

Please complete and return to _____ by _____. Thank you for your cooperation.

SEDGWICK COUNTY AREA EDUCATIONAL SERVICES INTERLOCAL COOPERATIVE

SPEECH THERAPIST REPORT

_____ STUDENT'S NAME _____ D.O.B. _____ SCHOOL

___ Report on referred student
___ Comprehensive Speech/Language

Previously in therapy? ___ Yes ___ No Currently in therapy? ___ Yes ___ No

CLASSROOM PERFORMANCE _____

DATES _____

ARTICULATION _____

DATES _____

LANGUAGE _____

DATES _____

VOICE _____

DATES _____

FLUENCY _____

DATES _____

SUMMARY/RECOMMENDATIONS _____

Speech Therapist's Signature

Date