

_____ COUNTY SCHOOLS STUDENT NAME: STUDENT DOB:
 DIAGNOSIS CODE:

SPEECH THERAPY LOG MONTH: _____ YEAR: _____

DEC 4 GOAL 1:
DEC 4 GOAL 2:
DEC 4 GOAL 3:
DEC 4 GOAL 4:
DEC 4 GOAL 5:
DEC 4 GOAL 6:
DEC 4 GOAL 7:
DEC 4 GOAL 8:

DOS: _____ DURATION IN MINUTES: _____ BILLING CODE: [] 92506 re-eval [] 92507 individual tx [] 92508 group tx

# Goal	% Accuracy	Notation of skilled intervention provided and patient response:

SLP / CFY/ SLPA Signature/ DATE: _____ Supervising SLP Signature/ DATE: _____

Caregiver Education: [] Written [] Verbal
 Comment: _____

DOS: _____ DURATION IN MINUTES: _____ BILLING CODE: [] 92506 re-eval [] 92507 individual tx [] 92508 group tx

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