

**NORTHERN ARIZONA UNIVERSITY
SPEECH-LANGUAGE-HEARING CLINIC
END OF SESSION CLINIC CASE RECOMMENDATION**

Please complete this form and return it to your supervisor. Your supervisor will give it to the Clinic Director.

Client's name: _____

Age: _____

Date of birth: _____

Phone number: _____

Previous treatment days and times: _____

ICD code (diagnosis): _____

CPT code (treatment): _____

Supervisor: _____

Clinician: _____

Case recommendation (please checkmark recommendations)

Dismiss, treatment completed

Dismiss, treatment not completed (explain why)

Continue next session

Fall Spring Summer

Re-evaluation (indicate date of last evaluation)

Refer (explain why)

Treatment recommended

Type: _____

Amount: _____

Duration: _____

Frequency: _____

**PLEASE SEND/GIVE THE APPROVED/SIGNED PROGRESS REPORT TO THE CLIENT!
INCLUDE THE PARENT/CLIENT RATING OF CLINICAL SERVICE FORM!**