ARKANSAS STATE UNIVERSITY
SPEECH AND HEARING CENTER
P.O. Box 910, State University, AR 72467-0910
Phone: 870-972-3301 Fax: 870-972-3788

Treatment Plan

NAME: CASE NUMBER:
BIRTHDATE: THERAPY PERIOD:
PARENTS: FREQUENCY:
ADDRESS: DATE:

Summary of Present Level of Functioning:
Include date of diagnosis, place, tests given, and results. Identify the primary and secondary diagnoses and severity. List previous treatment (where, how long, goals, and results). Level of functioning should be in objective, measurable functional terms, and may need to compare initial to current status.

Long Range Goals:
Should be appropriate for disorder, severity, and cognitive level and reflect client's greatest needs.

Short-Term Objectives:
Use behavioral language including given (conditions, materials, etc.); knowledge (area/skill); behavior (observable/countable); and level of proficiency.
Rationale for Treatment Methods

Method:
Explain the evidence based method of treatment proposed for this semester.

Frequency of Treatment:
State number of sessions per week and length of sessions. Include statement of treatment plan ie: 4 weeks, Fall semester, etc. Include statement of prognosis, identifying rational for that prognosis.

_____ _____
Student Clinician Supervisor (ask for their degree and CCC-)

I agree/do not agree with this plan of treatment. (Circle one)

_____
Client/Parent/Guardian