

ST Treatment Record For Patient: _____

S: Patient seen at Home / School / Daycare / Other _____ From _____ To _____

O: _____

A: Alert and Oriented / Lethargic Cooperative / Uncooperative. VC: Min / Mod / Max _____

P: Cont / Hold / D/C (See D/C Sum) due to _____

Date: ___/___/___ Therapist's Signature: _____ Parent / Client Signature: _____

Modalities	
	Articulation
	Language
	Oral Motor
	Swallowing
(Total Units)	

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