File number ..... **- CONFIDENTIAL** **- A.A. .....**

RADIOMARATHON FOUNDATION FOR CHILDREN WITH SPECIAL NEEDS

SPEECH THERAPY ***ASSESSMENT*** FORM

Therapist Name: ..... Register number.....

PRIVATE: Address ..... Tel. ……..…..

Date: Evaluation:.....

A. GENERAL INFORMATION OF THE CHILD:

Name:..... Date of birth.:.....

Father's Name: ..... Mother's name: .....

Address:..... Telephone:.....

Referred by: .....

Doctors / Therapists who monitor the child: .....

.....

Diagnosis:.....

B. CHILD'S HISTORY: .....

.....

.....

C. EVALUATION RESULTS/GENERAL REMARKS: .....

.....

.....

.....

D. THERAPEUTIC DIAGNOSIS:

Talking		**Speech**
1) Arting	**5) Dysarthria**	**1) Delay in speech development**
2) Stuttering	**6) Other**	**2) Speech disorders**
3) Voice		**3) Learning disabilities**
4) Inactivity		**4) Other**

PROBLEM LEVEL: Light / Medium / Severe / Very severe

E. OBJECTIVES: .....

Suggested frequency of treatment: .....

Frequency of treatment offered: .....

<u>Reassessment Date</u>: .....

Date:..... **Signature:.....**