESPONSE	<	>	>
M - NO RESPONSE	<	>	>
BONE CONDUCTION FOREHEAD			
UNMASKED		∨	
MASKED			
UM - NO RESPONSE		∨	
M - NO RESPONSE		∨	
AIR CONDUCTION - SF	⊙	⊙	*
SOUND FIELD - NO RESP	⊙	⊙	*



SPEECH AUDIOMETRY

	PTA (dB HL)	SRT (dB HL)	SIS (%)	SPIN (%) (0dB SNR)	SDT (dB HL)	UCL (dB HL)	Webber (500 Hz)	Webber (1000 Hz)
RIGHT EAR								
LEFT EAR								

IMMITTANCE EVALUATION

Tympanometry

Ear	Type	Tympanometric Pk. Pr. (daPa)	Static Admittance (mmho)	Gradient	EECV (cc)	Resonant Frequency(Hz)
RIGHT						
LEFT						

Acoustic Reflex Threshold

**BEHAVIOURAL OBSERVATION
AUDIOMETRY**

Probe Ear		500 Hz	1 kHz	2 kHz	4 kHz
RIGHT	Ipsi				
	Contra				
LEFT	Ipsi				
	Contra				

Stimuli	Minimum Response Level (dB HL)	Response Observed
500 Hz		
1000 Hz		
2000 Hz		
4000 Hz		
Speech		
BBN		

OTOACOUSTIC EMISSIONS

DPOAE:

Ear	RIGHT						LEFT					
	1kH z	1.5kH z	2kH z	3kH z	4kH z	6kH z	1kH z	1.5kH z	2kH z	3kH z	4kH z	6kH z
SNR												
Amplitude												
Noise floor												

TEOAE: Stimulus: Click / Tone Burst

Intensity:

Ear	RIGHT						LEFT					
	Global	1kH z	1.5k Hz	2kH z	3kH z	4kH z	Global	1kH z	1.5k Hz	2kH z	3kH z	4kH z
Echo/SNR												
Noise floor												
Reproducibility												

Interpretation:

AUDITORY BRAINSTEM RESPONSE (ABR)

Stimulus:		Latency (ms)					
Intensity (dB nHL)	Repetition Rate (Stimuli/sec)	Right Ear			Left Ear		
		I	III	V	I	III	V

Interpretation:

Hearing Disability Percentage

Functional Disability ICF core set:

Right Ear	Left Ear	Overall

Vestibular Evaluation:

DIAGNOSTIC FORMULATION:

DIAGNOSIS:

RECOMMENDATIONS:

Audiologist
Designation, Address & CRR No.

Annexure II
Diagnostic report format for Hearing and Balance Disorders (SAMPLE CASE REPORT)

Name: ABCD Case No: 1234 Age:XX Gender:M/F Phone no.:1234567890 Date: _____

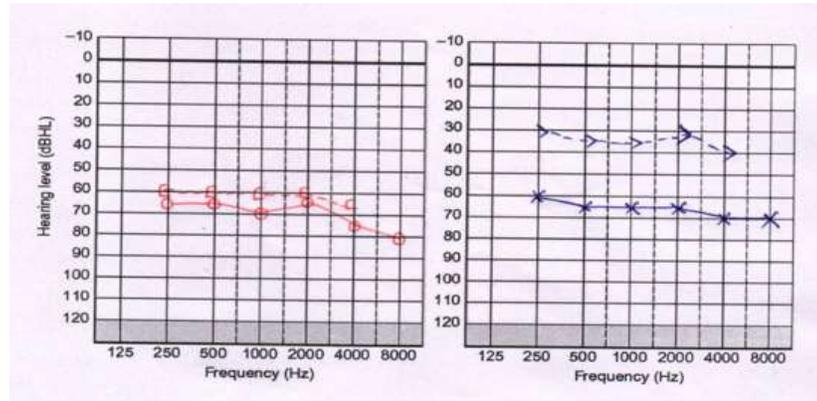
Equipment: _____

Key to Symbols

MODALITY	RIGHT	BOTH	LEFT
AIR CONDUCTION			
UNMASKED (UM)	○		X
MASKED (M)	△		□
UM - NO RESPONSE	○		X
M - NO RESPONSE	△		□
BONE CONDUCTION MASTOID			
UNMASKED	<	∨	>
MASKED	[]
UM - NO RESPONSE	<	∨	>
M - NO RESPONSE	<	∨	>
BONE CONDUCTION FOREHEAD			
UNMASKED		∨	
MASKED			
UM - NO RESPONSE		∨	
M - NO RESPONSE		∨	
AIR CONDUCTION SF	⊙	\$	*\$
SOUND FIELD NO RESP	⊙	\$	*\$

PURE TONE AUDIOGRAM
RIGHT

LEFT



SPEECH AUDIOMETRY

	PTA (dB HL)	SRT (dB HL)	SIS (%)	SPIN (%) (0dB SNR)	SDT (dB HL)	UCL (dB HL)
RIGHT EAR	68.75	75	90%	80%	65	110
LEFT EAR	66.25	70	100%	100%	65	115

IMMITTANCE EVALUATION

Tympanometry

Ear	Type	Tympanometric Pk. Pr. (daPa)	Static Admittance (mmho)	Gradient	EECV (cc)	Resonant Frequency(Hz)
RIGHT	A	23	1.1		1.3	
LEFT	A	-10	0.9		1.3	

Acoustic Reflex Threshold

Probe Ear		500 Hz	1 kHz	2 kHz	4 kHz
RIGHT	Ipsi	NR	NR	NR	NR
	Contra	NR	NR	NR	NR
LEFT	Ipsi	NR	NR	NR	NR
	Contra	NR	NR	NR	NR

BEHAVIOURAL OBSERVATION AUDIOMETRY

Stimuli	Minimum Response Level (dB HL)	Response Observed
500 Hz		
1000 Hz		
2000 Hz		
4000 Hz		
Speech		
BBN		

OTOACOUSTIC EMISSIONS

DPOAE: Absent

Ear	RIGHT						LEFT					
	1kHz	1.5kHz	2kHz	3kHz	4kHz	6kHz	1kHz	1.5kHz	2kHz	3kHz	4kHz	6kHz
SNR												
Amplitude												
Noise floor												

TEOAE: Stimulus: Click / Tone Burst

Intensity:

Ear	RIGHT						LEFT					
	Global	1kHz	1.5kHz	2kHz	3kHz	4kHz	Global	1kHz	1.5kHz	2kHz	3kHz	4kHz
Echo/SNR												
Noise floor												
Reproducibility												

Interpretation:

AUDITORY BRAINSTEM RESPONSE (ABR)

Stimulus:		Latency (ms)					
Intensity (dB nHL)	Repetition Rate (Stimuli/sec)	Right Ear			Left Ear		
		I	III	V	I	III	V
90	11.1	--	---	6.9	2.2	4.3	6.6
80	11.1	----	----	----	---	5	7
70	11.1	-----	-----	-----	-----	-----	-----

Interpretation:

Hearing Disability Percentage

Right Ear	Left Ear	Overall
65.62%	60%	60.9%

Vestibular Evaluation:

vHIT: Normal SSC function

cVEMP and oVEMP: Normal findings

DIAGNOSTIC FORMULATION:

Diagnosis:

Right: Moderately sever sensorineural hearing loss (H90.4)

Left: Moderately sever mixed hearing loss (H90.6)

RECOMMENDATIONS:

Audiologist
Designation, Address & CRR No.

Reference:

1. Goodman, A. (1965) Reference Zero Levels for Pure-Tone Audiometers. ASHA, 7, 262-273.
2. Katz J, Chasin M, English KM, Hood LJ, Tillery KL, editors. Handbook of clinical audiology. Philadelphia, PA: Wolters Kluwer Health; 2015.
3. Carhart R, Jerger JF. Preferred method for clinical determination of pure-tone thresholds. Journal of speech and hearing disorders. 1959 Nov;24(4):330-45.
4. https://legislative.gov.in/sites/default/files/A2016-49_1.pdf

Chapter II

Feeding and Swallowing Disorders

Feeding and Swallowing Disorders or Dysphagia can be described as difficulty moving food, liquid, saliva or medication from the mouth to the stomach. The signs and symptoms of dysphagia may involve the mouth, pharynx, larynx, and/or esophagus (ASHA, 2001b). Dysphagia can be seen in individuals of all age groups.

The presence of feeding and swallow disorders affects daily activities and participation in community. It can have an impact on educational, social, and occupational outcomes. Many personal and environmental factors including their context, background, and support structures will influence feeding and swallowing outcomes. Hence the assessment tools mentioned under each category of feeding and swallowing disorders is based on the International Classification of Functioning perspective (ICF, WHO,2007), which focusses on the body function, body structure, activity, participation, and the impact of personal and environmental factors as facilitators or barriers to functioning. These ICF domains have also been incorporated in the report format along with sample document is attached as Annexure III and IV. The conditions related to feeding and swallowing disorders directly do not fall under the disability. Hence, do not have any criteria for disability certification. However, these may be considered under various other conditions such as neurological, speech, language or any other conditions as stated under RPwD Act 2016. The different tests that are necessary for the assessment of feeding and swallowing disorders are provided based on the current available evidences are shown in Table 2.

Basis for the label: ICD-10 CM, 11 and ICCD – Feeding and Swallowing Disorders

Screening for Feeding and Swallowing Disorders:

1. Case history
2. Clinical observation
3. Perceptual evaluation
4. Gugging Swallowing Screen¹ (GUSS)
5. Modified Mann Assessment of swallowing Ability² (MMASA)
6. Bristol Breastfeeding Assessment Tool³
7. Neonatal Dysphagia Screening Tool⁴
8. Pediatric Dysphagia Risk Screening Instrument⁵

For certification purpose: The conditions related to feeding and swallowing disorders with organic and neurological basis presenting with speech, language and/or hearing disorder falls under speech-language disability. Thus, those having benchmark disability are eligible for disability certificate as stated under RPwD Act 2016.

Assess functional Disability: ICF generic set.

Report: Diagnostic report format for feeding and swallowing disorders (case history, voice test results, clinical observation). Conditions with psychogenic and neurogenic basis needs assessment reports of psychologist, neurologist and/or radiologist. Additional space can be allocated in the report for specifying any supplementary tests or information that has to be communicated to the referral source or the concerned.

Validity of the report: Three to six months or as deemed appropriate by the clinician.

Sl. No	1 Condition	2 Diagnostic tool	3 Diagnostic label and code
1.	Dysphagia a) Organic b) Functional	Manipal Manual for swallowing assessment ⁶ OR Nair Hospital Bedside Swallowing Assessment ⁷ Videofluoroscopic swallow study (VFSS) &/ Fiberoptic Endoscopic Evaluation of Swallowing (FEES) Dysphagia Handicap index in Kannada ⁸	Aphagia R13.0
			Dysphagia- unspecified R13.10
			Dysphagia- oral phase R13.11
			Dysphagia- oropharyngeal phase R13.12
			Dysphagia- pharyngeal phase R13.13
			Dysphagia- pharyngoesophageal phase R13.14
2.	Feeding problems in neonates	The Neonatal Oral- Motor Assessment Scale ⁹ (NOMAS)	Neonatal feeding difficulty and/or Dysphagia- oral phase R13.11
			Dysphagia- oropharyngeal phase R13.12
			Dysphagia- pharyngeal phase R13.13
			Dysphagia- pharyngoesophageal phase R13.14
3.	Feeding problems a) Children b) Adults	Behavioral Pediatric Feeding Assessment Scale ¹⁰ (BPFAS) Feeding Handicap Index ¹¹	Childhood Feeding difficulties ICCD-OSw-76
			Feeding difficulties ICCD-OSw-77

Table 2- Diagnostic tools, labels, report, and validity for Swallowing and Feeding disorders.

Annexure III

Diagnostic Report for Neonates/Children with feeding and Swallowing Disorders

Name of the Institution

Name:	Registration No:
Age/Gender:	Date of Birth:
Diagnosis:	Date of Evaluation:
Date of Issue of report:	Validity period of the report:

Referral information

Referral source:
Informant:
Reason for referral:

Background information

Prenatal and birth history:
Developmental history:
Medical history:
Family history:
Educational information:
Previous evaluations/Therapy details:

Assessment information

Informal assessment

General behaviour:
Hearing:
Intellectual status:
Cognition:
Play:
Motor skills:
Orofacial examination:
Language comprehension:
Language production:
Speech sound production and intelligibility:

Voice:

Fluency:

Feeding and swallowing:

Activities and participation

Communication:

Learning and applying knowledge:

Peer and family interactions and relationships:

Major life areas (Formal Education):

Environmental factors:

Support from immediate and extended family, friends, health professionals:

Use of Products and technology for daily living (including education and communication):

Attitudes of immediate and extended family, friends, health professionals (including societal attitudes, social norms, practices and ideologies):

Communication, health and, education systems and policies:

Personal factors

Attributes of the person and internal influences on functioning and disability:

Formal testing and results: Include tests of body structure and function, activities and participation)

Clinical impression/diagnostic summary:

Diagnostic label:

Recommendations:

Speech-Language Pathologist
Designation, Address & CRR.

Annexure IV

Diagnostic Report for Adults with swallowing disorders

Name of the Institution

Name:
Age/Gender:
Date of Evaluation:
Validity period of the report:

Registration No:
Diagnosis:
Date of Issue of report:

Referral information

Referral source:

Informant:

Reason for referral:

Background information

Medical history:

Family history:

Educational and occupational information:

Previous evaluations/Therapy details:

Assessment information

Informal assessment

General behaviour:

Cognition:

Hearing:

Motor status:

Orofacial examination:

Language comprehension:

Language production:

Speech sound production and intelligibility

Voice:

Fluency:

Feeding and swallowing:

Activities and participation

Communication:

Learning and applying knowledge:

Interpersonal interactions and relationships:

Domestic life/Household tasks:

Major life areas:

Community, social and civic life:

Environmental factors

Support from immediate and extended family, friends, health professionals:

Use of Products and technology for daily living:

Attitudes of immediate and extended family, friends, health professionals (including societal attitudes, social norms, practices and ideologies):

Services, systems and policies:

Personal factors

Attributes of the person and the internal influences on functioning and disability

Formal testing and results: Include tests of body structure and function, activities and participation)

Clinical impression/diagnostic summary:

Diagnostic label:

Recommendations:

Speech-Language Pathologist
Designation, Address & CRR.

References

1. Trapl M, Enderle P, Nowotny M, Teuschl Y, Matz K, Dachenhausen A, Brainin M. Dysphagia bedside screening for acute-stroke patients: the Gugging Swallowing Screen. *Stroke*. 2007 Nov 1;38(11):2948-52.
2. Antonios N, Carnaby-Mann G, Crary M, Miller L, Hubbard H, Hood K, Sambandam R, Xavier A, Silliman S. Analysis of a physician tool for evaluating dysphagia on an inpatient stroke unit: the modified Mann Assessment of Swallowing Ability. *Journal of Stroke and Cerebrovascular Diseases*. 2010 Jan 1;19(1):49-57.
3. Ingram J, Johnson D, Copeland M, Churchill C, Taylor H. The development of a new breast feeding assessment tool and the relationship with breast feeding self-efficacy. *Midwifery*. 2015 Jan 1;31(1):132-7.
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5. Etges CL, Barbosa LD, Cardoso MC. Development of the pediatric dysphagia risk screening instrument (PDRSI). *InCoDAS 2020 Oct 12 (Vol. 32)*. Sociedade Brasileira de Fonoaudiologia.
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9. Krishnamurthy R, Balasubramaniam R K. Translation and Validation of Kannada Version of the Dysphagia Handicap Index. *American Journal of Speech Language Pathology*. 2020. 29(1):255-262. doi: 10.1044/2019_AJSLP-19-00122. Epub 2020 Jan 15. PMID: 31940224.
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11. Allen SL, Smith IM, Duku E, Vaillancourt T, Szatmari P, Bryson S, Fombonne E, Volden J, Waddell C, Zwaigenbaum L, Roberts W. Behavioral pediatrics feeding assessment scale in young children with autism spectrum disorder: Psychometrics and associations with child and parent variables. *Journal of pediatric psychology*. 2015 Jul 1;40(6):581-90.
12. Swapna N, Srushti S. *Feeding Handicap Index for Children (FHI-C)*. Manual. A publication of the All India Institute of Speech and Hearing, Manasagangothri, Mysore-6. 2017. (ISBN No.-978-93-86511-17-1)

Chapter III

Fluency Disorders

Fluency disorders, namely stuttering and cluttering, comprise of interruptions in the forward flow of speech. They are characterized by atypical rate, rhythm and disfluencies such as repetitions, sound prolongations and blocks. Stuttering may be accompanied by secondary behaviors such as jaw jerks and movements of extremities, as well as negative attitudes related to speaking. Fluency disorders can have impact on overall wellbeing of the individual. The assessment of fluency disorders should tap the frequency and types of disfluencies as well as accompanying symptoms and impact. The different tests that are used for the assessment of fluency disorders are shown in Table 3. Annexures V to IX depict the diagnostic report format and a sample report of fluency disorders.

Basis for the label: ICD-10 CM and 11–Fluency disorders

Screening for fluency disorders:

1. Case history
2. Clinical observation
3. Perceptual evaluation

For certification purpose: Developmental disorders of fluency are not currently classified as disabilities, and hence, do not have any criteria for disability certification. However, neurogenic acquired fluency disorders may be considered under speech or language disability as stated under RPwD Act 2016.

Assess functional Disability: ICF generic set.

Report: Diagnostic report format for fluency disorders (case history, fluency test results, clinical observation). Conditions with psychogenic and neurogenic basis needs assessment reports of psychologist, neurologist and/or radiologist. Additional space can be allocated in the report for specifying any supplementary tests or information that has to be communicated to the referral source or the concerned.

Validity of the report: Three to six months or as deemed appropriate by the clinician.

Table 3- Diagnostic tools, labels, report, and validity for Fluency disorders.

Sl. No	1 Condition	2 Diagnostic tool	3 Diagnostic label and code
1	Develop-mental stuttering	Stuttering Prediction Instrument ¹ (SPI) Test of Childhood Stuttering ² (TOCS) Stuttering severity instrument ³ (SSI-4) Attitude assessment: KiddyCAT ⁵ (Comm. Attitude Test for preschoolers) CAT ⁶ Speech Situations Checklist: Emotional Reaction ⁷ (SSC-ER) BigCAT ⁸ Perceptions of stuttering inventory Stutterers' Self Ratings of Reactions to Speech Situations ⁹ Impact assessment: Overall Assessment of the Speaker's Experience of stuttering ¹⁰ (OASES- S/A/ T) ISACS ^{11 & 12}	Developmental stuttering F 80.81
2	Normal non-fluency	Stuttering Prediction Instrument ¹ (SPI) Test of Childhood Stuttering ² (TOCS)	At risk for developmental stuttering OR Normal non-fluency ICCD-FS-26*
3	Psychogenic acquired stuttering	Stuttering Prediction Instrument ¹ (SPI) Test of Childhood Stuttering ² (TOCS) 3 yrs to adult: Stuttering severity instrument (SSI-4) Attitude assessment and impact assessment: Overall Assessment of the Speaker's Experience of stuttering ¹⁰ (OASES- S/A/ T) ISACS ^{11 & 12}	Psychogenic acquired stuttering F98
4	Neurogenic acquired stuttering	Stuttering Prediction Instrument ¹ (SPI) Test of Childhood Stuttering ² (TOCS) Stuttering severity instrument ³ (SSI-4) Attitude assessment and impact assessment: Overall Assessment of the Speaker's Experience of stuttering ¹⁰ (OASES- S/A/ T) ISACS ^{11 & 12}	Neurogenic acquired stuttering I69 series and R47.82

5	(Developmental) cluttering	<p>Predictive Cluttering Inventory¹³ (PCI) Cluttering severity instrument¹⁴ (CSI) AND To quantify or rule out stuttering: Stuttering Prediction Instrument¹ (SPI) Test of Childhood Stuttering² (TOCS) Stuttering severity instrument³ (SSI-4) Attitude assessment: Perceptions of speech communication¹⁵ (PSC) Attitude assessment and impact assessment for stuttering: Overall Assessment of the Speaker's Experience of stuttering¹⁰ (OASES- S/A/ T) ISACS^{11 & 12}</p>	<p>Developmental cluttering F 80.81 Developmental cluttering-stuttering F 80.81 Developmental stuttering-cluttering F 80.81 Cluttering Spectrum Behavior F 80.81</p>
6	Neurogenic acquired cluttering	<p>Predictive Cluttering Inventory¹³ (PCI) Cluttering severity instrument¹⁴ (CSI) AND To quantify or rule out stuttering: Stuttering Prediction Instrument¹ (SPI) Test of Childhood Stuttering² (TOCS) Stuttering severity instrument³ (SSI-4) Attitude assessment: Perceptions of speech communication (PSC) Impact assessment: ISACS^{11 & 12} Attitude assessment and impact assessment for stuttering: Overall Assessment of the Speaker's Experience of stuttering¹⁰ (OASES- S/A/ T) ISACS^{11 & 12}</p>	<p>Neurogenic acquired cluttering ICCD-OS-27*</p>

* No code prescribed by ICD. The committee has recommended to use this code.

Annexure V

Diagnostic report format for developmental stuttering

Name of the Institution

Name:	Registration No:
Age/Gender:	Date of Birth:
Diagnosis:	Date of Evaluation:
Date of Issue of report:	Validity period of the report:

Referral information

Referral source: Informant:
Reason for referral:

Background information

Chief complaints:

-Brief history:

[For children and adolescents, should include birth history, developmental history, family history, academic history]

Variability of the speech problem

Difficult situations-
Difficult communicative partners-
Feared sounds/ words-

Any previous assessments done

[For children and adolescents, must include hearing, language, speech, scholastic, intellectual]

History of intervention taken in the past

Assessments:

- **OPME**
- **Attention** (for children)
- **Behavior** (for children)
- **Language** (for children) [formal assessments only if deemed necessary by the therapist]
- **Articulation** [formal assessments only if deemed necessary by the therapist]
- **Voice** [formal assessments only if deemed necessary by the therapist]
- **Fluency:** (severity, types of disfluencies and secondary behaviors)

Standardized test / tool results (Name of the tool used):

One of the diagnostic tools listed above + description

Naturalness rating:

Naturalness rating scale in SSI-4 along with a description can be used

Rate of speech (syll/min)**Rate of articulation (syll/min)****Impact on quality of life****Personal factors**

For children: KiddyCAT and a descriptive paragraph about the child's awareness, self-consciousness, feared sounds, words, situations, people, etc.

For adolescents or adults: CAT/ SSC-ER/ BigCAT/ PSI / SSRSS(I) and a descriptive paragraph about awareness, self-consciousness, feared sounds, words, situations, people, etc.

Activities and participation

[A descriptive paragraph elaborating on communication, interpersonal relationships and major life areas should be included based on OASES/ ISACS responses or clinical observation and interaction]

Environmental factors

[A descriptive paragraph elaborating on support and relationships, attitudes and reactions of significant others should be included based in OASES/ ISACS responses or clinical observation and interaction]

Clinical impression/diagnostic summary:**Diagnosis:****Recommendations:**

Speech-Language Pathologist
Designation, Address & CRR.

Annexure VI

Diagnostic report format for neurogenic acquired stuttering

Name of the Institution

Name:	Registration No:
Age/Gender:	Date of Birth:
Date of Evaluation	Validity period of the report:

Referral information

Referral source:	Informant:
Reason for referral:	

Background information

Chief complaints:

Brief history:

[For children and adolescents, should include birth history, developmental history, family history, academic history]

Variability of the speech problem

Difficult situations-
Difficult communicative partners-
Feared sounds/ words-

Any previous assessments done

[For children and adolescents, must include hearing, language, speech, scholastic, intellectual]

History of intervention taken in the past

History of neurosurgery (if any)

Details of medications being taken at present

Assessments:

- **OPME**
- **Attention** (for children)
- **Behavior** (for children)
- **Language** [Aphasia needs to be ruled out; if present, its subtype, eg. Anomic aphasia needs to be diagnosed and specified using WAB / BDAE or equivalent tools as available]
- **Articulation** [formal assessments only if deemed necessary by the therapist]
- **Voice** [formal assessments only if deemed necessary by the therapist]
- **Fluency:** (severity, types of disfluencies and secondary behaviors)

Standardized test / tool results (Name of the tool used):

One of the diagnostic tools listed above + description

Naturalness rating:

Naturalness rating scale in SSI-4 along with a description can be used

Rate of speech (syll/min)

Rate of articulation (syll/min)

Impact on quality of life

Personal factors

For children: KiddyCAT and a descriptive paragraph about the child's awareness, self-consciousness, feared sounds, words, situations, people, etc.

For adolescents or adults: CAT/ SSC-ER/ BigCAT/ PSI / SSRSS(I) and a descriptive paragraph about awareness, self-consciousness, feared sounds, words, situations, people, etc.

Activities and participation

[A descriptive paragraph elaborating on communication, interpersonal relationships and major life areas should be included based on OASES/ ISACS responses or clinical observation and interaction]

Environmental factors

[A descriptive paragraph elaborating on support and relationships, attitudes and reactions of significant others should be included based in OASES/ ISACS responses or clinical observation and interaction]

Clinical impression/diagnostic summary:

Diagnosis:

Recommendations:

Speech-Language Pathologist
Designation, Address & CRR.

Annexure VII

Diagnostic report format for developmental cluttering / cluttering-stuttering

Name of the Institution

Name:	Registration No:
Age/Gender:	Date of Birth:
Date of Evaluation	Validity period of the report:

Referral information

Referral source:	Informant:
Reason for referral:	

Background information

Chief complaints:

Brief history:

[For children and adolescents, should include birth history, developmental history, family history, academic history]

Variability of the speech problem

Difficult situations-

Difficult communicative partners-

Feared sounds/ words-

Any previous assessments done

[For children and adolescents, must include hearing, language, speech, scholastic, intellectual]

History of intervention taken in the past

Assessments:

- **OPME**
- **Attention** (for children)
- **Behavior** (for children)
- **Language** (for children) [formal assessments only if deemed necessary by the therapist]
- **Articulation** [formal assessments only if deemed necessary by the therapist]
- **Voice** [formal assessments only if deemed necessary by the therapist]
- **Fluency:** (severity, types of disfluencies and secondary behaviors)

Standardized test / tool results (Name of the tool used):

One of the diagnostic tools listed above + description

Naturalness rating:

Naturalness rating scale in SSI-4 along with a description can be used

Rate of speech (syll/min)**Rate of articulation (syll/min)****Impact on quality of life****Personal factors**

Perceptions of speech communication (*PSI with the word stuttering replaced with communication*)

A descriptive paragraph about awareness, self-consciousness, and variation across situations, people and content.

IF STUTTERING COEXISTS,

For children: KiddyCAT and a descriptive paragraph about the child's awareness, self-consciousness, feared sounds, words, situations, people, etc.

For adolescents or adults: CAT/ SSC-ER/ BigCAT/ PSI / SSRSS(I) and a descriptive paragraph about awareness, self-consciousness, feared sounds, words, situations, people, etc.

Activities and participation

[A descriptive paragraph elaborating on communication, interpersonal relationships and major life areas should be included based on OASES/ ISACS responses or clinical observation and interaction]

Environmental factors

[A descriptive paragraph elaborating on support and relationships, attitudes and reactions of significant others should be included based in OASES/ ISACS responses or clinical observation and interaction]

Clinical impression/diagnostic summary:**Diagnosis:****Recommendations:**

Speech-Language Pathologist
Designation, Address & CRR.

Annexure VIII

Diagnostic report format for neurogenic acquired cluttering

Name of the Institution

Name: Registration No:
Age/Gender: Date of Birth:
Date of Evaluation Validity period of the report:

Referral information

Referral source: Informant:
Reason for referral:

Background information

Chief complaints:

Brief history:

[For children and adolescents, should include birth history, developmental history, family history, academic history]

Variability of the speech problem

Difficult situations-
Difficult communicative partners-
Feared sounds/ words-

Any previous assessments done

[For children and adolescents, must include hearing, language, speech, scholastic, intellectual]

History of intervention taken in the past

History of neurosurgery (if any)

Details of medications being taken at present

Assessments:

- **OPME**
- **Attention** (for children)
- **Behavior** (for children)
- **Language** [Aphasia needs to be ruled out; if present, its subtype, eg. Anomic aphasia needs to be diagnosed and specified using WAB / BDAE or equivalent tools as available]
- **Articulation** [formal assessments only if deemed necessary by the therapist]
- **Voice** [formal assessments only if deemed necessary by the therapist]
- **Fluency:** (severity, types of disfluencies and secondary behaviors)

Standardized test / tool results (Name of the tool used):

One of the diagnostic tools listed above + description

Naturalness rating:

Naturalness rating scale in SSI-4 along with a description can be used

Rate of speech (syll/min)

Rate of articulation (syll/min)

Impact on quality of life

Personal factors

Perceptions of speech communication (*PSI with the word stuttering replaced with communication*)

A descriptive paragraph about awareness, self-consciousness, and variation across situations, people and content.

IF STUTTERING COEXISTS,

For children: KiddyCAT and a descriptive paragraph about the child’s awareness, self-consciousness, feared sounds, words, situations, people, etc.

For adolescents or adults: CAT/ SSC-ER/ BigCAT/ PSI / SSRSS(I) and a descriptive paragraph about awareness, self-consciousness, feared sounds, words, situations, people, etc.

Activities and participation

[A descriptive paragraph elaborating on communication, interpersonal relationships and major life areas should be included based on OASES/ ISACS responses or clinical observation and interaction]

Environmental factors

[A descriptive paragraph elaborating on support and relationships, attitudes and reactions of significant others should be included based in OASES/ ISACS responses or clinical observation and interaction]

Clinical impression/diagnostic summary:

Diagnosis:

Recommendations:

Speech-Language Pathologist
Designation, Address & CRR.

Annexure IX

Diagnostic report format for developmental stuttering (SAMPLE CASE REPORT)

Name of the Institution

Name: XYZ	Registration No: 000
Age/Gender: F/16 years	Date of Birth: 17/7/2005
Diagnosis: Developmental stuttering	Date of Evaluation: 12/3/2022
Date of Issue of report:	Validity period of the report: 3 months

Referral information

Referral source: Informant:
Reason for referral: Inability to speak fluently

Background information

Chief complaints: Inability to speak fluently noticed at 9 years of age. Fluency had improved post therapy at the age of 9 years, however, has worsened over the past 2 years.

Brief history:

No significant prenatal/ perinatal/ postnatal history
Motor and speech milestones were reportedly normal.
No family history of stuttering.
Academic performance was reportedly good.

Variability of the speech problem

Difficult situations- Disfluencies increase when she faces persons in authority or speaks before a group.

Difficult communicative partners- None in particular

Feared sounds/ words- She reports disfluencies particularly on the sound /r/ and at the beginning of any communicative attempt (reading/ speaking/ conversation).

Any previous assessments done

None in the last 6-7 years

History of intervention taken in the past

Had attended regular speech therapy for 6-8 months at the age of 9 years after which fluency had improved noticeably.

Assessments:

- **OPME:** Structures normal, functions adequate. Strength, tone and movement adequate.
- **Language** upon informal assessment seemed to be age appropriate.

- **Articulation, resonance and voice quality** was normal
- **Fluency:** (severity, types of disfluencies and secondary behaviors)

She displayed disfluencies on almost every alternate word, with predominantly hard blocks and silent pauses. The disfluencies were accompanied by secondary behaviors like hand tremors, eye blinks and head nods.

Standardized test results (Stuttering Severity Instrument- 4):

Frequency: % syllables stuttered in reading= 41.2% (score= 9)

% syllables stuttered in narration= 15.2% (score= 8)

Total frequency score= 17

Duration (Average of three longest blocks)= 1.5 seconds

Duration score=6

Physical concomitant score= 0 (distracting sounds) + 4 (facial grimaces)+ 2 (head movements)+ 2 (movements of extremities)= 8

Naturalness rating:

7 (presence of disfluencies interrupting the flow of speech; flat intonation patterns)

Rate of speech = 75 syll/min

Rate of articulation = 100 syll / min

Rate of speech seems to be within the normal range. However, the discrepancy indicates the presence of abnormally long pauses in speech

- **Impact on quality of life:**

The Impact Scale for Assessment of Cluttering and Stuttering (ISACS; Kelkar, 2013) is a self-assessment questionnaire to assess the impact that the speech problem has on the patient. The person with the speech problem fills form (A). A significant other for the person with the speech problem fills form (B). The total possible score is 500. The total score obtained is converted to a percentage score. It can be used to check if therapy has resulted in a reduction in impact on quality of life.

ISACS scores: ISACS (A) = 52%

ISACS (B) = 52.5% (respondent: father)

Impact scores indicate that the impact is above the range usually seen for people with no speech disorder. A comparison of A and B scores shows that the client's father is well aware of the difficulties she faces as a result of her speech.

Personal factors

Based on responses to individual items of the ISACS, the client seems to be very self-conscious of her speech. Speaking also seems to evoke feelings of nervousness, embarrassment and sadness. She tends to avoid speaking as far as possible. She seems to be particularly conscious of the presence of a /t/ sound in a narrative and reports that she inevitably gets a block on any word beginning with the sound. She faces particular difficulty while speaking to teachers in school or while getting introduced to new people.

Activities and participation

She tends to find most communicative situations moderately difficult. She perceives her social life and relationships to be significantly affected by her speech. She also feels that it might potentially affect her chances of employment.

Environmental factors

Based on her responses to the ISACS, most people around her have neutral to positive impressions of her. She however feels that people who do not know her might not judge her very positively. Attitudes of most people in her environment seem to matter to her.

Clinical impression/diagnostic summary:

XYZ has frequent interruptions lasting between 1-2 seconds in her speech accompanied by visible struggle, which puts her core speech characteristics in the **'severe'** range based on SSI-4 results. The speech interruptions are associated with feelings of sadness, frustration, embarrassment and self-consciousness related to communication. Although she perceives most speaking situations as moderately difficult at best, she tends to avoid speaking probably as a result of the associated negative thoughts and feelings. However, people in her immediate social circle (family and close friends) seem to be supportive and understand the impact that her speech interruptions currently have on her life.

Diagnosis: Developmental stuttering

Recommendations:

- Regular follow up for speech therapy focused on core speech characteristics as well as coping with related thoughts and feelings
- Regular practice at home
- Re-evaluation after three months

Speech-Language Pathologist
Designation, Address & CRR.

References

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2. Riley GD, Bakker K. Stuttering severity instrument: SSI-4. Pro-Ed; 2009.
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4. Veerabhadrapa RC, Krishnakumar J, Vanryckeghem M, Maruthy S. Communication attitude of Kannada-speaking adults who do and do not stutter. *Journal of Fluency Disorders*. 2021 Dec 1;70:105866.
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Chapter IV

Speech Sound Disorders

Speech sound disorders include any combination of difficulties with perception, articulation/motor production and phonological representation of speech segments that may affect speech intelligibility and acceptability. The speech sound disorders could be classified into functional (Phonetic or phonemic type) and organic occurring due to neurological disorders (Dysarthria and apraxia), structural anomalies (Cleft palate or other craniofacial anomalies, structural deficits due to trauma or surgery), sensory disorders (hearing impairment), ASD, motor impairment (Cerebral palsy), intellectual disability and genetic syndromes.

The presence of speech sound disorders affects daily activities and participation in community. It can have an impact on educational, social, and occupational outcomes. Many personal and environmental factors including their context, background, and support structures will influence speech outcomes. Hence the assessment tools mentioned under each category of speech sound disorders is based on the International Classification of Functioning perspective (ICF, WHO,2007), which focusses on the body function, body structure, activity, participation, and the impact of personal and environmental factors as facilitators or barriers to functioning. The different tests that are used for the assessment of speech sound disorders are shown in Table 4. It is recommended that language specific tools should be used for assessment where available. In this context, it is suggested that efforts be made by professionals to develop suitable tools in regional languages. Annexure X and XI depicts the diagnostic report format and a sample reports of speech sound disorders.

Basis for the label: ICD-10 CM, 11 and ICCD– Speech Sound disorders

Screening for speech sound disorders:

1. Case history
2. Clinical observation
3. Perceptual evaluation
4. a) Screening articulation test in different Indian languages such as screening articulation test in Kannada¹, Predictive screening test of articulation in Malayalam² and Predictive screening test of articulation in English³, KPVT- A Screening Picture Vocabulary Test in Kannada⁴ can be used for functional and organic speech sound disorders other than children with apraxia of speech.
 - b) The test recommended for children with apraxia of speech for screening purpose includes Screening Test for Developmental apraxia of speech⁵.
 - c) The screening tools recommended for adults is Apraxia of Speech Rating Scale⁶, Kannada version of National Institute of Health stroke scale⁷ (Ka-NIHSS) for dysarthria.

For certification purpose: The conditions related to speech sound disorders with organic and neurological basis falls under the speech disability. Thus, those having benchmark disability are eligible for disability certificate as stated under RPwD Act 2016. Further, the assessment tools mandated for certification (AYJNIHH/SRMC Speech Intelligibility Rating Scale, CAPE-V/DSI) should be administered.

Assess functional Disability: ICF generic set.

Report: Diagnostic report format for speech sound disorders (case history, test results, clinical observation). Conditions with psychogenic, organic and neurogenic basis needs assessment reports of psychologist, neurologist and/or paediatricians. Additional space can be allocated in the report for specifying any supplementary tests or information that has to be communicated to the referral source or the concerned.

Validity of the report: Three to six months or as deemed appropriate by the clinician.

Table 4- Diagnostic tools, labels, report, and validity for Speech Sound disorders.

Sl. No	1 Condition	2 Diagnostic tool	3 Diagnostic label and code
1	Functional speech sound disorder in children a) Articulation disorder b) Phonological disorder	Articulation assessment Kannada diagnostic photo articulation test ⁸ (KDPAT) Malayalam Articulation test ⁹ (MAT) Phonological process assessment Computerized assessment of phonological processes in Malayalam/Kannada ¹⁰ (CAPP-M/K)	a) Developmental speech sound disorder- Phonetic type F80.0 b) Developmental speech sound disorder- Phonemic type F80.0
2	Organic Speech sound disorders developmental or acquired specifically due to: a) Hearing impairment. b) Orofacial and maxillofacial anomalies c) Intellectual disabilities /ASD /cerebral palsy /genetic syndromes.	Articulation assessment Kannada diagnostic photo articulation test ⁸ (KDPAT) Malayalam Articulation test ⁹ (MAT) Universal parameters for reporting speech outcomes in individuals with cleft palate ¹⁰ Kannada version of Speech handicap index ¹¹	If Developmental F80.4 a) Developmental speech sound disorder secondary to hearing impairment F80.4 b) Developmental speech sound disorder secondary to orofacial and maxillofacial anomalies ICCD-OS-28 d) Acquired speech sound disorder secondary to Orofacial and maxillofacial anomalies ICCD-OS-29 c) Developmental speech sound disorder secondary to Intellectual disabilities /ASD /cerebral palsy /genetic syndromes F70-F79
3	Motor Speech disorders (a) Apraxia of speech in children (b) Apraxia of speech in adults	Apraxia assessment in children: Dynamic Evaluation of Motor Speech Skill ¹² (DEMSS) OR Verbal Motor Production Assessment for Children ¹³ (VMPAC) Apraxia assessment in adults: Apraxia Battery for Adults- Second Edition ¹⁴ (ABA-2) Kannada version of Speech handicap index ¹¹	a) Childhood apraxia of speech ICCD-OS-30 b) Apraxia of speech-ICCD-OS-31 c) Primary progressive apraxia of speech-ICCD-OS-32

4	<p>Motor Speech disorders</p> <p>a) Dysarthria in children</p> <p>b) Dysarthria in adults</p>	<p>Dysarthria assessment in children: Pediatric Radboud dysarthria assessment¹⁵</p> <p>Dysarthria assessment in adults: Frenchay Dysarthria Assessment¹⁶</p> <p style="text-align: center;">OR</p> <p>The Radboud Dysarthria Assessment¹⁷</p> <p>Kannada version of Speech handicap index¹¹</p>	<p>a) Childhood dysarthria- ICCD-OS-33</p> <p>b) Dysarthria-ICCD-OS-34</p>
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Certification is feasible only in cases of speech disorders caused due to organic causes.

Annexure X

Diagnostic Report for Children with Speech Sound Disorders

Name of the Institution

Name:	Registration No:
Age/Gender:	Date of Birth:
Diagnosis:	Date of Evaluation:
Date of Issue of report:	Validity period of the report:

Referral information

Referral source:	Informant:
Reason for referral:	

Background information

Prenatal and birth history:
Developmental history:
Medical history:
Family history:
Educational information:
Previous evaluations/Therapy details:

Assessment information

Informal assessment

General behaviour:
Hearing:
Intellectual status:
Cognition:
Play:
Motor skills:
Orofacial examination:
Language comprehension:
Language production:
Speech sound production and intelligibility:

Voice:

Fluency:

Feeding and swallowing:

Activities and participation

Communication:

Learning and applying knowledge:

Peer and family interactions and relationships:

Major life areas (Formal Education):

Environmental factors:

Support from immediate and extended family, friends, health professionals:

Use of Products and technology for daily living (including education and communication):

Attitudes of immediate and extended family, friends, health professionals (including societal attitudes, social norms, practices and ideologies):

Communication, health and, education systems and policies:

Personal factors

Attributes of the person and internal influences on functioning and disability:

Formal testing and results: Include tests of body structure and function, activities and participation)

Clinical impression/diagnostic summary:

Diagnostic label:

Recommendations:

Speech-Language Pathologist
Designation, Address & CRR.

Annexure XI

Diagnostic Report for Adults with Speech Sound Disorders

Name of the Institution

Name:	Registration No:
Age/Gender:	Date of Birth:
Diagnosis:	Date of Evaluation:
Date of Issue of report:	Validity period of the report:

Referral information

Referral source:	Informant:
Reason for referral:	

Background information

Medical history:
Family history:
Educational and occupational information:
Previous evaluations/Therapy details:

Assessment information

Informal assessment

General behaviour:
Cognition:
Hearing:
Motor status:
Orofacial examination:
Language comprehension:
Language production:
Speech sound production and intelligibility
Voice:
Fluency:
Feeding and swallowing:

Activities and participation

Communication:

Learning and applying knowledge:

Interpersonal interactions and relationships:

Domestic life/Household tasks:

Major life areas:

Community, social and civic life:

Environmental factors

Support from immediate and extended family, friends, health professionals:

Use of Products and technology for daily living:

Attitudes of immediate and extended family, friends, health professionals (including societal attitudes, social norms, practices and ideologies):

Services, systems and policies:

Personal factors

Attributes of the person and the internal influences on functioning and disability

Formal testing and results: Include tests of body structure and function, activities and participation)

Clinical impression/diagnostic summary:

Diagnostic label:

Recommendations:

Speech-Language Pathologist
Designation, Address & CRR.

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Chapter V

Voice Disorders

Voice disorders can be seen across the life span. Individuals can have problems in being audible, speaking in an age and sex appropriate pitch, speaking with clarity of tone and a quality that is non distracting to the listener. The voice demands required from a vocational or professional need may not be met adequately with ease and comfort by those individuals who suffer voice disorders. The conditions related to voice disorders having neurological or structural deficits fall under speech disability as per RPwD Act 2016. The tools suggested for diagnosis of voice disorders, and the labels that are acceptable are detailed below. The different tests that are used for the assessment of voice disorders are shown in Table 5 and 6. The Annexure XII to XIII depicts the diagnostic report format and a sample reports of voice disorders.

Basis for the label: ICD-10 CM 11 and SIG 3- ASHA–Voice disorders

Screening for Voice disorders:

1. Case history
2. Clinical observation
3. Perceptual evaluation (GRBAS¹²³⁴⁵, CAPE-V¹²³⁴⁵)
4. PROM (Patient Reported Outcome Measures)

For certification purpose: The conditions related to voice disorders with organic and neurological basis falls under the speech disability. Thus, those having benchmark disability are eligible for disability certificate as stated under RPwD Act 2016.

Assess functional Disability: ICF generic set.

Report: Diagnostic report format for voice disorders (case history, voice test results, clinical observation). Conditions with psychogenic and neurogenic basis needs assessment reports of psychologist, neurologist and/or radiologist. Additional space can be allocated in the report for specifying any supplementary tests or information that has to be communicated to the referral source or the concerned.

Validity of the report: Three to six months or as deemed appropriate by the clinician.

Table 5- Diagnostic tools, labels, report, and validity for Voice disorders.

Sl. No	1 Condition	2 Diagnostic tool	3 Diagnostic label and code
1.	Puberphonia	Perceptual evaluation, visual imaging, acoustic analysis, clinical aerodynamic analysis	Puberphonia ICCD-FS-34 Mutational Falsetto ICCD-OS-36
2.	Presbyphonia	Perceptual evaluation, visual imaging, acoustic analysis, clinical aerodynamic analysis	Hoarse voice ICCD-OS-37
3.	Muscle Tension Dysphonia (Primary) Muscle Tension/Adaptive Dysphonia (Secondary) Ventricular Dysphonia Paradoxical Vocal Fold Movement Disorder (Vocal Cord Dysfunction)	Perceptual evaluation, visual imaging, acoustic analysis, clinical aerodynamic analysis	Muscle Tension Dysphonia ICCD-FS-38 Muscle Tension Dysphonia ICCD-OS-39 Muscle Tension Dysphonia ICCD-FS-40 Vocal Cord Dysfunction ICCD-FS-41

Table 6- Diagnostic tools, labels, report and validity for Voice disorders (Diagnostic labels not exclusive to SLP - ICD codes available)

Sl. No	1 Condition	2 Diagnostic tool	3 Diagnostic label and code
1.	Malignant neoplasm of larynx (Glottal, Supra-glottal & subglottal)*	Stroboscopy, acoustic analysis, clinical aerodynamic analysis	Hoarseness of voice secondary to Cancer of the larynx C32 (C32.0 - C32.9), R49.0, R49.1
2.	Carcinoma in situ of larynx	Stroboscopy, acoustic analysis, clinical aerodynamic analysis	Hoarseness of voice secondary to Cancer of the larynx D02.0, R49.0, R49.1
3.	Benign neoplasm of larynx (Neoplastic tumors- Squamous papilloma (Juvenile & adult); Chondroma; Haemangioma; Granular cell tumor; Glandular cell tumor; Rhabdomyoma; Lipoma; Fibroma)	Perceptual evaluation, visual imaging, acoustic analysis, clinical aerodynamic analysis	Hoarseness of voice secondary to Laryngeal Mass D14.1, R49.0, R49.1
4.	Non-neoplastic lesions of larynx: Epithelial and lamina propria abnormalities of vocal folds	Stroboscopy, acoustic analysis, clinical aerodynamic analysis	Phonotraumatic vocal hyperfunction with Laryngeal mass J38.1-38.7 , R49.0
5.	Psychogenic aphonia Psychogenic dysphonia	Stroboscopy	Functional voice disorder – Non-Phonotraumatic vocal hyperfunction F44.4-, F68.1, R49.0,

6.	Acute laryngitis	Stroboscopy, acoustic analysis, clinical aerodynamic analysis	Phonotraumatic vocal hyperfunction J04, R49.0
7.	Acute obstructive laryngitis	Stroboscopy, acoustic analysis, aerodynamic analysis	Phonotraumatic vocal hyperfunction J05, R49.0
8.	Chronic laryngitis	Stroboscopy, acoustic analysis, clinical aerodynamic analysis	Phonotraumatic vocal hyperfunction J37, R49.0, R49.1 J37.0, R49.0, R49.1
9.	<p>Diseases of vocal cords and larynx, not elsewhere classified</p> <p>Paralysis of vocal cords and larynx, unspecified</p> <p>Paralysis of vocal cords and larynx, unilateral</p> <p>Paralysis of vocal cords and larynx, bilateral</p> <p>Unilateral or Bilateral Recurrent Laryngeal Nerve (RLN) Paresis</p> <p>Bilateral Recurrent Laryngeal Nerve (RLN) Paralysis–Peripheral</p> <p>Myasthenia Gravis</p>	Stroboscopy, acoustic analysis, clinical aerodynamic analysis	<p>Non-phonotraumatic vocal hypofunction</p> <p>Non-Phonotraumatic vocal hyperfunction (compensated)</p> <p>J38- J38.02 R49.0,</p>
10.	Movement Disorders Affecting the Larynx	Stroboscopy, acoustic analysis, clinical aerodynamic analysis,	<p>Hyperkinetic/tonic voice disorder</p> <p>Vocal tremors</p> <p>Spasmodic dysphonia</p> <p>Spasmodic dysphonia</p> <p>Spasmodic dysphonia</p> <p>Spasmodic dysphonia</p> <p>G20-G26, R49.0</p>
11.	Gastro-esophageal reflux disease	Stroboscopy, acoustic analysis	<p>Non-Phonotraumatic vocal hyperfunction secondary to Laryngo-Pharyngeal Reflux</p> <p>K21.0, R49.0</p>

12.	<p>Congenital malformations of larynx</p> <p>Web of larynx Glottic web of larynx Web of larynx NOS</p> <p>Congenital subglottic stenosis</p> <p>Laryngeal hypoplasia</p> <p>Laryngocele</p> <p>Congenital laryngomalacia</p> <p>Other congenital malformations of larynx</p> <p>Congenital malformation of larynx, unspecified</p>	Stroboscopy, acoustic analysis, clinical aerodynamic analysis,	<p>Hoarseness of voice (with other symptomatic description if any)</p> <p>Q31 -31.9, R49.0</p>
13.	<p>Injuries to the neck</p> <p>Laryngeal mucosa trauma (chemical and thermal)</p>	Stroboscopy, acoustic analysis, clinical aerodynamic analysis	<p>Hoarseness of voice - Phonotraumatic vocal hyperfunction subsequent to injuries to the neck</p> <p>S10-S19, R49.0, R49.1</p>
14.	<p>Internal laryngeal trauma</p> <p>External laryngeal trauma</p> <p>Hoarseness/Dysphonia</p>	Stroboscopy, acoustic analysis, clinical aerodynamic analysis	<p>Phonotraumatic/non-phonotraumatic vocal hyperfunction</p> <p>R49.0</p>
15.	<p>Internal laryngeal trauma</p> <p>External laryngeal trauma</p> <p>Aphonia</p>	Stroboscopy, acoustic analysis, clinical aerodynamic analysis	<p>Aphonia</p> <p>R49.1</p>
16.	Cricoarytenoid and Cricothyroid Arthritis	Stroboscopy, acoustic analysis, clinical aerodynamic analysis	<p>Non-phonotraumatic vocal hyperfunction(compensatory)</p> <p>S13.5, R49.0, R49.1</p>
17.	Systemic conditions affecting voice	Stroboscopy, acoustic analysis, clinical aerodynamic analysis,	<p>Non-phonotraumatic vocal hyperfunction(compensatory)</p> <p>E00- E05 E89, R49.0</p>
18.	Immunological condition affecting voice	Stroboscopy, acoustic analysis, clinical aerodynamic analysis	<p>Non-phonotraumatic vocal hyperfunction (Compensatoy)</p> <p>J30-J39, R49.0</p>
19.	Neurogenic Voice Disorders	Stroboscopy, acoustic analysis, clinical aerodynamic analysis	<p>Hoarseness of voice (Hypo-functional voice disorder) subsequent to -Unilateral/bilateral vocal fold paralysis</p> <p>G20-G35 R49.0</p>
20.	Other Disorders Affecting Voice	Stroboscopy, acoustic analysis, clinical aerodynamic analysis	<p>Hoarseness of voice</p> <p>R49.8, R49.0, R49.1</p>

Annexure XII

Diagnostic Report of a person with voice concern

Name of the Institution

Demographic details

Name:	Registration No:
Age/Gender:	Date of Birth:
Diagnosis:	Date of Evaluation:
Date of Issue of report:	Validity period of the report:

Referral information

Referral source:
Informant:
Reason for referral:

Background information

Brief complaint:

Brief history

Onset of the problem: Sudden/ Gradual

Nature of the problem: Progressive/ Non-progressive

When was the problem first noticed? _____

Complaint of throat pain while speaking/ swallowing: Yes/No (If Yes, Morning/ After talking for extended periods of time/ Always)

Voice is better in the morning/midday/ evening/ no change during the day

Complaint of pain the neck: Yes. No, (If yes, describe the nature of pain _____)

Voice change during emotional overlay: Yes/No, (If yes, specify _____)

Any other significant information:

Medical History and findings

Vocal and Non-Vocal habits

Talking in a noisy environment- Present/ Absent, if present explain why and for how many hours/day

Excessive speaking- Present/ Absent, if present why and for how many hours/day _____

Shouting, Screaming, Yelling, Cheering or Cheerleading- Present/ Absent

Coughing- Present/ Absent

Voice impersonations- Present/ Absent

Whispering- Present/ Absent

Clearing throat- Present/ Absent, if present how frequently _____

Caffeine consumption- Present/ Absent, if present how many cups/day?

Amount of water intake _____ in litres

Frequency of water intake _____

Intake of spicy food- Present/ Absent

Skipping of meals- Present/ Absent

Smoking habits- Present/ Absent, if present how many cigars/ day _____

Passive smoking- Present/ Absent

Alcohol consumption- Present/ Absent

Others if any specify:

Voice Profile:

Pitch:

Loudness:

Quality:

Pitch breaks: Present/ Absent

Voice breaks: Present/ Absent

Vocal fatigue: Present/ Absent

Perceptual evaluation: GRBAS/CAPE-V (specify the Indian Language of the test stimuli)

Visual imaging (Stroboscopy/laryngoscopy findings):

Clinical voice measures: MPT & s/z ratio:

PFT measures:

Acoustic voice analysis: Mention signal type and analysis software information:

PROM: (VDOP/ VHI and VFI – mention the language of the tool)

Clinical impression/diagnosis:

Recommendations:

Speech-Language Pathologist
Designation, Address & CRR.

Annexure XIII

Diagnostic Report of a person with voice concern (Sample case report)

ABC institution of Higher Education and Research

Demographic details

Name: ABC	Registration No: 2345627
Age/Gender: 27Y/F	Date of Birth: 11-03-1995
Date of Evaluation: 20-06-2022	Occupation: Teacher: (III grade – Primary school)
Date of Issue of report: 20-06-2022	Validity period of the report: 20-09-2022

Referral information

Referral source: Dr. XYZ (ENT –Surgeon)

Informant: Self

Reason for referral: Voice therapist consultation

Background information

Brief complaint: Ms. XYZ, 27 years female came to the department of Speech, Language and Hearing Sciences with the complaint of change in voice quality for the past 6 months.

Brief history

Onset of the problem: Gradual

Nature of the problem: Progressive

When was the problem first noticed?: Since 6 months (exact date not available)

Complaint of throat pain while speaking/ swallowing: No

Voice is better in the morning/midday/ evening/ no change during the day: Better during midday

Complaint of pain the neck: Yes. No

Voice change during emotional overlay: No

Any other significant information: nil

Medical History and findings:

Previous investigation: ENT evaluation done in the year 2016 revealed B/L early vocal cord nodule. The client attended voice therapy sessions for 2 months (16 sessions). Improvements were significant. However, the patient reported that she does not follow exercises consistently anymore.

Vocal and Non-Vocal habits

Talking in a noisy environment: Present (approximately 10 hours/day)

Excessive speaking: Present, 6 hours (during class and while at school)

Shouting, Screaming, Yelling, Cheering or Cheerleading: Present (Shouting, Screaming and yelling – Patient reports children are unruly and so she is necessitated to use voice excessively and in difficult ways, patient reports she has difficulty talking soft)

Coughing: Present (most often as she starts speaking loud)

Voice impersonations: Absent

Whispering: Absent

Clearing throat: Present, Very frequently as reported and observed (5-7 times in a five minute conversation)

Caffeine consumption: Present: 4 cups/day (volume of cup 100ml)

Amount of water intake: 2 litres (approximately)

Frequency of water intake: Approximately Once in 3hours

Intake of spicy food: Present (frequent)

Skipping of meals: Present (typically misses Breakfast)

Smoking habits: Absent

Passive smoking: Absent

Alcohol consumption: Absent

Others if any specify: Allergies due to dust was reported

Voice Profile:

Pitch: Low (speaking voice)

Loudness: Loud effortful (speaking voice)

Quality: Hoarse (severe)

Pitch breaks: Absent

Voice breaks: Present

Vocal fatigue: Present

Perceptual evaluation: GRBAS/CAPE-V (If in Indian Languages): G3R3B2A2S3

Visual imaging (Stroboscopy/laryngoscopy findings): Done on 19-06-2022 revealed B/L vocal fold nodules (Rt> Lt), Hour glass closure pattern, Asymmetrical, Periodic, Ventricular Band Hyper function- Present, Non-vibratory portion- nil, Other significant findings: LPR

Clinical voice measures: MPT & s/z ratio: MPT – 10 seconds (/a/ vowel); s/z ratio: 1.7

PFT measures: Parameters are within expected norms

Acoustic voice analysis: Mention signal type and analysis software information: Type II signal; F_0 (speaking voice – 178Hz – impression: Reduced for age and sex) and F_0 Range (speaking: 1-2 ST; Phonation Glide: 13 ST - Impression – reduced) & I_0 range (loud: 75dB SPL, soft 65 dB SPL – Range: 10dB- Impression: Reduced). DSI was – 3.5 revealed severe deviation

PROM: (VDOP/ VHI and VFI – mention the language of the tool): Vocal Fatigue Index – Tiredness and avoidance of voice use: 27; Physical discomfort: 11;

Improvement of symptoms with rest: 3; VFI indicates vocal fatigue in all three factors.

Clinical impression/Diagnosis: Phonotraumatic Vocal Hyperfunction with Bilateral Vocal Nodules

Recommendations:

- Follow vocal hygiene tips and conservative voice use (directed towards reduction of reflux and phonotrauma)
- Voice therapy to reduce vocal hyperfunction and improve phonatory function for speaking (Frequency of session: Weekly twice)
- Repeat assessment after 6 weeks of voice therapy for further advice

Speech-Language Pathologist
Designation, Address & CRR.

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Chapter VI

Child Language Disorders

A category of disorders, either developmental or acquired, characterized by an impairment in an individual's language capabilities. These includes various conditions characterized by delay/inadequacy of comprehension or expression of spoken and/or written forms of language. Child language disorders can occur in isolation or along with other comorbid conditions. The tools listed for assessment of child language disorders can be used for either screening or diagnostic purposes on a case-to-case basis. Some of the Child Language Disorders fall under the purview of disability certification as per the RPwD Act 2016. The process of certification involves a team of professionals including Speech-Language Pathologists, Clinical Psychologists and other medical professionals. The different tests that are used for the assessment of child language disorders are shown in Table 7. Annexure XIV to XXV depicts the diagnostic report format and sample reports of child language disorders. However, in cases of children who are non-compliant/non-cooperative and whose language abilities cannot be derived on the bases of standardised tests, language skills can be profiled based on informal/dynamic assessments and the same can be documented in the diagnostic report.

Basis for the label: ICD-10 CM, 11 and ICCD – Child Language Disorders

Screening for Child Language Disorders:

1. Case history
2. Clinical observation

For certification purpose: The conditions related to child language disorders with organic and neurological basis falls under language disability. Thus, those having benchmark disability are eligible for disability certificate as stated under RPwD Act 2016.

Assess functional Disability: ICF generic set.

Report: Diagnostic report format for child language disorders (case history, test results, clinical observation). Conditions with psychogenic and neurogenic basis needs assessment reports of psychologist, neurologist and/or radiologist. Additional space can be allocated in the report for specifying any supplementary tests or information that has to be communicated to the referral source or the concerned.

Validity of the report: Three to six months or as deemed appropriate by the clinician.

Table 7- Diagnostic tools, labels, report, and validity for Child Language disorders.

Sl. No	1 Condition	2 Co-morbid condition	3 Diagnostic Tool	4 Diagnostic label & Code
1.	Delay in Receptive and Expressive Language Skills with co-morbidities	HI	Scales of Early Communication Skills for Hearing-Impaired Children ¹ (SECS) Language Sampling*	Spoken Language disorder secondary to hearing loss ICCD-OL-51
		ADHD	Assessment of Language Development ² (ALD) Receptive Expressive Emergent Language Scale ³ (REELS) Diagnostic and Statistical Manual of Mental Disorders- 5 th Edition ⁴ (DSM 5) checklist for ADHD Communication DEALL Developmental Checklists ²⁰ (CDDC) Language Sampling*	Spoken language disorder secondary to ADHD ICCD-OL-52
		ID	Assessment of Language Development ² (ALD) 3 Dimensional Language Assessment Tool ⁵ (3DLAT) Comprehensive Language Assessment Tool ⁶ (CLAT) Communication DEALL Developmental Checklists ²⁰ (CDDC) Language Sampling*	Spoken language disorder secondary to intellectual disability ICCD-OL-53
		ASD	Modified Checklist for of Autism in Toddlers ⁷ (MCHAT) Childhood Autism Rating Scale ⁸ (CARS) Indian Scale for Assessment of Autism ⁹ (ISAA) Assessment of Language Development ² (ALD) Receptive Expressive Emergent Language Scale ³ (REELS) Communication DEALL Developmental Checklists ²⁰ (CDDC) Language Sampling*	Spoken language disorder secondary to autism spectrum disorder ICCD-OL-54
2.	Delay in Receptive and Expressive Language Skills with no co-morbidities	NA	Assessment of Language Development ² (ALD) Receptive Expressive Emergent Language Scale ³ (REELS) Communication DEALL Developmental Checklists ²⁰ (CDDC) Language Sampling*	Developmental language Disorder F80.9 OR Late language emergence ICCD-FL-55

3.	Social Communication Disorder	NA	Assessment of Language Development ² (ALD) Receptive Expressive Emergent Language Scale ³ (REELS) Tests to assess context specific pragmatic abilities- Descriptive Pragmatic Profile of Clinical Evaluation of Language Fundamentals –Preschool ¹⁰ (CELF-PS), pragmatic profile, pragmatic language skill inventory, The pragmatic profile of everyday communication skills, Communication DEALL Developmental Checklists ²⁰ (CDDC) Applicable tests to rule out any comorbidities like ID and ASD Language Sampling*	Social communication disorder F80.82
5.	Reading and Writing Disorder		Linguistic Profile Test ¹¹ (LPT) Assessment of Language Development ² (ALD) Manipal manual of adolescent language assessment ¹² (MMALA) Dyslexia assessment profile for Indian children ¹³ (DAPIC) Dyslexia assessment in languages of India ¹⁴ (DALI) Language Sampling*	Specific learning disability F81.0
6.	Childhood Aphasia		Western Aphasia Battery ¹⁵ (WAB) Boston Diagnostic Aphasia Examination ¹⁶ (BDAE) Boston Naming Test ¹⁷ (BNT) (Based on Child’s age and linguistic abilities) Children’s acquired aphasia screening test ¹⁸ (CAAST) Clinical Evaluation of Language Fundamentals ¹⁹ (CELF) Communication DEALL Developmental Checklists ²⁰ (CDDC) Language Sampling*	Acquired childhood aphasia R47. 01

*To be carried out preferably for children from whom conversation/narrative/picture description sample can be elicited

Annexure XIV

Diagnostic report format for Language Disorders (Sample case report)

Name of the Institute

SH/ER-14/June/2022-23

Date: 16/06/2022

EVALUATION REPORT

Case Name: XXX
Age/Gender: 5.8 Years/Female

Case No: 486153
Date of Evaluation: 10/06/2022
Validity of the report: 09.12.2022

XXX was evaluated with the complaint of delayed speech-language skills and hearing loss.

Speech and Language Evaluation tests administration:

Sl No.	Tests	Scores
1.	Assessment Checklist for Speech and Language Skills (AC-SLS)	Receptive Language Age : 0.10 – 1.0 years Expressive Language Age : 0.10 – 1.0 years
2.	Scales of Early Communication Skills (SECS)	Combined Receptive Language Age: <2.0 – 2.11 years Combined Expressive Language Age: <2.0 – 2.11 years with gestures

Clinical Impressions:

Speech and Language Evaluation	Hearing Evaluation
<ul style="list-style-type: none"> Age inadequate receptive and expressive language skills 	<ul style="list-style-type: none"> Bilateral Profound Hearing Loss

Provisional Diagnosis: Spoken Language Disorder secondary to Hearing Impairment.

Recommendations:

- Speech and Language Therapy
- Follow –up

Speech-Language Pathologist
Designation, Address & CRR.

NOTE: The comprehensive report is issued upon the request of the client. This report is a summary of the latest evaluation done at our institute. For further assistance please contact us.

Annexure XV

Diagnostic report format for Language Disorders (Sample case report)

Name of the Institute

SH/ER-12/June/2022-23

Date: 17/06/2022

EVALUATION REPORT

Case Name: ABC

Case No: 547952

Age/Gender: 12.9 Years/Male

Date of Evaluation: 25/04/2022

Validity of the report: 25.10.2022

ABC was brought with the complaint of inadequate speech-language skills.

Speech and Language Evaluation tests administration:

Tests	Scores
Assessment Checklist for Speech and Language Skills (AC-SLS)	Receptive Language Age : 2.10 – 3.0 years Expressive Language Age : 1.7 – 1.9 years
Clinical Impressions:	
Speech and Language Evaluation	Psychological Evaluation
<ul style="list-style-type: none"> • Age inadequate receptive and expressive language skills 	<ul style="list-style-type: none"> • MA : 8.11 years • IQ : 70 • Borderline Intellectual Functioning

Provisional Diagnosis: Spoken Language Disorder secondary to Borderline Intellectual Functioning.

Recommendations:

- Speech and Language Therapy
- Follow –up

Speech-Language Pathologist
Designation, Address & CRR.

NOTE: The comprehensive report is issued upon the request of the client. This report is a summary of the latest evaluation done at our institute. For further assistance please contact us.

Annexure XVI

Diagnostic report format for Language Disorders (Sample case report)

Name of the institute

SH/ER-11/January/2021-22

Date: 21/1/2022

EVALUATION REPORT

Case Name: PQR

Case No: 473310

Age/Gender: 6.3 Years/Male

Date of Re-Evaluation: 12/01/2022

Validity of the report: 11.07.2022

PQR was evaluated with the complaint of inadequate speech-language skills and poor mental abilities.

Speech and Language Evaluation tests administration:

Sl No.	Tests	Scores
1.	Assessment Checklist for Speech and Language Skills (AC-SLS)	Receptive Language Age : 2.7 – 2.9 years Expressive Language Age : Scattered between 2.4 – 2.6 years and 2.7 – 2.9 years

Clinical Impressions:

Speech and Language Evaluation	Psychological Evaluation	Physio/Occupational Therapy Evaluation
<ul style="list-style-type: none"> • Age inadequate receptive and expressive language skills 	<ul style="list-style-type: none"> • MA : 4 years • IQ : 64 • Mild Mental Retardation 	<ul style="list-style-type: none"> • Intellectual Disability

Provisional Diagnosis: Spoken Language Disorder secondary to Intellectual Disability.

Recommendations:

- Speech and Language Therapy
- Occupational Therapy
- Follow –up after six months

Speech-Language Pathologist
Designation, Address & CRR.

NOTE: The comprehensive report is issued upon the request of the client. This report is a summary of the latest evaluation done at our institute. For further assistance please contact us.

Annexure XVII

Diagnostic report format for Language Disorders (Sample case report)

Name of the institute

SH/ER-32/June/2022-23

Date: 28/06/2022

EVALUATION REPORT

Case Name: ABC

Case No: 552447

Age/Gender: 3.2 Years/Female

Date of Evaluation: 27.06.2022

Validity of the report: 26.12.2022

ABC was brought with the complaint of delayed speech-language skills.

Speech and Language Evaluation tests administration:

Sl No.	Tests	Scores
1.	Assessment Checklist for Speech and Language Skills (AC-SLS)	Receptive Language Age : 1.7 – 1.9 years Expressive Language Age : 1.4 – 1.6years
2.	Modified Checklist for Autism in Toddlers(M-CHAT)	Failed in 4 critical items
3.	Indian Scale For Assessment of Autism (ISAA)	Score : 91 Severity : Mild Autism

Clinical Impressions:

Speech and Language Evaluation	Psychological Evaluation	Autism Spectrum Disorder Evaluation	Physio/ Occupational Therapy Evaluation
<ul style="list-style-type: none"> Age inadequate receptive and expressive language skills 	<ul style="list-style-type: none"> MA : 3 years IQ : 95 Average Intelligence 	<ul style="list-style-type: none"> Autism Spectrum Disorder (Mild level) 	<ul style="list-style-type: none"> Sensory Issues

Provisional Diagnosis: Spoken Language Disorder secondary to Autism Spectrum Disorder.

Recommendations:

- Speech and Language Therapy
- Sensory Integration Therapy
- Follow –up

Speech-Language Pathologist
Designation, Address & CRR.

NOTE: The comprehensive report is issued upon the request of the client. This report is a summary of the latest evaluation done at our institute. For further assistance please contact us.

Annexure XVIII

Diagnostic report format for Language Disorders (Sample case report)

Name of the institute

SH/ER-09/December/2021-22

Date: 22/12/2021

EVALUATION REPORT

Case Name: XYZ

Case No: 537265

Age/Gender: 7.4 Years/Female

Date of Evaluation: 22/10/2021

Validity of the report: 21.04.2022

XYZ was brought with the complaint of reduced clarity of speech and poor motor abilities.

Speech and Language Evaluation tests administration:

Sl No.	Tests	Scores
1.	Assessment Checklist for Speech and Language Skills (AC-SLS)	Receptive Language Age : 3.0 – 3.6 years Expressive Language Age : 1.10 – 2.0 years

Clinical Impressions:

Speech and Language Evaluation	Psychological Evaluation	Hearing Evaluation	Physio/Occupational Therapy Evaluation
<ul style="list-style-type: none"> • Age inadequate receptive and expressive language skills 	<ul style="list-style-type: none"> • MA : 6 years • IQ : 82 • Borderline Intellectual Functioning 	<ul style="list-style-type: none"> • Bilateral hearing sensitivity within normal limits (Based on OAE) 	<ul style="list-style-type: none"> • Global Developmental Delay

Provisional Diagnosis: Spoken Language Disorder secondary to Developmental Delay.

Recommendations:

- Speech and Language Therapy
- Follow –up

Speech-Language Pathologist
Designation, Address & CRR.

NOTE: The comprehensive report is issued upon the request of the client. This report is a summary of the latest evaluation done at our institute. For further assistance please contact us.

Annexure XIX

Diagnostic report format for Language Disorders (Sample case report)

Name of the Institute

SH/ER-11/May/2022-23

Date: 17/05/2022

EVALUATION REPORT

Case Name: ABC
Age/Gender: 2.2 Years/Male

Case No: 548502
Date of Evaluation: 03.05.2022
Validity of the report: 02.11.2022

ABC was evaluated with the complaint of inadequate speech-language skills.

Speech and Language Evaluation tests administration:

Tests	Scores
Assessment Checklist for Speech and Language Skills (AC-SLS)	Receptive Language Age : Scattered between 1.7 – 1.9 years to 1.10 – 2.0 years Expressive Language Age : 0.7 – 0.9 years

Clinical Impressions:

Speech and Language Evaluation	Psychological Evaluation	Physio/Occupational Therapy Evaluation
<ul style="list-style-type: none"> • Age inadequate receptive and expressive language skills 	<ul style="list-style-type: none"> • MA : 2 years • IQ : 92 • Average Intelligence 	<ul style="list-style-type: none"> • Sensory Issues

Provisional Diagnosis: Spoken Language Disorder with Sensory Issues.

Recommendations:

- Speech and Language Therapy
- Sensory Integration Therapy
- Follow –up

Speech-Language Pathologist
Designation, Address & CRR.

NOTE: The comprehensive report is issued upon the request of the client. This report is a summary of the latest evaluation done at our institute. For further assistance please contact us.

Annexure XX

Diagnostic report format for Language Disorders (Sample case report)

Name of the Institute

SH/ER-31/June/2022-23

Date: 04/07/2022

EVALUATION REPORT

Case Name: XYZ

Case No: 549473

Age/Gender: 16.5 Years/Male

Date of Evaluation: 17.05.2022

Validity of the report: 16.11.2022

XYZ was brought with the complaint of poor speech-language skills and weakness in upper and lower limbs.

Speech and Language Evaluation tests administration:

Tests	Scores
Assessment Checklist for Speech and Language Skills (AC-SLS)	Receptive Language Age : 5.7 – 6.0 years Expressive Language Age : 4.7 – 5.0 years

Clinical Impressions:

Speech and Language Evaluation	Psychological Evaluation	Physio/Occupational Therapy Evaluation
<ul style="list-style-type: none"> • Age inadequate receptive and expressive language skills 	<ul style="list-style-type: none"> • MA : 11.4 years • IQ : 71 • Borderline Intellectual Functioning with (?) Cerebral Palsy 	<ul style="list-style-type: none"> • Spastic Cerebral Palsy

Provisional Diagnosis: Spoken Language Disorder secondary to Cerebral Palsy.

Recommendations:

- Speech and Language Therapy
- Physiotherapy
- Follow –up

Speech-Language Pathologist
Designation, Address & CRR.

NOTE: The comprehensive report is issued upon the request of the client. This report is a summary of the latest evaluation done at our institute. For further assistance please contact us.

Annexure XXI

Diagnostic report format for Language Disorders

Name of the institute

SH/ER-/2022-23

Date:

Case Name:

Case No:

Age/Gender:

Date of Evaluation:

Validity of the report:

Mr./Ms. ABC reported at (Name of the institute) with the complaint of delayed speech-language skills. The details of the evaluation carried out are as follows.

Speech and Language Evaluation tests administration:

Sl No.	Tests	Scores
1.	Assessment Checklist for Speech and Language Skills (AC-SLS)	Receptive Language Age : Expressive Language Age :
2.	Modified Checklist for Autism in Toddlers(M-CHAT)	
3.	Indian Scale For Assessment of Autism (ISAA)	Score : Severity :
Clinical Impression		

Clinical Psychological Evaluation:

Test(s) administered	Scores
Clinical Impression:	

Physio/Occupational Therapy Evaluation

Test(s) administered	Scores
Clinical Impression:	

Any other evaluation:

Diagnosis:

Recommendations:

Owing to this condition, the student stands eligible for the following benefits/exemptions especially as mandated by Rights of Persons with Disability (2016)

- (a) Exemption from study of additional language/s
- (b) Provision for extra one-hour time in public examinations
- (c) Reader/Writer facility during examinations (to read out the questions aloud or pantomime them); or alternatively, provide for enlarged print size question papers amenable for reading by partially sighted
- (d) Objective type questions (such as, match the following, one word answers, "True"/"False" statements, etc.) during examinations in place of descriptive and "long" answers.
- (e) No denial of admission; Integration with "normal" school going children for pursuit of regular school education.
- (f) Prohibition of Holding Back and Expulsion; Non-discrimination in provision of opportunities, school admission and/or inclusion in regular academic programs.
- (g) Barrier free environment by elimination of physical, psychological or attitude barriers that prevent the child from having access to normal education.
- (h) Non-use of physical or psychological punishment pressure provoking practices either intended or otherwise.

The above information on rights and privileges is given in the interest of necessary planning, programming and education of persons with special needs.

Speech-Language Pathologist
Designation, Address & CRR.

NOTE: *The comprehensive report is issued upon the request of the client. This report is a summary of the latest evaluation done at our institute. For further assistance, please contact us.*

Annexure XXII

Diagnostic report format for Language Disorders

Name of the institute

SH/ER /2022-23

Date:

Case Name:

Case No:

Age/Gender:

Date of Evaluation:

Validity of the report:

Mr./Ms. ABC reported at (Name of the institute) with the complaint of delayed speech-language skills. The details of the evaluation carried out are as follows.

Speech and Language Evaluation tests administration:

Tests	Scores
Assessment Checklist for Speech and Language Skills (AC-SLS)	Receptive Language Age : Expressive Language Age :

Clinical Impressions:

Speech and Language Evaluation	Psychological Evaluation	Physio/Occupational Therapy Evaluation
•	•	•

Provisional Diagnosis:

Recommendations:

Speech-Language Pathologist
Designation, Address & CRR.

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Annexure XXIII

Diagnostic report format for Language Disorders

Name of the institute

SH/ER/2022-23

Date:

Case Name:

Case No:

Age/Gender:

Date of Evaluation:

Validity of the report:

Mr./Ms. ABC reported at (Name of the institute) with the complaint of delayed speech-language skills. The details of the evaluation carried out are as follows.

Speech and Language Evaluation:

Test(s) administered	Scores
3DLAT	Receptive Language Age: Expressive Language Age: Cognitive Language Age:
Clinical Impression:	

Clinical Psychological Evaluation:

Test(s) administered	Scores
Clinical Impression:	

Diagnostic formulation:

Diagnosis:

Recommendations:

Owing to this condition, the student stands eligible for the following benefits/exemptions especially as mandated by Rights of Persons with Disability (2016)

- (a) Exemption from study of additional language/s
- (b) Provision for extra one-hour time in public examinations
- (c) Reader/Writer facility during examinations (to read out the questions aloud or pantomime them); or alternatively, provide for enlarged print size question papers amenable for reading by partially sighted

- (d) Objective type questions (such as, match the following, one word answers, "True"/"False" statements, etc.) during examinations in place of descriptive and "long" answers.
- (e) No denial of admission; Integration with "normal" school going children for pursuit of regular school education.
- (f) Prohibition of Holding Back and Expulsion; Non-discrimination in provision of opportunities, school admission and/or inclusion in regular academic programs.
- (g) Barrier free environment by elimination of physical, psychological or attitude barriers that prevent the child from having access to normal education.
- (h) Non-use of physical or psychological punishment pressure provoking practices either intended or otherwise.

The above information on rights and privileges is given in the interest of necessary planning, programming and education of persons with special needs.

Speech-Language Pathologist
Designation, Address & CRR.

***NOTE:** The comprehensive report is issued upon the request of the client. This report is a summary of the latest evaluation done at our institute. For further assistance, please contact us.*

Annexure XXIV

Diagnostic report format for Language Disorders

Name of the institute

SH/ER-2022-23

Date:

Case Name:

Case No:

Age/Gender:

Date of Evaluation:

Validity of the report:

Mr./Ms. ABC reported at (Name of the institute) with the complaint of delayed speech-language skills. The details of the evaluation carried out are as follows.

Speech and Language Evaluation tests administration:

Sl No.	Tests	Scores
1.	Assessment Checklist for Speech and Language Skills (AC-SLS)	Receptive Language Age: Expressive Language Age :
2.	Scales of Early Communication Skills (SECS)	Combined Receptive Language Age: Combined Expressive Language Age:

Clinical Psychological Evaluation:

Test(s) administered	Scores
Clinical Impression:	

Physio/Occupational Therapy Evaluation

Test(s) administered	Scores
Clinical Impression:	

Diagnostic formulation:

Diagnosis:

Recommendations:

Owing to this condition, the student stands eligible for the following benefits/exemptions especially as mandated by Rights of Persons with Disability (2016)

- (a) Exemption from study of additional language/s
- (b) Provision for extra one-hour time in public examinations

- (c) Reader/Writer facility during examinations (to read out the questions aloud or pantomime them); or alternatively, provide for enlarged print size question papers amenable for reading by partially sighted
- (d) Objective type questions (such as, match the following, one word answers, "True"/"False" statements, etc.) during examinations in place of descriptive and "long" answers.
- (e) No denial of admission; Integration with "normal" school going children for pursuit of regular school education.
- (f) Prohibition of Holding Back and Expulsion; Non-discrimination in provision of opportunities, school admission and/or inclusion in regular academic programs.
- (g) Barrier free environment by elimination of physical, psychological or attitude barriers that prevent the child from having access to normal education.
- (h) Non-use of physical or psychological punishment provoking practices either intended or otherwise.

The above information on rights and privileges is given in the interest of necessary planning, programming and education of persons with special needs.

Speech-Language Pathologist
Designation, Address & CRR.

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Annexure XXV

Diagnostic report format for Language Disorders

Name of the institute

SH/ER-2022-23

Date:

Case Name:

Case No:

Age/Gender:

Date of Re-Evaluation:

Validity of the report:

Mr./Ms. ABC reported at (Name of the institute) with the complaint of delayed speech-language skills. The details of the evaluation carried out are as follows.

Speech and Language Evaluation tests administration:

Sl No.	Tests	Scores
1.	Kannada Diagnostic Photo Articulation Test (KDPAT)	
2.	Checklist for Apraxia of Speech	
3.	Linguistic Profile Test- (LPT)	
Clinical impressions		

Clinical Psychological Evaluation:

Test(s) administered	Scores
Clinical Impression:	

Diagnostic formulation:

Diagnosis:

Recommendations:

Owing to this condition, the student stands eligible for the following benefits/exemptions especially as mandated by Rights of Persons with Disability (2016)

- (a) Exemption from study of additional language/s
- (b) Provision for extra one-hour time in public examinations
- (c) Reader/Writer facility during examinations (to read out the questions aloud or pantomime them); or alternatively, provide for enlarged print size question papers amenable for reading by partially sighted

- (d) Objective type questions (such as, match the following, one word answers, "True"/"False" statements, etc.) during examinations in place of descriptive and "long" answers.
- (e) No denial of admission; Integration with "normal" school going children for pursuit of regular school education.
- (f) Prohibition of Holding Back and Expulsion; Non-discrimination in provision of opportunities, school admission and/or inclusion in regular academic programs.
- (g) Barrier free environment by elimination of physical, psychological or attitude barriers that prevent the child from having access to normal education.
- (h) Non-use of physical or psychological punishment pressure provoking practices either intended or otherwise.

The above information on rights and privileges is given in the interest of necessary planning, programming and education of persons with special needs.

Speech-Language Pathologist
Designation, Address & CRR.

***NOTE:** The comprehensive report is issued upon the request of the client. This report is a summary of the latest evaluation done at our institute. For further assistance, please contact us.*

Chapter VII

Adult Language Disorder

An Adult Language Disorder is an acquired impairment in comprehension and/or use of spoken, written and/or other symbol systems. The various components of the language affected includes (1) the form of language (phonology, morphology, syntax), (2) the content of language (semantics), and/or (3) the function of language in communication (pragmatics) in any combination. Adult language disorders are neurological in nature , which includes Cerebrovascular accident, traumatic brain injury, neoplasms, metabolic, alcohol induced and degenerative conditions .The different tests that are used for the assessment of adult language disorders are shown in Table 8. Annexure XXVI to XXXI depicts the diagnostic report format and a sample reports of adult language disorders.

Basis for the label: Adult Language Disorder

- (a) ICD-10 CM, 11 for dementia, TBI, MCI, RHD, in addition Goodglass-Kaplan's classification system for Aphasia and ICCD.
- (b) Gorno-Tempani classification (2011) for Primary Progressive Aphasia

Screening for Adult Language disorders:

1. Case history
2. Clinical observation
3. Bedside Screening Test- in Indian languages for persons with aphasia, TBI and RHD. In addition either Mini Mental Status Examination²⁷(MMSE) or Montreal cognitive assessment²⁸ (MOCA) or Cognitive Linguistic quick Test²⁹ (CLQT) to be administered on persons with Dementia.

Assess functional Disability: ICF generic set.

For certification purpose: Aphasia quotient score to be used for the calculation of language disability. The mild cognitive impairment, dementia may either fall under language disability or neurological disability. Based on the severity, one can decide the type of disability i.e. either language or neurological disability.

Report: Diagnostic report format for adult language (case history, test results, clinical observation). Further assessment reports of neurologist along with radiological report are required for correlation of the neurological lesions in the brain. Dedicated space to mention any additional tests or information to be conveyed

Validity of the report: Three to six months based on the onset and nature of the condition.

Table 8- Diagnostic tools, labels, report, and validity for Adult Language disorders.

Sl. No	1 Condition	2 Diagnostic Tool	3 Diagnostic labels and code
1	Aphasia	Western Aphasia Battery ¹⁵ (WAB)- in Indian languages Assessment for Living with Aphasia ²⁰ (ALA) Stroke-Aphasia Quality of Life ²¹ (SAQOL-39)	Anomic Aphasia ICCD-OL-56 Transcortical motor ICCD-OL-57 Transcortical sensory ICCD-OL-58 Conduction Aphasia ICCD-OL-59 Broca's Aphasia ICCD-OL-60 Wernicke's Aphasia ICCD-OL-61 Isolation Aphasia ICCD-OL-62 Global Aphasia ICCD-OL-63
2	Mild Cognitive Impairment	Cognitive Linguistic Assessment Protocol ²² (CLAP) Battery for Cognitive Communication Disorders in Kannada ²³ (BCCK)- In Indian languages Everyday Cognition Questionnaire ²⁴ (ECog)	Mild Cognitive Impairment ICCD-OL-64
3	Dementia	Western Aphasia Battery ¹⁵ (WAB) Cognitive Linguistic Assessment Protocol ²² (CLAP) Dementia Assessment Battery ²⁴ (DAB) Battery for Cognitive Communication Disorders in Kannada ²³ (BCCK)- In Indian languages	Mild Cognitive Communication Disorder secondary to Alzheimer's disease G30.0 Moderate Cognitive Communication Disorder secondary to Alzheimer's disease G30.1 Severe Cognitive Communication Disorder Alzheimer's disease G30.8 Cognitive Communication Disorder secondary to unspecified disease G30.9
4	Primary Progressive Aphasia	Cognitive Linguistic Assessment Protocol ²² (CLAP) Western Aphasia Battery ¹⁵ (WAB) Dementia Assessment Battery ²⁴ (DAB) Battery for Cognitive Communication Disorders in Kannada ²³ (BCCK)- In Indian languages	Non Fluent Primary Progressive Aphasia ICCD-OL-65 Semantic Primary Progressive Aphasia ICCD-OL-66 Logopenic Primary Progressive Aphasia ICCD-OL-67
5	Traumatic Brain Injury	Western Aphasia Battery ¹⁵ (WAB) Cognitive Linguistic Assessment Protocol ²² (CLAP) Battery for Cognitive Communication Disorders in Kannada ²³ (BCCK)- In Indian languages Franchay Dysarthria Assessment ²⁵ (FDA)* *if obvious dysarthria component dominates aphasia component	Cognitive Communication Disorder secondary to TBI ICCD-OL-68

6	Right Hemisphere Damage	Western Aphasia Battery ¹⁵ (WAB)- in Indian languages Mini Inventory of Right Brain Injury Right Hemisphere Language Battery ²⁶ - in Indian languages	Cognitive Communication Disorder secondary to RHD ICCD-OL-69
7	Metabolic disorders	Western Aphasia Battery ¹⁵ (WAB) Cognitive Linguistic Assessment Protocol ²² (CLAP) Battery for Cognitive Communication Disorders in Kannada ²³ (BCKK)- In Indian languages Franchay Dysarthria Assessment ²⁵ (FDA)* *if obvious dysarthria component dominates aphasia component	Cognitive Communication Disorder secondary to Metabolic Disorder ICCD-OL-70

Abbreviation and brief explanation of the test

Bedside screening test- in Indian languages:
MMSE: The Mini-Mental Status Examination (MMSE) is a widely used test of cognitive function among the elderly; it includes tests of orientation, attention, memory, language and visual-spatial skills
MoCA: Montreal Cognitive Assessment is a cognitive screening test designed to assist Health Professionals in the detection of mild cognitive impairment and Alzheimer's disease.
CLQT: Cognitive Linguistic Quick Test- quickly assesses strengths and weaknesses in five cognitive domains,
Cancellation test: In a cancellation task, a participant is required to search for and cross out (“cancel”) targets, which are usually embedded among distractor stimuli. Line Cancellation Task and Letter Cancellation Task are variants of this test.
BCKK: battery for cognitive communicative disorders-Kannada
WAB: Western Aphasia Battery (WAB) is an instrument for assessing the language function of adults with suspected neurological disorders as a result of a stroke, head injury, or dementia
CLAP: Cognitive Linguistic Assessment Protocol- The CLAP provides a time-efficient measure of strengths and weaknesses across 5 cognitive domains – attention, memory, arranging functions, language and visuospatial skills – in adults with neurological impairment due to stroke, head trauma or dementia
MIRBI: Mini Inventory of Right Brain Injury- MIRBI is a brief, standardized screening instrument for neurocognitive deficits associated with right-hemisphere brain injury and its severity level in adults.
RHLB: Right Hemisphere Language Battery- The RHLB is used as a comprehensive battery to help provide a quantitative and qualitative assessment of the language and communication impairments that can arise as a result of right hemisphere cerebral damage.
FDA: Frenchay Dysarthria Assessment- It is a quick and simple test to rate person’s performance on tasks related to speech function. These includes reflexes, respiration, lips, palate, laryngeal, tongue, intelligibility and influencing factors.
DAB: Dementia Assessment Battery- designed to assess key cognitive abilities including attention, concentration, verbal learning and memory, verbal fluency, working memory and executive function as well as global cognitive functioning
ALA: Assessment for living with Aphasia- It is a pictographic, self-report measure of aphasia-related quality-of-life.

Annexure XXVI

Diagnostic report format for Adult Language Disorders (Sample case report)

Name of the institute

Case Name: Mrs ABC
 Age/Gender: 44years/ F
 Source of reference: KRH

Case No: 12345
 Date of Evaluation: 01/10/2021
 Validity of the report: 30.04.2022

Brief History:

Mrs ABC accompanied by her husband was brought on 12/09/2017 with the chief complaint of word finding difficulty, poor speech intelligibility, poor writing and limb weakness following ICA aneurysm surgery on 04.05.2017.

Speech and Language Evaluation:

Pre-morbid: Mrs ABC was independent in her communicative skills and was fluent in Kannada, English and Hindi.

Post morbid: On initial evaluation, on 13.09.2017 she was able to reply in 2-3 word phrases along with gestures, had fair repetition skills and poor naming skills. Her reading and writing was poor. She was diagnosed as Anomic aphasia on Western Aphasia Battery with aphasia quotient (AQ) of 74. She has been attending regular and intensive speech and language therapy ever since.

Western Aphasia Battery (WAB) was administered on 13.09.2017, and scores were:

Domains	Score
Spontaneous speech	16
Auditory verbal comprehension	7.5
Repetition	7.7
Naming	5.8
Aphasia Quotient	74
Impression	Anomic aphasia

According to the Gazette of India notification (January 5, 2018), the percentage of disability on 13.09.2017 was 21.1%

Physiotherapy Evaluation:

Left hemiplegia with post aneurysm of right ICA, with gait abnormalities and inadequate left hand functions. Activities of daily living: modified independent.

Impression: Aphasia with Left hemiplegia

Details of Speech and Language therapy:

Mrs. ABC has been attending regular speech and language therapy for three days a week since the initial assessment on September 2017 at the institute. She has also been attending regular group therapy sessions once a week in the unit of centre for adult and elderly persons with language disorders and has shown tremendous improvement in her speech and language skills.

Current condition: Mrs. ABC is independent for activities of daily living as well as to fulfill communicative needs. She uses simple phrases along with occasional gestures to communicate. She is also able to read and write with less than 5% mistakes and is able to do simple mathematical calculations.

Re-evaluation results (29.08.2019)

Speech and Language:

Domains	Score (29.08.2019)
Spontaneous speech	19
Auditory verbal comprehension	10
Repetition	9.5
Naming	10
Aphasia Quotient	97
Impression	Non-aphasic

According to the Gazette of India notification (January 5, 2018), the percentage of language disability is: 0.0%

Owing to the acquired nature of her condition, Mrs. ABC speech and language re-evaluation has shown a significant improvement across all domains as evidenced by the scores and percentage of disability with positive improvement in reading and writing and mathematical skills.

Mrs. ABC has completely recovered from aphasia, but has subtle higher order naming and writing deficits with mild word retrieval issues; mild pauses and hesitations are also found in connected speech resulting in poor communication. This has restricted her activity and participation in society. The UN Convention for Rights of Persons with Disabilities (UNCRPD) has clearly stated that any condition which restricts the activity and participation of an individual, which may also be influenced by the environmental, and personal factors need to be looked upon. Further, according to the Rights of Persons with Disabilities (RPWD) Act, 2016, aphasia has been categorized as a disability. Moreover, Mrs. ABC progress bears testimony to the fact that she is capable of performing well if given an opportunity. Hence, it is requested that she may kindly be given an opportunity to pursue her work status, for her to be an independent and productive member of society. ***She is fit to resume her duty at her work place from 02.10.2019***

Diagnostic formulation: Based on clinical observations and WAB score the patient falls under the category of Aphasia

Diagnosis: Anomic Aphasia

Further recommendations:

Follow up once in six month

Should you have any question related to Mrs. ABC communication skills, feel free to contact me. My best wishes for the speedy recovery of Mrs. ABC.

Speech-Language Pathologist
Designation, Address & CRR.

***NOTE:** This comprehensive report is issued upon the request of the patient and is as per the latest evaluation done at our Institute. We hope it satisfies your records and if you need any further assistance, please do not hesitate to contact us.*

Annexure XXVII

Diagnostic report format for Adult Language Disorders - Mild Cognitive Impairment/Primary Progressive Aphasia/Dementia (Sample case report)

Name of the institute

Case Name: MNO
Age/Gender: 79 years/ Male
Validity of Report: 3 months

Case No: 537057
Date of Evaluation: 16/11/2021

Brief History

MNO accompanied by his daughter-in-law was brought with the chief complaint of reduced memory, attention, and concentration; Word finding difficulty and circumlocutions since 4-5 months.

Speech and Language Evaluation

MNO is independent in his communicative skills and is fluent in Kannada. On initial evaluation, on 16/11/2021 it was observed that he is able to communicate well however few word finding difficulties and circumlocutions were also noticed. His reading fluency and writing skills were good. He presented himself as a friendly, responsive and verbal communicator. He seems to continue to have good self-help skills and is independent for her daily routine activities.

Orientation of place and time was poor when compared to orientation of person. Sustained and selective attention was fair than divided attention. Executive functions, which include organization, logical thinking, sequencing and reasoning skills, were poor. His memory functions pertaining to immediate memory and declarative memory were poor. His semantic memory for language was fair.

a) Montreal Cognitive Assessment (MoCA)

SL.NO	Sub-section	Score
1	Executive	03
2	Naming	02
3	Memory	0
4	Attention	02
5	Language	0
6	Abstraction	0
7	Orientation	01
	Total	08

Battery for Cognitive Communication Disorder- Kannada (BCC-K)

Sl. No	Linguistic domain	Patient's Score
1	Spoken language comprehension	
	a. Object comprehension	5
	b. Picture comprehension	10
	c. Yes/No questions	06
	d. Following commands	16
	Spoken language comprehension score (max score: 45)	37
2	Repetition	
	a. Automatic speech	20
	b. Repetition of words and non-words	09
	c. Repetition of phrases	10
	Repetition total (max score: 105)	39

3	Naming	
	a. Confrontation Naming	18
	b. Generative Naming	01
	c. Responsive Naming	05
	Naming total (max score: 55.9)	24
4	Spoken Language Expression	
	a. Story Narrative	00
	b. Picture Description	03
	Spoken Language Expression total (max score: 19.20)	03
5	Reading	
	a. Functional reading	07
	b. Reading letters	05
	c. Reading comprehension	05
	Reading total(max score: 24.8)	17
6	Writing	
	a. Copying shapes	05
	b. Copying letters	04
	c. Dictation of words and non-words	6.5
	d. Functional writing	03
	Writing total (max score: 25)	18.5
	LINGUISTIC DOMAIN TOTAL	138.5
II	Cognitive domain	
1	Clock drawing test	16
2	Attention	
	a. Sustained attention	39
	b. Selective attention	06
	c. Alternating/divided attention	00
	Attention total (max score: 82.05)	45
3	Memory	
	a. Immediate memory	03
	b. Declarative memory	11
	c. Semantic memory for language	22
	d. Working memory	05
	Memory total (max score: 110.4)	41
4	Executive functioning	
	a. Organization	00
	b. Logical thinking	03
	c. Sequencing	00
	d. Reasoning	04
	Executive functioning total (max score: 34.4)	07
	COGNITIVE DOMAIN TOTAL (max score: 237.4)	99
	BCC-K total score (LD + CD) (max score: 511.8)	237.5

Interpretation:

Sl. No	Domain	Areas affected	Interpretation
1.	Linguistic domain :	Comprehension, expression Naming, repetition, reading and writing	Severe impairment
2.	Cognitive domain	Attention, memory and executive functioning	Severe impairment
3.	Overall Impression :	Indicative of severe cognitive impairment	

Psychological Evaluation:

Impression: (?) Mild cognitive impairment

Recommendation: Speech and language therapy

Overall it appears based on clinical observation and formal tests, MNO shows obvious cognitive linguistic deficits and BCC-K score is also compromised indicative of severe cognitive impairment.

Provisional Diagnosis: Severe cognitive impairment

Diagnostic formulation: Based on clinical observation, MOCA and BCC-K indicative of severe cognitive impairment which is degenerative in nature.

Diagnosis: Severe Cognitive Impairment

Further recommendations:

- Speech and language therapy twice a week (Tuesday and Thursday)
- Needs support from family members
- Advised not to handle financial and legal matter.
- Advised to use identity card while moving out of house
- Follow up

Should you have any question related to MNC communication skills, feel free to contact me. My best wishes for the speedy recovery of MNC

Speech-Language Pathologist
Designation, Address & CRR.

***NOTE:** This comprehensive report is issued upon the request of the patient and is as per the latest evaluation done at our Institute. We hope it satisfies your records and if you need any further assistance, please do not hesitate to contact us.*

Annexure XXVIII

Diagnostic report format for Adult Language Disorders - Aphasia secondary/ Cognitive Communication Disorder to Traumatic Brain Injury/Right Hemisphere Damage (Sample case report)

Name of the Institute

Case Name: XYZ

Case No: 430555

Validity of Report 3 months from the date of issue

Date of Evaluation: 30/05/2016

Age/Gender: 29 years/Male

Brief History:

XYZ accompanied by his spouse was brought with the chief complaint of difficulty in verbal expression and weakness in right limbs post road traffic accident which occurred on 09/06/2016.

Medical history revealed that the he was hospitalized for approximately 10 weeks. MRI scanning conducted on 13/06/2015 revealed diffuse axonal injury grade III with punctate basal ganglia haemorrhages. He also experienced few episodes of focal seizures for which he is receiving medication. As reported by the spouse, the frequency of seizures has drastically reduced.

He has consistently been attending physiotherapy, occupational therapy and speech-language therapy sessions. Right sided weakness is still persisting and complains of speaking slowly and monotonous voice.

Speech and Language Evaluation (30-05-2016):

Pre-morbid: He was independent in his communicative skills. He fluently spoke Punjabi, English and Hindi. He was working as an IAS officer in New Delhi. He enjoyed engaging in sports like badminton, lawn tennis, etc.

Post morbid: He is able to comprehend well and can carry out long conversations with good turn taking and topic maintenance. No deficits in cognitive communication skills were observed. He is able to produce grammatically complete sentences with complex construction and responses are relevant to the presented stimuli. Clarity of speech is moderately affected; rate of speech is slow and restricted use of supra-segmentals was observed. Following the accident, he resumed his official duty from April 2016 as Deputy Director in Directorate of Training and Technical Education, GNCTD.

Western Aphasia Battery (WAB) was administered to assess language abilities.

Aphasia Quotient (AQ)- >97.5

Impression- Non-aphasia

Oral Speech Mechanism Evaluation revealed slight deviation of lips to left side. Restricted range and speed of movement of lips (spreading and puckering) and tongue (protrusion, retraction, elevation and lateral movements) was observed. Movement of the soft palate was observed to be slightly asymmetrical; however, there is no perceivable nasal emission or hypernasality. Diadochokinetic rate was observed to be slow.

Frenchay Dysarthria Assessment (FDA) was administered to reveal mild deficits in respiration, laryngeal and palatal movements. Moderate deficits were observed in domains of lips, tongue and

intelligibility. He reports of choking occasionally when taking large sips of water, however no difficulty was reported with the consumption of thick liquids, semi-solids and solids.

Impression- Dysarthria

Physiotherapy Evaluation:

Complaint of right sided weakness and difficulty in performing fine motor movement

Muscle tone in left>right; no contractures, no tightness; inadequate balance and equilibrium; typical circumlocutory gait; almost independent while performing activities of daily living.

Impression: Wallerian degeneration on left cerebral peduncle (Right hemiplegia)

Following his evaluations XYZ was recommended to attend Speech Language therapy and Physiotherapy as rehabilitation options.

Therapy details:

Speech therapy: XYZ received daily speech therapy sessions for four days for duration of approximately 2 hours each day. Various oro-motor exercises for lip and tongue strengthening were demonstrated and practised during the session. Strategies to improve intelligibility like use of open mouth approach, loud voice, placing stress on each word while speaking, etc were practised during the session. He has been advised to use a cup while drinking and to take small sips of water to avoid coughing while drinking water.

Physiotherapy & Occupational therapy: Physiotherapy focussed on improving balance and coordination. Occupational therapy has been given to improve fine motor functions and shoulder-hand function.

Diagnostic formulation: Based on Clinical observation, WAB and FDA, patient is labelled as Dysarthria

Diagnosis: Dysarthria

Further recommendations:

Intensive speech therapy for improving speech intelligibility

Physiotherapy and Occupational therapy- to improve motor balance and coordination and fine motor functions

Follow up

The UN Convention for Rights of Persons with Disabilities (UNCRPD) has clearly stated that any condition which restricts the activity and participation of an individual, which may also be influenced by the environmental, and personal factors need to be looked upon. The overall activity and participation will have to be facilitated by giving favorable opportunities. This will help him in being an active member of the society and support his family.

Should you have any question related to XYZ communication skills, feel free to contact me. My best wishes for speedy recovery XYZ.

Speech-Language Pathologist
Designation, Address & CRR.

Annexure XXIX
Diagnostic report format for Adult Language Disorders

Name of the Institute

Case Name:
 Age/Gender:
 Source of reference:

Case No:
 Date of Evaluation:
 Validity of the report:

Brief History:

Speech and Language Evaluation:

Pre-morbid:

Post morbid:

Western Aphasia Battery (WAB), and scores were:

Domains	Score
Spontaneous speech	
Auditory verbal comprehension	
Repetition	
Naming	
Aphasia Quotient	
Impression	

Physiotherapy Evaluation:

Impression:

Details of Speech and Language therapy:

Current condition:

Re-evaluation results

Speech and Language:

Domains	Score
Spontaneous speech	
Auditory verbal comprehension	
Repetition	
Naming	
Aphasia Quotient	
Impression	

Diagnostic formulation:

Diagnosis:

Further recommendations:

Speech-Language Pathologist
 Designation, Address & CRR.

***NOTE:** This comprehensive report is issued upon the request of the patient and is as per the latest evaluation done at our Institute. We hope it satisfies your records and if you need any further assistance, please do not hesitate to contact us.*

Annexure XXX

Diagnostic report format for Adult Language Disorders- Mild Cognitive Impairment/Primary Progressive Aphasia/Dementia (Sample Case Report)

Name of the Institute

Case Name:
Age/Gender:

Case No:
Date of Evaluation:
Validity of Report:

Brief History

Speech and Language Evaluation

b) Montreal Cognitive Assessment (MoCA)

SL.NO	Sub-section	Score
1	Executive	
2	Naming	
3	Memory	
4	Attention	
5	Language	
6	Abstraction	
7	Orientation	
	Total	

Battery for Cognitive Communication Disorder- Kannada (BCC-K)

Sl. No	Linguistic domain	Patient's Score
1	Spoken language comprehension	
	e. Object comprehension	
	f. Picture comprehension	
	g. Yes/No questions	
	h. Following commands	
	Spoken language comprehension score (max score: 45)	
2	Repetition	
	d. Automatic speech	
	e. Repetition of words and non-words	
	f. Repetition of phrases	
	Repetition total (max score: 105)	
3	Naming	
	d. Confrontation Naming	
	e. Generative Naming	
	f. Responsive Naming	
	Naming total (max score: 55.9)	
4	Spoken Language Expression	
	c. Story Narrative	
	d. Picture Description	
	Spoken Language Expression total (max score: 19.20)	
5	Reading	
	d. Functional reading	
	e. Reading letters	
	f. Reading comprehension	
	Reading total(max score: 24.8)	

6	Writing	
	e. Copying shapes	
	f. Copying letters	
	g. Dictation of words and non-words	
	h. Functional writing	
	Writing total (max score: 25)	
	LINGUISTIC DOMAIN TOTAL	
II	Cognitive domain	
1	Clock drawing test	
2	Attention	
	d. Sustained attention	
	e. Selective attention	
	f. Alternating/divided attention	
	Attention total (max score: 82.05)	
3	Memory	
	e. Immediate memory	
	f. Declarative memory	
	g. Semantic memory for language	
	h. Working memory	
	Memory total (max score: 110.4)	
4	Executive functioning	
	e. Organization	
	f. Logical thinking	
	g. Sequencing	
	h. Reasoning	
	Executive functioning total (max score: 34.4)	
	COGNITIVE DOMAIN TOTAL (max score: 237.4)	
	BCC-K total score (LD + CD) (max score: 511.8)	

Interpretation:

Sl. No	Domain	Areas affected	Interpretation
4.	Linguistic domain :		
5.	Cognitive domain		
6.	Overall Impression :		

Psychological Evaluation:

Impression:

Recommendation:

Diagnostic formulation:

Diagnosis:

Further recommendations:

Speech-Language Pathologist
Designation, Address & CRR.

***NOTE:** This comprehensive report is issued upon the request of the patient and is as per the latest evaluation done at our Institute. We hope it satisfies your records and if you need any further assistance, please do not hesitate to contact us.*

Annexure XXXI

Diagnostic report format for Adult Language Disorders: Aphasia secondary/ Cognitive Communication Disorder to Traumatic Brain Injury/Right Hemisphere Damage

Name of the Institute

Case Name:
Age/Gender:

Case No:
Date of Evaluation:
Validity of Report

Brief History:

Speech and Language Evaluation (30-05-2016):

Pre-morbid:

Post morbid:

Western Aphasia Battery (WAB)

Aphasia Quotient (AQ)-
Impression-

Oral Speech Mechanism Evaluation

Frenchay Dysarthria Assessment (FDA)

Impression-

Physiotherapy Evaluation:

Impression:

Therapy details:

Speech therapy:

Physiotherapy & Occupational therapy:

Diagnostic formulation:

Diagnosis:

Further recommendations:

Speech-Language Pathologist
Designation, Address & CRR.

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