MSB CONSULTING

SPEECH / LANGUAGE / AUDIOLOGY SERVICES NOTES

STUDENT NAME: ______________________________ DATE OF BIRTH: ____________ SAU #: _______

DISTRICT OF LIABILITY: ____

Session Date: ______________________

Start Time: ______________________

Stop Time: ______________________

Total Minutes: ______________________

Circle One: (G) Group (I) Individual

Provider Initial: _____

- ☐ Consultation of Speech Fluency
- ☐ Consultation of Speech Sound production
- ☐ Consultation of Speech Sound production with consultation of language comprehension and expression
- ☐ Consultation of behavioral and qualitative analysis of voice and resonance
- ☐ Evaluation of Speech Fluency (e.g. stuttering, cluttering)
- ☐ Evaluation of Speech Sound production (e.g. articulation, phonological process, apraxia, dysarthia)
- ☐ Evaluation of Speech Sound production (e.g. articulation, phonological process, apraxia, dysarthia) with evaluation of language comprehension and expression (e.g. receptive and expressive language)
- ☐ Behavioral and qualitative analysis of voice and resonance
- ☐ Individual Treatment/Therapy/Services
- ☐ Group Treatment/Therapy/Services

_____ Group Size (all students actually receiving the service)

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Unless so noted, school was in session and students were in attendance on all days recorded above. I have edited this form to correctly reflect services delivered on the above dates.

PRACTITIONER SIGNATURE: ____ DATE: ______________

PRACTITIONER PRINTED NAME: ____ DATE: ______________

LICENSE / CERTIFICATION / DOE ENDORSEMENT: ____

(Second signature of directing practitioner required if services are provided by a certified speech/language assistant/specialist or aide, as applicable)

DIRECTING PRACTITIONER SIGNATURE: ____ DATE: ______________

LICENSE: ____

(Properly qualified Licensed Practitioner of the Healing Arts providing direction, within scope of practice, to the certified speech/language assistant/specialist or aide, as applicable)