splose

Ask AI prompts for Speech Pathologists

Welcome!
These prompts have been designed to give splose AI the context and instructions it needs to draft your most common clinical notes and reports. Each one is a strong starting point, designed to work straight away, but built to be adjusted to match your clinic's documentation style, the patients you see, and the way your team works.

Feel free to modify the structure, add your preferred headings, or change the level of detail to suit your needs.

Do your practitioners share patients?
If multiple practitioners at your clinic see the same patients and have permission to see each other's notes, you may want to scope certain prompts to that practitioner's notes only.
For example, where a prompt reads "the most recent 3 previous progress notes for this patient, you can add "written by the current practitioner" to the end of the instruction to ensure the AI is only pulling in relevant notes as context.

Still like to write rough notes while transcribing the session?
If you like to add written notes (on the LHS of the page) while you're transcribing, ensure you've made it clear that those notes relate to the current session. This is particularly important if your preferred workflow is to copy your recent not into your new note – if you're mixing two pieces of context together, splose AI will get confused trying to determine what is related to today's session vs what you copied from your previous session.

Catch me up on this patient

I am a practitioner preparing for an upcoming speech pathology session with this patient. Using the information available for this patient, create a concise pre-session briefing so I can review their history and plan before the session begins.

First, get patient details and include only clinically relevant information. Then get previous progress notes from the last 3 months. Then get appointments and support activities from the last 3 months and the next 2 weeks.

Using the retrieved information, write a structured pre-session briefing. Use bold headings and dot points. Fill each section using only what is explicitly documented:

Background
Diagnosis, presenting concerns, and any key clinical context relevant to understanding this patient.

Goals
List each goal documented for this patient. For each goal found, note any documented progress trend across recent progress notes (for example: improving, maintaining, plateauing, or not yet addressed). Also include whether any goal had been described as achieved in any of the progress notes and the date it was recorded as such.

Last session
Summarise the most recent progress note. Include: the main focus of the session, how the patient presented, what was covered, and what was agreed at the end of the session including any homework, tasks, or strategies the patient committed to.

Upcoming
List the next scheduled appointment or support activity. Include the date, type, and any relevant context documented.

Important instructions:
Use dot points only. Do not use paragraphs.
Do not fabricate or assume any clinical information.
Do not include clinical judgements or interpretations that are not explicitly stated in the notes.
If a section has no relevant documented information, leave it blank rather than filling it with placeholder text.
If this patient has no previous progress notes, summarise patient details only and note that no session history has been documented yet.
Maximum length: one page

Running an initial assessment in a multidisciplinary clinic?
If your clinic shares patient notes across practitioners, consider adding a separate saved prompt with the following section added to it:

Other treating practitioners at this clinic
List any other disciplines currently seeing this patient at this clinic. For each, note the discipline, the treating practitioner's name if documented, and any clinically relevant context from their most recent notes that may inform today's session.

This can help you understand the full picture before an initial session. For example, if a patient is already seeing a dietician or physiotherapist for related concerns that may inform your care.

Write a Speech Pathology progress note

I am a Speech Pathologist and I have just completed a session with a patient. I need to write a progress note documenting today's session.

First review any content already written in the current progress note. Then the patient details. Then the most recent 3 previous progress notes for this patient. Then the most recent appointment details, and the next 2 upcoming booked appointments if any exist.

Using the session transcript as the primary source of clinical content and all retrieved information, write a complete speech pathology progress note for today's session using the following bold headings: Presenting Focus, Observations, Activities and Strategies, Plan.

Presenting Focus:
Document the clinical focus for today's session. Include the presenting communication, language, fluency, voice, or swallowing concern being addressed, and any relevant changes or updates reported by the patient or carer since the last session.

Observations:
Document objective clinical observations from today's session. Include observed communication behaviours, language performance, fluency, voice quality, swallowing function, or any other domain relevant to today's focus. Note the patient's engagement, response to tasks, and level of support required. Note changes from previous sessions where documented.

Activities and Strategies:
Document the specific activities, tasks, and therapeutic strategies used during today's session. Include the therapeutic rationale where evident from the session content. Include any carer coaching, home program instructions, or education provided.

Plan:
Document agreed next steps, strategies or tasks the patient and/or carer will work on before the next session, planned interventions, referrals, and follow-up arrangements. Where upcoming appointments are available, use them to inform the timing and sequencing of planned follow-up. This section must contain only clinical content.

Content rules:
Only include information explicitly present in the transcript, current note content, patient details, appointment details, or previous progress notes. Do not fabricate or infer clinical content not present in these sources. Silently discard anything that is not clinically relevant: personal reminders, uncertainties, admin notes and self-corrections. If something is unclear or uncertain, omit it.
Write in plain, direct clinical language. Use short, active and simple sentences. Avoid formal report language, passive constructions, and clinical jargon where plain language conveys the same meaning.
Refer to the patient by their preferred name (not "the patient").
Format each section using concise dot points unless this practitioner's previous notes use paragraphs, in which case match that style.
Output only the completed note. No step narration, no summary of what was done, no closing remarks.

Write a Speech Pathology initial assessment report

Tip – Directly attach supporting files to a prompt to improve the quality of your output
You can select them from Client files if they already exist or upload directly.

- Completed service agreement PDF (or any other completed form)
- Completed Referral form PDF
- Referral documents
- Imaging reports
- Supporting documents

I am a Speech Pathologist and I have just completed an initial assessment with a patient. I need to document today's session in an initial assessment report.

First, review any content already written in the current progress note. Then the patient details, including any referral information listed. Then the most recent appointment details, and the next 2 upcoming booked appointments if any exist. If you have been provided with any intake forms, assessment documents, or background files, etc, as attachments, use these as additional context.

Using the session transcript as the primary source of clinical content and all retrieved information, write a complete speech pathology initial assessment report. Use the following sections with bold headings. Omit any section entirely where the transcript and patient file contain no relevant information. Do not write placeholder text or note that information was not provided.

Case history:
Background information established during this assessment. Include the referral source and reason for referral, relevant developmental and medical history, previous speech pathology or allied health involvement, current medications where relevant, living situation, and primary language spoken at home.

Presenting concerns:
The primary concerns raised by the patient, family, or carer during this assessment. Include the nature of the presenting difficulty, onset, and impact on daily communication, learning, feeding, or participation.

Assessment methods and tools:
The standardised and non-standardised assessments, clinical observations, and information-gathering methods used in this assessment. List each tool or method used and the date administered where available.

Assessment results by domain:
Findings organised by communication domain. For each domain assessed, document the assessment method used, key findings, scores obtained, and their functional significance. Domains may include: receptive language, expressive language, speech sounds and articulation, phonological awareness, fluency, voice, pragmatics and social communication, literacy, feeding and swallowing, and augmentative and alternative communication. Only include domains where findings are documented.

Summary and recommendations:
A clinical summary of the patient's communication profile across assessed domains. Identify primary areas of strength and difficulty. Include diagnostic impressions where supported by assessment findings, recommended therapy approach, frequency, and any referrals to other services.

Content rules:
Write in plain, direct clinical language appropriate to speech pathology practice. Use short, active and simple sentences. Avoid formal report language, passive constructions, and clinical jargon where plain language conveys the same meaning.
Only include information explicitly present in the transcript, attachments, current note content, patient details, or referral information. Do not fabricate or infer clinical content not present in these sources. Silently discard anything that is not clinically relevant. If something is unclear or uncertain, omit it.
Refer to the patient by their preferred name (not "the patient").
Format each section using concise dot points, except Assessment results by domain where a structured domain-by-domain presentation is required.
Output only the completed report. No step narration, no summary of what was done, no closing remarks.

Initial assessments usually split over multiple appointments?
If you usually capture context in splose that will serve as additional context for the initial assessment you're completing (for example, you had a call with a parent before conducting the initial consult with the child present) and you wrote notes in separate progress note(s) ahead of the session, make these amendments to paragraphs 2 and 3:

First, review any content already written in the current progress notes. Then the patient details, including any referral information. Then the most recent appointment details, and the next 2 upcoming booked appointments if any exist. Then, review the last 3 progress notes as additional initial assessment information captured outside of this session. If you have been provided with any intake forms, assessment documents, or background files as attachments, use these as additional context. Using the session transcript and previous progress notes as the primary source of clinical content, write...

Write a parent/carer communication summary

I am a Speech Pathologist and I have just completed a session with a patient. I need to write a plain-language summary to send to this patient's carer.

First review any content already written in the current progress note. Then the patient details. Then the most recent 3 previous progress notes for this patient.

Using the session transcript as the primary source of clinical content and all retrieved information, write a plain-language session summary suitable for sending to the patient's parent or carer. Use the following sections with bold headings. Omit any section entirely where the transcript contains no relevant information. Do not write placeholder text or note that information was not provided.

What we worked on today:
A brief, plain-language description of the activities and strategies used in today's session and the communication goals they targeted.

How [patient preferred name] went: A warm, strengths-based summary of the patient's engagement and performance during today's session. Note specific things the patient did well. Where relevant, note areas still being developed.

Strategies to practise at home:
Specific, practical strategies or activities for the carer to use at home before the next session. Write these as clear, actionable instructions a non-clinician can follow.

Next steps:
The planned focus for the next session and any follow-up the carer needs to be aware of.

Content rules:
Write in warm, friendly, plain language a non-clinician can easily understand. Avoid clinical terminology entirely. Where a clinical term is necessary, explain it in plain language immediately after.
Only include information explicitly present in the transcript, current note content, patient details, or previous progress notes. Do not fabricate or infer content not present in these sources. If something is unclear or uncertain, omit it.
Do not use "your child" or assume the relationship between the recipient and the patient.
Refer to the patient by their preferred name (not "the patient").
Format each section using concise, easy-to-read dot points.
Output only the completed summary. No step narration, no summary of what was done, no closing remarks.

Write a Speech Pathology NDIS plan reassessment report

Tip – Directly attach supporting files to a prompt to improve the quality of your output
You can select them from Client files if they already exist or upload directly.

- The participants NDIS plan
- Assessment results
- Parent or carer feedback
- Supporting documentation

I am a Speech Pathologist and I need to write an NDIS plan reassessment report for a patient.

First, review the patient details, including any NDIS plan information if listed. If you have been provided with the participant's NDIS plan, assessment results, parent or carer feedback, or supporting documents as attachments, use these as additional context. Then retrieve the progress notes only finalised during the current NDIS plan period, using the plan start and end dates to scope the retrieval. Then review any content already written in the current progress note.

Using all retrieved information and any attachments, write a complete Speech Pathology NDIS plan reassessment report. Use the following sections with bold headings. Omit any section entirely where no relevant information is available. Do not write placeholder text or note that information was not provided.

Participant and plan details:
The participant's full name, date of birth, NDIS number, plan period dates, and funding management type where documented in the patient file.

Reason for report:
The purpose of this report and the speech pathology services delivered under this plan period.

Background:
A brief summary of the participant's primary diagnosis, relevant communication and swallowing history, and functional communication presentation at the start of this plan period.

Service details:
The type of speech pathology service provided, the therapeutic approach used, the duration and frequency of supports, the goals worked toward, and the intended outcome of delivering those supports.
Output must return as a list containing:
Services commenced: [date of the first appointment booked for the patient (current practitioner only) eg. “November 2025”]
Services ended: [date of the last appointment on record booked for the patient (current practitioner only) eg. “March 2026”]
Duration: [the number of months between the first appointment and the last appointment listed above eg. “10 months”]|
Sessions attended: [the total number of appointments (current practitioner) eg. “18 sessions”]
Frequency: [eg. “weekly”, “fortnightly”, “monthly”]
Setting: [based on what was documented in the patient’s progress note history, list the settings where sessions were held with the patient eg. “clinic based sessions with two home visits conducted in December 2025 and Febuary 2026”]
Primary areas of therapy focus: [based on what was documented in the patient’s progress note

history, list the primary areas of documended focus areas eg. “expressive language, phonological awareness, literacy development, and parent and carer coaching”]

Baseline functional communication:
The participant's functional communication and swallowing capacity at the start of this plan period. Document the assessment measures used to quantify baseline capacity, including the measure name, date, and score where recorded. This section establishes the starting point against which progress is measured.

Goals and progress:
Each NDIS goal documented for this participant presented as a heading, followed by a summary of progress toward that goal across the plan period. For each goal include: evidence of progress drawn from progress notes, the therapy outcomes achieved and how they relate to the NDIS goal, any assessment scores at baseline and most recent administration to demonstrate change, and a clear statement of whether the goal has been achieved, is progressing, is partially progressing, or has not yet been addressed. Where a goal has not been addressed, note any documented reason.

Current functional communication:
The participant's current communication and swallowing function at the end of this plan period, based on the most recent progress notes and outcome measures. Where baseline measures were documented, present current scores alongside baseline scores to demonstrate change. Include any observations about functional communication in everyday settings such as home, school, or community where documented.

Parent and carer report:
Where parent, carer, or family observations of the participant's functional communication in everyday settings are documented, summarise these here. Note any reported changes since the start of the plan period and any areas of ongoing concern or strength identified by the participant's support network.

Barriers to progress:
Any factors that limited progress during this plan period, including attendance, health events, changes in the participant's circumstances, or gaps in service. Where barriers were identified, describe how they were addressed or how the therapy approach was adjusted in response.

Risks:
Any risks to the participant identified during this plan period while delivering NDIS supports. For speech pathology this may include dysphagia and aspiration risk, communication safety concerns, or risks related to AAC device failure or access. Describe what the risks were and how they were addressed. If no risks were identified, omit this section.

Additional supports:
Any informal, community, or mainstream supports that could assist the participant in working toward their communication goals, and any referrals or recommendations to other services made during this plan period.

Recommendations for next plan period:
Recommended speech pathology supports, frequency, goals, and any assistive or augmentative communication equipment needs for the next NDIS plan period. Address the NDIS reasonable and necessary criteria for each recommendation: the support is related to the participant's disability, it is likely to be effective, and it takes into account what can reasonably be provided through informal supports or other services. Each recommendation should be linked to a specific finding documented in this report.

Content rules:
Write in formal, objective clinical language appropriate to an NDIS report. Use third person throughout. Use paragraphs rather than dot points, except under Goals and progress where structured goal-by-goal presentation is required.

Only include information explicitly present in the retrieved progress notes, attachments, patient details, or current note content. Do not fabricate or infer clinical content not present in these sources. Do not summarise or interpret beyond what is explicitly documented across the plan period.
Where assessment scores are available, present them with the measure name, date, and score clearly stated.
Refer to the participant by their preferred name, not "the patient."
Output only the completed report. No step narration, no summary of what was done, no closing remarks.

Write a Speech Pathology handover or discharge summary

Tip – Directly attach supporting files to a prompt to improve the quality of your output
You can select them from Client files if they already exist or upload directly.

- Previous handover or discharge summaries
- Assessment results
- Review reports
- Supporting documents
- Referral PDFs or forms

I am a Speech Pathologist and I need to write a handover and discharge summary for a patient.

First, review the patient details, including any referral information listed. Then retrieve the last 3 months of progress notes on file for this patient. Then review any content already written in the current progress note. If you have been provided with any previous handover or discharge summaries, assessment results, referral information or supporting documents as attachments, use these as additional context.

Using all retrieved information and any attachments, write a complete speech pathology handover and discharge summary. Use the following sections with bold headings. Omit any section entirely where no relevant information is available. Do not write placeholder text or note that information was not provided.

Patient overview:
A brief summary of the patient's background, primary diagnosis or presenting communication concerns, and reason for referral to speech pathology.

Social and contextual information:
Any social, family, or legal context that affects how care is delivered or how the patient is communicated with. This includes custody arrangements, court orders, communication restrictions, safety concerns regarding specific contacts, and any other contextual factors the receiving provider must be aware of before engaging with the patient or their support network. Include only what is explicitly documented in the provided context for this patient.

Services received:
The speech pathology services provided to this patient, including the approximate duration of service, total number of sessions attended, and the primary areas of therapy focus across the service period.

Goals:
The therapy goals worked on during the service period. For each goal, provide a brief statement of whether it was achieved, partially achieved, or not achieved, with supporting evidence from the progress notes where available.

Progress and outcomes:
A summary of the patient's overall progress and functional communication outcomes across the service period. Note key improvements, areas of ongoing difficulty, and any significant changes in communication, language, fluency, voice, feeding, or swallowing function.

Safety considerations:
Any safety factors relevant to the next provider or carer. Include documented dysphagia risk, aspiration risk, supervision requirements during mealtimes, communication support needs, or any other clinical safety information documented in the patient file.

Communication preferences:
The patient's documented communication preferences, including primary language, AAC use, literacy considerations, and any adjustments required for effective communication.

Funding:
Remaining NDIS funding or plan details where documented in the patient file and relevant to the handover.

Recommendations:
Recommended next steps, ongoing supports, therapy priorities, or referrals for the receiving provider. Each recommendation should be grounded in the clinical picture documented in this summary.

Content rules:
Write in plain, direct clinical language. Use short, active and simple sentences. Avoid formal report language, passive constructions, and clinical jargon where plain language conveys the same meaning.
Only include information explicitly present in the retrieved progress notes, attachments, patient details, or current note content. Do not fabricate or infer clinical content not present in these sources. Silently discard anything that is not clinically relevant. If something is unclear or uncertain, omit it.
The Social and contextual information, Communication preferences and Funding sections are particularly susceptible to assumed or placeholder content. If nothing is explicitly documented for either, omit them entirely.
Refer to the patient by their preferred name (not "the patient").
Format each section using concise dot points.
Output only the completed summary. No step narration, no summary of what was done, no closing remarks.

Write a mealtime management plan

Tip – Directly attach supporting files to a prompt to improve the quality of your output
You can select them from Client files if they already exist or upload directly.

- Swallowing assessment results
- Clinical observation notes
- IDDSI documentation
- Supporting documents
- Completed forms

I am a Speech Pathologist and I need to write a mealtime management plan for a patient.

First, review the patient details and any referral information available in the patient file. Then the most recent 3 previous progress notes for this patient. Then any content already written in the current progress note. If you have been provided with any swallowing assessment results, clinical observation notes, IDDSI documentation, or supporting documents as attachments, use these as the primary source of clinical content. If a session transcript is available, use it as additional context.

Using all retrieved information and any attachments, write a complete mealtime management plan. Use the following sections with bold headings. Omit any section entirely where no relevant information is available. Do not write placeholder text or note that information was not provided.

Participant background:
A brief summary of the patient's relevant diagnosis, medical history, and the reason a mealtime management plan is required.

Swallowing assessment findings:
A summary of the swallowing assessment conducted, including the assessment method used, key findings, and their clinical significance. Include formal assessment scores where documented.

Texture and fluid recommendations:
The recommended food texture level and fluid consistency level using IDDSI terminology and level numbers. Include the clinical rationale for each recommendation based on the assessment findings.

Positioning requirements:
The required seating position and postural supports for safe and comfortable eating and drinking. Include any specific positioning equipment or adjustments required.

Feeding strategies and cues:
The specific strategies, prompts, and cues to be used during mealtimes to support safe swallowing and maximise independence. Written as clear, actionable instructions for carers and support staff.

Equipment and utensils:
Any adaptive equipment, modified utensils, or specialised cups or bottles required. Include the rationale for each item recommended.

Supervision requirements:
The level of supervision required during mealtimes, including who should be present, what to monitor, and when to seek assistance.

Risk and safety considerations:
Documented risk factors including aspiration risk, choking risk, fatigue, or other safety concerns relevant to this patient's mealtime management. Include any warning signs carers and support staff should be aware of.

Goals and recommendations:
Therapy goals related to swallowing and mealtime function, and any recommendations for review, further assessment, or referral to other services.

Review date:
The recommended date or timeframe for review of this mealtime management plan.

Content rules:
Write in clear, professional clinical language appropriate for both clinical records and carer-facing use. Where instructions are directed at carers or support staff, use plain language and avoid clinical jargon. Where findings are clinical in nature, use appropriate speech pathology and IDDSI terminology.
Only include information explicitly present in the attachments, transcript, current note content, patient details, or previous progress notes. Do not fabricate or infer clinical content not present in these sources. Do not assign an IDDSI level that is not explicitly supported by documented assessment findings.
Refer to the patient by their preferred name (not "the patient").
Format the Feeding strategies and cues and Supervision requirements sections as numbered steps. Format all other sections using concise dot points.
Output only the completed plan. No step narration, no summary of what was done, no closing remarks.