

THE CHILDREN'S CENTER

THERAPEUTIC PRESCHOOL-INITIAL TREATMENT PLAN REVIEW

Child: _____ Date: _____
DOB: _____ Therapeutic Preschool Specialist: _____
Age: _____ Co-Therapeutic Preschool Specialist: _____
Supervisor: _____

Attendees:

Douglas Goldsmith, PhD; Kristina Hindert, MD; Kristin Rokop, PhD; Pamela Wilkison, PhD;
Julia Lidgard, MS/SLP; Eve Smith, LCSW; Nellie Arrieta, LCSW; Mariel Balzotti, BA;
Katherine Gardiner, LPC, Leslie Spear, MS; Danielle Warthen, BS

Observations of Initial Referral Concerns:

Group Observations:

Group Readiness:

Relationships with Adults/Peers:

Behavioral Control:

Emotional Regulation:

Communication:

Services Provided for the last 90 days: (please check)

Speech Therapy ___ Individual Therapy ___ Coll. Therapy ___ Medication Management ___
New Assessment ___ (Change in Diagnosis: Yes ___ No ___)

Progress Toward Treatment Goals:

Goal #___:

Frequency/Duration Update:

Goal #___:

Frequency/Duration Update:

Goal #___:

Frequency/Duration Update:

Goal# ____:

Frequency/Duration Update:

Current Functioning of Child in Family:

Collateral Goal ____:

Frequency/Duration Update:

Collateral Goal ____:

Frequency/Duration Update:

Review of Speech/Language Treatment:

Review of Individual Therapy:

Medication Management: (See Medical Section in Chart)

Strengths of Child

Strengths of Family

Continued Need for Treatment, Recommendations & Discharge Plan (Address appropriateness of treatment provided):

Signature/Title