

Speech Therapy Treatment Log

Month/Year _____, **2016 / 2017**

Name: _____ **DOB:** _____ **Diagnosis:** _____ **School:** _____ **Grade:** _____

Goals: _____ **Medicaid #:** _____

IEP Services: _____ **Consent to Bill Medicaid:** _____ **1 UNIT = 1 Session**

Start Time	End Time	Min	Units	G/# I/E	Attendance	Location of Service	Date	Activity	1	2	3	4	5	6	7	8	9	10	%	C = Continue A = Achieved M = Monitored	Provider's Signature

Attendance: P=Present A=Absent U=Unavailable H=Holiday C/A=Cancelled (SLP absent) C/M=Cancelled (SLP Meeting) C/O= Cancelled (other) HB=Hospital Home Bound
Session: G = Group # = Number in Group I = Individual E = Evaluation **Location:** Reg = Regular Ed. RC = Speech Room SPED = Special ed. Room

Monthly Progress Summary: _____

Signature of Therapist **CCC-SLP**
Title