

SHARS Speech-Language Session Notes

Optional

(Please Print)
Practitioner

Student: _____

Annual
ARD Date: _____

Credentials

____ SLP-CCC _____ ASLP
____ SLP _____ Tx Lic. SLP
____ (CFY/Intern) _____ TEA SLP

Student
DOB: _____

of Sessions: _____

Speech Eval/Referral
(SLP of MD)

Medicaid # _____

Time (Minutes
per session): _____

Eval/Referral Date: _____

School District: _____

Co-op/SSA: _____

Goal/Objective from IEP (Focus for Direct Services): _____

Date	Svc Code	Start/Stop Time	Billable Time	Activity	Related Goal	Observations	Initials (Req'd)

Start/StopTime: time of day (i.e: 10-10:30 am) Billable Time: Total minutes/hours (i.e.: 30 min)

Svc Code: E = Evaluation, G = Group Therapy, I = Individual Therapy

Signature: _____

(Required)