ARKANSAS STATE UNIVERSITY
SPEECH AND HEARING CENTER
P.O. Box 910, State University, AR 72467-0910
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Treatment Summary

Name: **File #:**
Birth date: **Referral Source:**
Parents (if applicable): **Therapy Period:**
Address: **No. of Sessions:**
Date of Report:

History:
_____'s most recent speech/language evaluation on _____ indicates a: _____mild_____moderate_____severe_____ disorder characterized by:

Previous therapy at _____ emphasized remediation of:

Therapy results:_____ was enrolled at the ASUS&HC from ____to _____ with the following therapy program:

Long Range Goals:
Long range goals were identified on _____'s most recent IEP (__/__/__) were as follows:

Short Range Goals:

Short Range Goals	Pre-Therapy Baseline in % of Correct Response	Post-Therapy Baseline in % of Correct Response	Date Completed
1.1xxxxxxxxxxxx	10%	90%	04/03/93
1.2xxxxxxxxxxxx			
2.1xxxxxxxxxxxx			
2.2xxxxxxxxxxxx			

End of semester testing: (Indicate tests given, scores, and results)

Summary:
Given _____ pre-therapy condition, the progress noted above is felt to be significant/not significant:
_____'s lack of notable progress may be explained by:
Include the result of the proposed method of treatment.

Recommendations:
Based on _____'s progress during this therapy period, the following recommendation(s) are made:
1. (continue therapy with emphasis on : [specific long range/short range goals and objectives])
2. (discontinue therapy) [reason; follow-up?])