

skilled speech therapy documentation examples

Introduction

skilled speech therapy documentation examples are crucial for demonstrating the necessity and effectiveness of speech-language pathology services. Accurate and comprehensive documentation serves as a vital communication tool between therapists, patients, families, and payers, justifying treatment plans and outcomes. This article delves into various skilled speech therapy documentation examples, exploring their importance across different settings and patient populations. We will examine the core components of effective documentation, including objective findings, subjective reports, skilled interventions, progress towards goals, and recommendations. Understanding these examples will empower therapists to craft compelling documentation that highlights the unique value and complexity of their skilled interventions, ensuring appropriate reimbursement and continued access to care for individuals with communication and swallowing disorders. By providing clear and actionable examples, this guide aims to enhance the quality and impact of speech therapy documentation.

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The Crucial Role of Skilled Speech Therapy Documentation

Skilled speech therapy documentation is more than just a record-keeping task; it is the cornerstone of ethical and effective practice. It provides a clear, objective account of the patient's condition, the skilled interventions provided, and the progress made towards established goals. For insurance companies and other payers, this documentation serves as the primary justification for the medical necessity of speech therapy services. Without robust documentation, it can be challenging to demonstrate that the interventions are specialized, require the expertise of a licensed speech-language pathologist, and are essential for improving the patient's functional communication or swallowing abilities. High-quality documentation also facilitates interdisciplinary communication, ensuring that all members of the healthcare team are informed about the patient's progress and needs, thereby promoting a coordinated and holistic approach to care. Furthermore, it plays a vital role in legal and regulatory compliance, protecting both the therapist and the patient.

The complexity of speech and language disorders necessitates detailed documentation to capture the nuances of assessment and treatment. A skilled speech therapist doesn't just administer exercises; they analyze deficits, adapt strategies based on patient response, educate families, and modify the treatment plan as needed. All these skilled actions must be clearly articulated in the documentation. This record also serves as a historical account of the patient's journey, allowing for tracking of long-term progress and informing future treatment decisions. Therefore, investing time and effort into creating thorough and accurate skilled speech therapy documentation is paramount for the profession.

Essential Components of Speech Therapy Documentation

Effective speech therapy documentation typically follows a standardized format, often referred to as the SOAP note format. This structure ensures that all critical information is captured systematically, making it easy for other healthcare professionals to understand the patient's status and the therapist's rationale. Each component plays a distinct and important role in painting a complete picture of the patient's experience and the skilled interventions provided.

Subjective (S) Component

The subjective component of the documentation captures information reported by the patient, their family, or caregivers. This includes the patient's current complaints, perceived progress or regressions, pain levels, emotional state, and any relevant lifestyle factors that might impact therapy. For example, a patient might report, "I felt more tired today when trying to swallow my lunch," or a caregiver might state, "He seems to be understanding me better when I simplify my sentences." This subjective data provides valuable context for the objective findings and helps the therapist understand the patient's perspective and lived experience of their condition.

Objective (O) Component

The objective component details the therapist's direct observations and findings during the session. This is where the therapist records objective measurements, test results, and specific responses to skilled interventions. For a patient with dysphagia, this might include details about the number of sips of liquid taken, the type of food texture tolerated, the presence or absence of coughing during specific consistencies, and observations of oral motor control. For a patient with aphasia, objective findings could involve the percentage of correctly identified words, the fluency of spontaneous speech production, or the success rate with specific compensatory strategies. This section should be factual and avoid interpretation.

Assessment (A) Component

The assessment component is where the speech-language pathologist interprets the subjective and objective findings. This section synthesizes the data to provide a clinical impression of the patient's progress, identify barriers to improvement, and explain the significance of the findings in relation to the patient's overall functional status and established goals. It should clearly articulate why the observed deficits are occurring and how the skilled interventions are addressing them. For instance, the assessment might state, "Patient demonstrates continued difficulty with pharyngeal clearance secondary to

reduced laryngeal elevation, impacting safe swallowing of thin liquids. Current interventions are targeting improved hyolaryngeal excursion."

Plan (P) Component

The plan component outlines the proposed course of action for future treatment sessions. This includes specific interventions to be implemented, modifications to the current plan based on the day's session, frequency and duration of future therapy, and any referrals or consultations needed. It should directly relate to the assessment and demonstrate a clear progression towards the patient's rehabilitation goals. For example, "Continue with compensatory strategies for aphasia, increasing complexity of sentence structures targeted. Introduce visual cues for word retrieval. Schedule consultation with occupational therapy regarding upper extremity support for utensil manipulation during mealtimes."

Skilled Speech Therapy Documentation Examples by Setting

The documentation requirements and focus can vary significantly depending on the clinical setting. Each setting presents unique challenges and reimbursement structures that influence the emphasis placed on specific aspects of speech therapy documentation.

Skilled Nursing Facility (SNF) Documentation Examples

In SNFs, documentation often emphasizes functional improvement and the patient's ability to participate in activities of daily living (ADLs). It's crucial to demonstrate how speech therapy is contributing to the patient's independence and safety.

- **Subjective:** Patient reports, "I can swallow my soup without coughing now, but I still need to take small bites of chicken." Family notes improved understanding during meal times.
- **Objective:** Patient presented for swallow evaluation with thickened liquids (nectar-thick) and pureed solids. Tolerated 4 oz nectar-thick liquid with 2 instances of mild throat clearing, managed with 2 dry swallows. Tolerated 2 oz pureed pudding with no overt signs of aspiration. Oral motor exercises completed: 3 sets of 10 tongue lateralizations with good range of motion.
- **Assessment:** Patient demonstrates improved swallow safety with thickened liquids and pureed textures, indicating progress towards dysphagia management goals. Reduced throat clearing suggests improved pharyngeal clearance. Continued difficulty with bolus manipulation and transport of semi-solid textures necessitates ongoing skilled intervention to minimize aspiration risk and improve mealtime independence.

- **Plan:** Continue swallow therapy 5x/week, focusing on tongue base retraction exercises and chin tuck maneuvers. Progress to mechanically altered diet with continued use of nectar-thick liquids. Educate patient on safe swallowing strategies for all food textures. Monitor for signs/symptoms of aspiration pneumonia.

Home Health Speech Therapy Documentation Examples

Home health documentation highlights the patient's ability to manage their condition in the home environment and the therapist's role in caregiver training and ensuring safety within the home setting.

- **Subjective:** Patient states, "I'm having trouble finding the right words when I talk to my grandchildren on the phone. It's frustrating." Caregiver reports difficulty understanding patient's requests for medication.
- **Objective:** Aphasia assessment: Patient produced 50% of target words in confrontation naming task. Spontaneous speech characterized by word-finding pauses and circumlocutions. Comprehension task demonstrated 75% accuracy for 2-step commands with visual supports. Patient participated in compensatory strategy training (e.g., gesturing, writing) with moderate success.
- **Assessment:** Patient exhibits moderate expressive aphasia, impacting functional communication for personal needs and social interaction within the home environment. Word retrieval deficits are a significant barrier. Skilled intervention is necessary to improve functional communication, enhance caregiver understanding, and promote patient's independence in verbalizing needs.
- **Plan:** Continue speech therapy 3x/week. Focus on functional word retrieval strategies using cueing hierarchies. Implement a communication board for high-frequency needs. Provide caregiver education on effective communication strategies for aphasia, including pacing and rephrasing.

Outpatient Speech Therapy Documentation Examples

Outpatient documentation often focuses on progress towards specific functional goals and the patient's ability to participate in community or work-related activities.

- **Subjective:** Patient reports, "I'm feeling more confident speaking in small groups at my book club. I'm still a little nervous, but I'm not avoiding it anymore."
- **Objective:** Voice therapy session included: Vocal hygiene education review. Resonant voice therapy exercises (e.g., humming, forward focus) with improved vocal quality (reduced breathiness, increased loudness). Patient achieved 70% of target

loudness during reading tasks. Biofeedback demonstrated reduced laryngeal tension during sustained phonation.

- **Assessment:** Patient demonstrates continued progress in voice quality and reduction of vocal effort as evidenced by decreased breathiness and improved loudness. The application of resonant voice techniques is facilitating a more efficient and less strained vocal production, directly impacting functional communication in social settings. Increased confidence reported by the patient signifies improved participation.
- **Plan:** Continue outpatient speech therapy 2x/week. Progress resonant voice exercises to sentence and paragraph level tasks. Introduce conversational practice with emphasis on carryover of learned techniques. Monitor for vocal fatigue and adjust intensity as needed.

Acute Care/Hospital Speech Therapy Documentation Examples

In acute care, documentation is critical for justifying continued hospitalization, discharge planning, and the patient's readiness for less intensive levels of care.

- **Subjective:** Patient, post-stroke, states, "I can't find the words to ask the nurse for my water. It's very difficult."
- **Objective:** Bedside swallow evaluation: Patient presented with intact alertness and cooperation. Initial trials with thickened liquids (nectar-thick) resulted in mild coughing after bolus ingestion. Oral motor exam revealed moderate tongue weakness affecting bolus manipulation. Pharyngeal swallow was delayed by 3 seconds. Patient able to clear pharyngeal residue with a voluntary cough.
- **Assessment:** Patient exhibits dysphagia secondary to acute cerebrovascular accident, presenting with a delayed pharyngeal swallow and reduced pharyngeal clearance, placing them at risk for aspiration. Oral phase deficits further compromise swallow safety. Skilled speech therapy intervention is required to assess swallow function, initiate safe oral intake, and prevent aspiration pneumonia, thereby supporting patient recovery and reducing length of stay.
- **Plan:** Initiate speech therapy 2x/day. Nectar-thick liquids only. Strict chin tuck strategy with each swallow. Small bolus sizes. Monitor vital signs and respiratory status for any signs of aspiration. Patient to remain NPO pending further evaluation and potential instrumental assessment (e.g., FEES/VFSS).

Skilled Speech Therapy Documentation Examples by Disorder

Beyond the setting, documentation can be tailored to the specific disorder being addressed, ensuring that the skilled nature of the intervention is clearly communicated in relation to the patient's unique challenges.

Dysphagia (Swallowing Disorder) Documentation Examples

Documentation for dysphagia must clearly articulate the specific deficits identified, the impact on nutritional and hydration status, and the skilled strategies employed to ensure safe swallowing.

- **Subjective:** Patient reports, "I get tired when I eat, and sometimes I feel food stuck in my throat."
- **Objective:** Modified Barium Swallow Study (MBSS) results: noted pharyngeal residue of 25% with thin liquids, delayed pharyngeal swallow initiation (2-second delay), and reduced laryngeal elevation. Compensatory strategies (chin tuck, single swallow) reduced residue to 5% and normalized swallow initiation. Patient tolerated pureed diet without aspiration.
- **Assessment:** Patient presents with moderate oropharyngeal dysphagia, characterized by pharyngeal residue and delayed swallow, increasing aspiration risk. The application of skilled compensatory strategies via MBSS proved effective in mitigating these risks, allowing for safe progression to a pureed diet. Ongoing skilled intervention is crucial for improving swallow efficiency and endurance.
- **Plan:** Continue speech therapy 5x/week. Focus on exercises to improve laryngeal elevation and pharyngeal squeeze. Introduce sequential swallows for pureed textures. Gradually advance to mechanically altered diet as tolerated.

Aphasia (Language Disorder) Documentation Examples

For aphasia, documentation should highlight the impact on communication, the specific language deficits (e.g., word retrieval, comprehension, grammar), and the skilled techniques used to facilitate functional communication.

- **Subjective:** Patient states, "I can't find the words I want to say. It makes it hard to tell my doctor how I'm feeling."

- **Objective:** Boston Naming Test: Mean accuracy of 40%. Auditory comprehension: Patient able to follow 2-step commands with contextual cues, 60% accuracy without cues. Verbal expression: Characterized by significant word-finding pauses and frequent use of circumlocutions. Patient successfully utilized semantic feature analysis strategy to retrieve 3 target words.
- **Assessment:** Patient exhibits moderate to severe expressive aphasia, significantly impairing functional communication and participation in medical conversations. Word retrieval deficits are the primary barrier. Skilled intervention utilizing evidence-based techniques like semantic feature analysis is demonstrating potential for improving access to lexical items.
- **Plan:** Continue speech therapy 3x/week. Focus on functional communication strategies for obtaining medical information. Implement a structured cueing hierarchy for word retrieval. Introduce sentence completion tasks for grammatical structure.

Apraxia of Speech Documentation Examples

Documentation for apraxia of speech should focus on the motor planning and programming deficits, the characteristics of speech errors (inconsistent, distorted sounds), and the specific articulatory and prosodic interventions employed.

- **Subjective:** Patient reports, "Sometimes I can say a word clearly, and then the next time it comes out all jumbled."
- **Objective:** Spontaneous speech sample: characterized by significant articulatory errors, including sound omissions, substitutions, and distortions, with high inconsistency. Inconsistent production of multi-syllabic words. Integral stimulation (E-V-E-RY) approach: Patient demonstrated a 50% improvement in articulatory accuracy for targeted phonemes when provided with multi-sensory cueing (visual, auditory, tactile).
- **Assessment:** Patient presents with moderate to severe Childhood Apraxia of Speech (CAS), evidenced by inconsistent and distorted productions and difficulty with motor planning for speech. The integral stimulation approach is proving effective in improving articulatory precision and reducing speech errors by addressing the underlying motor planning deficits.
- **Plan:** Continue speech therapy 5x/week. Intensify integral stimulation practice with increasing word and phrase complexity. Incorporate rhythmic cueing for prosody. Gradually fade cues as patient demonstrates consistent production.

Articulation/Phonological Disorder Documentation Examples

Documentation for articulation and phonological disorders should clearly identify the phonological processes or individual sound errors and the targeted intervention strategies aimed at improving intelligibility.

- **Subjective:** Parent reports, "Other children have trouble understanding what my son is saying."
- **Objective:** Phonological process analysis: Identified multiple patterns including fronting of velars (/k/ -> /t/), stopping of fricatives (/s/ -> /p/), and cluster reduction. Intelligibility rating: 40% in spontaneous speech. Minimal pairs therapy: Patient demonstrated a 70% accuracy rate in discriminating and producing minimal pairs targeting fronting (/k/ vs /t/ in word initial position).
- **Assessment:** Patient exhibits moderate phonological disorder impacting speech intelligibility. The identified phonological processes significantly hinder effective communication with peers and adults. Targeted minimal pairs therapy is effectively addressing the phonological processes by improving the child's ability to differentiate and produce target sounds.
- **Plan:** Continue speech therapy 3x/week. Focus on clinician-directed and child-centered activities to facilitate generalization of target phonemes to spontaneous speech. Expand target sounds to include stopping of fricatives.

Voice Disorder Documentation Examples

Documentation for voice disorders should describe the perceived vocal quality, contributing factors, and the specific vocal exercises and strategies implemented to improve vocal health and function.

- **Subjective:** Patient reports, "My voice gets hoarse after talking for a short while, and it feels strained."
- **Objective:** Perceptual evaluation: Voice characterized by breathiness, reduced loudness, and vocal fry. Laryngeal palpation: Increased palpable tension in the laryngeal region. Vocal function exercises: Patient completed exercises targeting breath support and laryngeal strengthening with improved vocal fold closure observed during sustained phonation.
- **Assessment:** Patient presents with dysphonia, likely functional, characterized by breathy and strained vocal quality and decreased vocal endurance. Increased laryngeal tension contributes to the symptomatic presentation. Skilled vocal exercises targeting breath support and efficient phonation are indicated to improve

vocal fold adduction and reduce vocal effort.

- **Plan:** Continue speech therapy 2x/week. Focus on progressive muscle relaxation techniques for the laryngeal region. Implement resonant voice therapy to promote efficient vocal fold vibration. Provide ongoing vocal hygiene education.

Pediatric Feeding Disorder Documentation Examples

Documentation for pediatric feeding disorders needs to detail the specific feeding challenges, potential underlying medical or developmental factors, and the skilled interventions aimed at improving oral intake and promoting growth.

- **Subjective:** Parent reports, "My child only eats pureed foods and gags on anything with texture. Growth is a concern."
- **Objective:** Oral motor feeding assessment: Patient exhibits limited tongue mobility and poor lip closure during spoon feeding. Gag reflex elicited with textured purees. Tolerated 1 oz of smooth puree with 2 instances of mild gagging. Patient demonstrated increased oral aversion to thicker consistencies.
- **Assessment:** Patient presents with a pediatric feeding disorder characterized by oral motor deficits and texture aversion, impacting adequate nutritional intake and posing a risk to growth. Skilled intervention is required to improve oral motor skills, desensitize to textures, and promote safe and functional oral feeding.
- **Plan:** Continue speech therapy 3x/week. Implement gradual texture progression program starting with thicker smooth purees. Utilize sensory-based feeding strategies to increase acceptance of new textures. Provide parent education on feeding techniques and strategies to reduce mealtime stress.

Tips for Crafting Effective Skilled Speech Therapy Documentation

Creating effective documentation is an ongoing learning process. Therapists who prioritize clarity, specificity, and a focus on skilled intervention will produce records that not only meet regulatory requirements but also truly advocate for their patients' needs.

- **Be Specific and Objective:** Avoid vague terms. Instead of "patient improved," state "patient accurately produced target sound /s/ in 80% of elicited words." Quantify whenever possible.
- **Focus on Skilled Intervention:** Clearly articulate why your actions are skilled.

Highlight your clinical reasoning, the complexity of the tasks, and your professional judgment in adapting strategies based on patient response. Explain how your expertise is necessary for the patient's progress.

- **Link Interventions to Goals:** Every intervention should directly relate to one or more of the patient's established functional goals. Make this connection explicit in your assessment and plan.
- **Use Action Verbs:** Describe what you did and what the patient did. Verbs like "analyzed," "evaluated," "modified," "instructed," "demonstrated," and "participated" are stronger than passive language.
- **Document Patient/Caregiver Education:** Educating patients and their families is a crucial skilled intervention. Detail the information provided, the materials used, and the patient's/caregiver's understanding and ability to implement strategies.
- **Be Timely:** Complete your documentation promptly after each session to ensure accuracy and completeness. Delays can lead to forgotten details or a less accurate reflection of the session.
- **Know Your Payer Requirements:** Familiarize yourself with the specific documentation guidelines and expectations of different insurance providers and healthcare systems.
- **Use Standardized Terminology:** Employ commonly accepted clinical terms and abbreviations to ensure clarity and consistency among healthcare professionals.
- **Review and Edit:** Proofread your documentation for any errors in grammar, spelling, or factual accuracy before finalizing it.

Frequently Asked Questions

What are the current trending considerations for speech therapy documentation in 2024?

In 2024, trending considerations for speech therapy documentation include emphasizing functional communication outcomes, incorporating patient-centered goals, documenting progress towards short-term and long-term objectives transparently, utilizing teletherapy-specific notes, and ensuring compliance with evolving payer requirements and data privacy regulations (e.g., HIPAA).

How can speech therapists best document the impact of teletherapy sessions?

Documenting teletherapy involves noting the platform used, any technical challenges encountered and their impact on therapy, the client's engagement and attentiveness,

adaptations made for the virtual environment, and how progress was measured effectively through the remote modality. Specific objective measures and qualitative observations of functional communication are crucial.

What are examples of trending objective measures for tracking speech therapy progress?

Trending objective measures include quantifiable improvements in speech intelligibility (e.g., percentage of intelligible utterances), accuracy on specific phoneme productions, increased duration of sustained phonation, reduced latency in verbal responses, improvements in reading fluency (words per minute), and objective scores on standardized assessments relevant to the client's goals.

How can documentation showcase patient-centered goal achievement effectively?

To showcase patient-centered goals, documentation should clearly link interventions to the client's stated desires and functional needs. For example, instead of 'improved articulation,' document 'client can now verbally order a coffee independently with 90% intelligibility,' reflecting a real-world, patient-defined goal.

What is the trend in documenting functional communication outcomes versus just skill acquisition?

The trend is shifting towards documenting how acquired speech and language skills translate into meaningful functional communication in the client's daily life. This means moving beyond isolated skill practice to describing how improvements impact social participation, independence, vocational success, or quality of life.

How are AI and predictive analytics influencing speech therapy documentation practices?

AI and predictive analytics are emerging influencers. While not yet widespread for direct documentation, they are beginning to inform documentation by suggesting relevant goals based on initial assessments, identifying potential therapy trajectories, and potentially automating some data entry aspects, though human oversight remains critical for clinical judgment.

What are best practices for documenting interdisciplinary collaboration in speech therapy?

Documenting interdisciplinary collaboration involves clearly stating the names of other professionals consulted, the date of communication, the specific topic discussed, key information shared, and any resulting plan modifications or recommendations implemented. This demonstrates a holistic approach to client care and coordinated efforts.

Additional Resources

Here are 9 book titles related to skilled speech therapy documentation examples, each with a short description:

1. The Art of Concise Clinical Notes: Speech Therapy Edition

This book delves into the principles of effective and efficient documentation for speech-language pathologists. It provides practical strategies for capturing essential patient information concisely, focusing on the "skilled" aspects of therapy interventions. Readers will find sample notes for various settings and conditions, emphasizing justification for continued services.

2. Mastering Medical Necessity: Documenting Speech Therapy for Reimbursement

Designed to help SLPs navigate the complexities of insurance and billing, this guide highlights how to meticulously document medical necessity. It offers templates and real-world examples demonstrating how to link therapy interventions directly to functional goals and patient progress. The book aims to empower therapists to create documentation that supports appropriate reimbursement.

3. Evidence-Based Practice in Action: Documentation for SLPs

This resource bridges the gap between research and clinical application through its focus on documentation. It showcases how to integrate evidence-based practice into daily notes, providing examples that clearly articulate the rationale behind specific therapeutic approaches. The book emphasizes documenting patient response and progress in relation to established treatment protocols.

4. From Assessment to Discharge: Comprehensive Speech Therapy Documentation

This comprehensive guide walks SLPs through the entire documentation process, from initial evaluations to discharge summaries. It offers detailed examples for each stage, emphasizing the importance of clear, objective, and goal-oriented language. The book aims to equip therapists with the skills to create thorough and defensible records.

5. Goal-Oriented Documentation: Driving Progress in Speech Therapy

This book centers on the critical role of goal setting and progress monitoring in speech therapy documentation. It provides numerous examples of well-defined, measurable, achievable, relevant, and time-bound (SMART) goals and how to effectively document progress towards them. The emphasis is on demonstrating the direct impact of therapy on functional outcomes.

6. Pediatric Speech Therapy: Essential Documentation Strategies

Tailored specifically for SLPs working with children, this book offers practical guidance on documenting pediatric speech and language interventions. It includes a wealth of sample notes for common pediatric disorders, focusing on capturing development, family involvement, and the unique challenges of this population. The text aims to streamline the documentation process for busy pediatric therapists.

7. Adult Neurogenic Communication Disorders: Skilled Documentation Examples

This specialized text provides in-depth examples of documentation for adults with conditions like stroke, traumatic brain injury, and progressive neurological diseases. It highlights how to document the complexities of cognitive-communication disorders, dysphagia, and aphasia, emphasizing skilled interventions and functional improvements.

Therapists will find strategies for clearly articulating the impact of therapy on daily living.

8. The SLP's Guide to Interdisciplinary Collaboration: Documentation for Teamwork

This book focuses on the importance of clear and collaborative documentation when working as part of a multidisciplinary healthcare team. It offers examples of how to effectively communicate a patient's speech and swallowing status, progress, and recommendations to other professionals. The goal is to enhance interprofessional communication through precise and informative notes.

9. Compliance and Quality in Speech Therapy Documentation

This essential resource guides SLPs on how to maintain compliance with regulatory standards and ensure high-quality documentation practices. It provides examples that demonstrate adherence to ethical guidelines, privacy regulations, and best practices in record-keeping. The book aims to help therapists create documentation that is both thorough and legally sound.

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