**Functional Adult Screening Tool**

**Language and Cognitive Profile**

Elizabeth Peterson, M.A., CCC-SLP

Name__________________________________________ Date_______________________

Diagnosis______________________________________ Onset Date _____________________________

Date of Birth_________________ Age_______  Physician ________________________________________

Significant Medical History: _________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

Significant Social History: ___________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

**F.A.S.T.**

is a non-standardized screening tool. It was designed for clinicians to evaluate clients’ complete language and cognitive tasks while determining how much assistance is needed to perform functional activities. Since it is non-standardized, it is only necessary to assess areas of concern instead of the entire protocol.

This tool will complement FIM scoring, ASHA Facts, Minimum, Moderate and Maximum cuing styles and other documentation requirements for the amount of support a client needs to complete goal-directed activities.

At the end of each primary section, opportunity is available to comment on the client’s functional ability for that area of skill. A small grid is present for indicating the amount of support the client requires to complete tasks. The grid is useful for re-screening purposes to comment on progress. For example, if 95% support was required for task completion, that would be considered maximum assistance. If one week later the client required 85% support for the same task, it would still be categorized as maximum assistance, however, the client improved level of function by 10%. The grid allows for documenting small increments of progress.

Receptive and expressive language, cognition, reading and writing can be profiled in functional situations with this tool. By completion, a clinician will be able to formulate an opinion regarding a client’s functional ability, the amount of cuing required to complete tasks and generate recommendations. Based on the amount of personal information collected, it will be easy to implement a functional therapy program designed to meet specific client needs.
RECEPTIVE LANGUAGE
Auditory Comprehension

FOLLOWING ONE-PART DIRECTIONS (also Oral Motor Screen)

☐ Open your mouth  ☐ Push your cheek using your tongue  ☐ Blow a kiss
☐ Wiggle your nose  ☐ Move your tongue side to side  ☐ Smile

Note: Combine tasks to increase complexity if appropriate

FOLLOWING TWO-PART DIRECTIONS

☐ Raise your eyebrows then hand
☐ Show me how you brush your teeth and use mouthwash
☐ Place this pen on the bottom of the paper/desk
☐ Do a dry swallow then open your mouth
☐ Place your left hand over your right knee and blink your eyes
☐ Show me where you wear a wedding ring and watch

COMPLEX DIRECTIONS

☐ Blink your eyes twice, smile with your lips closed then cough
☐ Point to the ceiling, open your mouth then snap your fingers
☐ Show me how to use a hammer, screwdriver and a spoon
☐ Before you say your name, wave hello
☐ Take a deep breath after you look at the ceiling and point to me

Comments on oral motor function

YES/NO RELIABILITY

☐ Do you use a wheelchair?  ☐ Were you born in__________?
☐ Do you live alone?  ☐ Do you take medication every other day?
☐ Is it the afternoon?  ☐ Did you have dinner yet?

RECEPTIVE VOCABULARY

Name items available in the environment for the client to identify by pointing

Prompt: Show me the_________

☐ Phone  ☐ Trash Can  ☐ Watch  ☐ Shirt  ☐ Other_________
☐ Tissue  ☐ Blanket  ☐ Floor  ☐ Chair  ☐ Other_________

Delayed Responses?  ☐ YES  ☐ NO

Presents with receptive language impairments?  ☐ YES  ☐ NO

Level of assistance required to complete tasks:

Impression of functional ability:

Amount of assistance required:

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EXPRESSIVE LANGUAGE

AUTOMATIC SPEECH

Complete the following:

☐ Count from 1-20  ☐ Name the months of the year  ☐ Recite the alphabet

Suspect apraxia?  ☐ YES  ☐ NO  

Signs of groping or struggle?  ☐ YES  ☐ NO

SINGLE WORD NAMING

Present objects available in the environment for the client to name

Prompt: What is the name for this?

☐ Thumb  ☐ Hair  ☐ Wrist  ☐ Shoes  ☐ Other ___________

☐ Cup  ☐ Wall  ☐ Ceiling  ☐ Pen  ☐ Other ___________

SENTENCE LEVEL

Have the client describe the following concepts

Therapist: __________________________________________________________

Wall: ________________________________________________________________

Shirt: _______________________________________________________________

Medication: __________________________________________________________

CONVERSATIONAL

Have the client respond to the following:

What is a typical day like for you? _______________________________________

What is your role at work? ______________________________________________

What are your hobbies and why they are of interest? __________________________

What is your goal one month from today? _________________________________

Any idea why I am here to meet you? _____________________________________

Fluent and appropriate?  ☐ YES  ☐ NO  

Tangential or off topic?  ☐ YES  ☐ NO

Word finding difficulties?  ☐ YES  ☐ NO

Thought organization/formulation difficulties?  ☐ YES  ☐ NO

Presents with expressive language impairments?  ☐ YES  ☐ NO

Level of assistance required to complete tasks: _____________________________

Impression for communicating needs: _____________________________________

Speech production intelligibility: __________________________________________

Amount of assistance required:  

LOGO

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### COGNITION

#### ORIENTATION

- [ ] Person
- [ ] Time
- [ ] Place
- [ ] Purpose
- Cuing required?

#### ATTENTION

- Sustains attention for ________ minutes.
- 
- Easily distracted?  □ YES  □ NO
- Responds to redirection?  □ YES  □ NO
- Comments on functional ability: _______________________________________________________
  _______________________________________________________

#### VERBAL SEQUENCING

- Name the steps for putting on a dress shirt: ____________________________________________
  _______________________________________________________
- Name the steps for preparing a scrambled egg: __________________________________________
  _______________________________________________________
- What steps are required for a safe transfer into a wheelchair? ____________________________
  _______________________________________________________
  _______________________________________________________
- **Level of assistance required to complete tasks:** ______________________________________
  _______________________________________________________
  _______________________________________________________

#### PROBLEM SOLVING AND REASONING

- How can you get help for an item you are unable to reach? ________________________________
  _______________________________________________________
- Name two ways to obtain your doctor’s phone number: _________________________________
  _______________________________________________________
- What can you do to be certain all of your medication will be taken on time? _________________
  _______________________________________________________
- You need to take medication every 6 hours three times a day. Your first dose was at 7:00am, what times during the day will you take the rest of your medication? _____________________________
  _______________________________________________________
- How can you remember who your therapists are and other professionals working with you? _______
**MEMORY**

Long term/Biographical memory refer to “Personal Inquiry Form”

**Prospective Memory**

Have client remember that the clinician is a speech-language pathologist. *Recall Time:*

☐ Immediate  ☐ 5 minutes  ☐ 30 minutes  ☐ 45 minutes  Cuing required? __________

Have client recall the purpose for the consultation. *Recall Time:*

☐ Immediate  ☐ 5 minutes  ☐ 30 minutes  ☐ 45 minutes  Cuing required? __________

**New Learning**

Read one or both of the paragraphs to assess recall of details based on the provided recall questions listed below. To evaluate delayed recall ask the same questions 15, 30 or 60 minutes later.

**Speech Therapy**

Speech therapy is not a good title to describe all that they do. Most people believe they only teach people how to talk, however, that is only one small part of their training. A speech therapist will help people process and understand what they hear. They also work with a person’s thought organization skills and vocabulary so they can communicate their needs clearly. They also help with a person’s thinking and memory skills. What is surprising to learn is that they work with people who have swallowing difficulties. They teach people how to swallow foods and liquids safely so it does not go down the wrong pipe and into their lungs causing a possible pneumonia. A speech therapist does much more than people realize.

**Occupational Therapy**

Many people believe an occupational therapist helps people find jobs. That is not the case. An occupational therapist helps people return to everyday activities. They assist people with life skills such as getting dressed, bathing, eating and grooming. They also work with writing skills. Some occupational therapists will provide assistance for visual problems as well as hand and wrist injuries. They are very creative. If someone is having a particular problem with dressing or working with an appliance, they will introduce a tool that will make the task easier. An occupational therapist is dedicated to helping people become as independent as possible.

**Recall Questions for Speech Therapy**

Allotted recall time before answering questions: ☐ Immediate  ☐ 15 min.  ☐ 30 min.  ☐ 60 min.

Is the main part of a speech therapist’s job to teach people how to talk?  ☐ YES  ☐ NO

What other areas do speech therapists provide assistance? ____________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

Where does food go when it enters the wrong pipe? _____________________________________________

____________________________________________________________________________________________

**Delayed Responses?**  ☐ YES  ☐ NO

**Level of assistance required to facilitate memory:** ____________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

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Recall Questions for Occupational Therapy

Allotted recall time before answering questions: □ Immediate □ 15 min. □ 30 min. □ 60 min.

Do occupational therapists help with dressing skills? □ YES □ NO

Name two life skills where occupational therapists provide assistance. ________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

Some unique areas an occupational therapist addresses are hand and wrist injuries and _______________

____________________________________________________________________________________________

____________________________________________________________________________________________

Delayed Responses? □ YES □ NO

Level of assistance required to facilitate memory: ________________________________________________________________

____________________________________________________________________________________________

General impression for cognitive skills: ________________________________________________________________

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 Amount of assistance required:

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<tr>
<th>PERCENTAGE OF SUPPORT REQUIRED BY CLINICIAN TO COMPLETE TASK</th>
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PERSONAL INQUIRY
Completed by client if appropriate to assess reading, writing and memory

Name __________________________________ Date__________________________

Date of birth_________________________ Age________ Sex: M F

Address ______________________________ Phone Hm ( )_____________________
____________________________________ Phone Wk ( )_____________________
____________________________________ Cell ( )__________________________

You wear: □ Glasses □ Contact Lenses □ Dentures □ Hearing Aides

Education Completed: □ Grammar School □ High School □ College □ Degree_____

Marital Status: □ Married □ Single □ Divorced □ Widowed

Children: □ Yes □ No How many__________

Names of Children Age City of residence
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Grandchildren □ Yes □ No How many?__________

Names of Grandchildren Age Names of parents
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Describe your typical day__________________________________________________
________________________________________________________________________
________________________________________________________________________

List your hobbies and interests _____________________________________________
________________________________________________________________________
Clinical Summary
Clinical Summary/Impressions for Language and Cognitive Skills ________________________________________________
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Recommending a swallow evaluation? □ YES □ NO
Recommending speech therapy? □ YES □ NO
Frequency and duration for therapy plan ________________________________________________________
Prior level of function: _______________________________________________________________________
Projected discharge plan: _____________________________________________________________________
Level of support available from family: __________________________________________________________
Client has reasonable insight and awareness into deficits? □ YES □ NO
Client uses appropriate pragmatics □ YES □ NO

Additional Comments
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
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____________________________________________________________________________________________
____________________________________________________________________________________________

_____________________________________________ _______________________
Therapist Date

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