

**COUNSELING AS A RELATED SERVICE**

 **(Annual Review Progress Report and Recommendations)**

**FOR SCHOOL YEAR: 2020-2021**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Student’s Name: Date of Birth:**

**School: Grade:**

**Service Provider: Teacher:**

**Progress Note:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_ has been receiving counseling services for the 2019-2020 school**

 **(NAME)**

**year**

**as follows: ­**

 **(FREQUENCY/DURATION/RATIO/LOCATION – e.g. 2x/wk/30min/Individual/Therapy Room)**

**The following progress has been noted: (Present Level of Functioning)**

**The following strength, preferences, and/or interests have also been noted:**

**2020-2021 Counseling Recommendations: (CHOOSE ONE)**

[ ]  **It is recommended that speech-language services continue for the 2020-2021 school year as follows:**

 **\_\_\_ x per** [ ]  **week 30 min** [ ]  **Individual** [ ]  **Classroom** [ ]  **Therapy Room**

 **\_\_\_ x per** [ ]  **week 30 min** [ ]  **Group** [ ]  **Classroom** [ ]  **Therapy Room**

**Therapy will focus on the following: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

[ ]  **Current speech-language evaluation(s) indicate that service(s) are no longer warranted.**

**Signature: (include credentials) (Date)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

[ ]  **Goals Entered on IEP**