

File number.....

- CONFIDENTIAL

- A.A.

RADIOMARATHON FOUNDATION FOR CHILDREN WITH SPECIAL NEEDS

SPEECH THERAPY REASSESSMENT FORM

Therapist Name: Register number.....

PRIVATE: Address Tel.

Date: Evaluation:

Child's Name: Date: Born.

A. REASSESSMENT RESULTS / GENERAL REMARKS:

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B. OBJECTIVES:

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Re-evaluation Date:

C. OBSERVANCE OF SPEECH THERAPY SESSIONS: Attended times in

Planned treatments

D. OTHER TREATMENTS AND THEIR FREQUENCY: Speech therapy times a week

Physiotherapy..... " " "

Occupational therapy..... " " "

Hydrotherapy..... " " "

Special Education..... " " "

Psychol. Support..... " " "

Name of therapist: Signature:

Date: