

**SPEECH 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:**

**Current Status:**

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

 **(NAME)**

**year**

**as follows: ­**

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

**Please see IEP for present level of functioning, strengths, preferences and/or interests.**

**Standardized Test Scores (PLEASE INDICATE ANY TESTING / DATE (COMPLETED THROUGH ANNUAL REVIEW DATE)**

**Vocabulary: PPVT: ROWPVT: EOWPVT:**

**Articulation: GFT:**

**CELF-4: Receptive: Expressive: Core Language:**

**OWLS: Listening Comprehension: Oral Expression:**

**OTHER:**

**Speech-Language Therapy 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**