|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Client Name: | |  | | Date of Service: | |  |
| Medical Record Number (MRN): | |  | | Session Start Time: | |  |
| Location of Service: | | Office/Clinic  Home  Community  School  Telehealth  Other: \_\_\_\_\_\_ | | Session End Time: | |  |
| Also Present: | | Parent  SLP  OT  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Total duration of Session: | |  |
| Procedure Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Direct  Indirect  Tele-Health | | | | | | |
| Telehealth Consent | Parent Consent to Telehealth on file and current?  Yes  No | | | | | |
| Purpose of Session: | (Please include the reason for and the purpose of the appointment/session. Should also include why it is needed) | | | | | |
| Treatment Goals  Addressed | (Please indicate which treatment goals from the treatment plan were targeted during the service) | | | | | |
| Interventions Rendered | (Please include a description of what clinical intervention took place during the session) | | | | | |
| Client’s Response | (Please indicate client’s degree of participation, and client’s response to the intervention) | | | | | |
| **Practitioner Attestation:** My signature below certifies that I have completed the above tasks as part of the client’s treatment and care. | | | | | | |
|  | | |  | |  | |
| **Practitioner**  **PRINTED Name & Credentials** | | | **Practitioner Signature** | | **Date** | |
| **Parent/Guardian/Client (if over 18) Attestation:**  My signature below certifies that my child received services at the date/time stated above. | | | | | | |
|  | | |  | |  | |
| **Client/Parent/Guardian**  **PRINTED Name** | | | **Client/Parent/Guardian Signature** | | **Date** | |