COORDINATION SUMMARY REPORT FORM (CM-5A)
CONTRACT YEAR 2015-2016

Student's Name:_____ DOB:_____ Date of Report:_____

Coordinator's Name:_____ Discipline: **Special Educator (SEIT)** Agency: **TheraCare**

School District:_____

COORDINATION CONTACT DATES: Write in Month, year and circle or X out dates of contact.

MONTH: _____ YEAR_____

DATES: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 (parent/guardian)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 (providers)

COORDINATION ACTIVITIES: Specify coordination activities. Include service coordination activities with related service providers. Discuss the general plan for the period and expected outcomes. Include issues effecting service delivery, and make a statement about the student's progress to date based on feedback from the therapists. List contact dates for conference/training with student's parent/training with student's parent/guardian. Include issues discussed, feedback about their feelings concerning their child's progress and the effectiveness of the activities they have been given to use with their child. Discuss CPSE attendance and summarize the discussion and outcome of the meeting. Reference dates in discussion, as appropriate.

Related Services (as per IEP): Speech _____ OT _____ PT _____ Other _____

{ } I certify that the indirect activities summarized above were performed on the dates indicated

Document number of hours spent monthly on coordination activities (outside of sessions) for this child. This can include: discussion with parents, collaboration with related service providers, prep for and attendance at meetings and travel. _____

PLEASE NOTE:
Speech services delivered by a TSHH MUST BE completed under the direction of a Speech and Language Pathologist.
Occupational Therapy delivered by a COTA MUST BE done under the supervision of an OTR.

THERACARE	Special Educator (SEIT)	n/a	
Name of Agency	**Type of License/Certification of Direct Provider & License #**	**Lic/Cert # direct Provider**	**Signature of Direct service Provider**

SLP providing Speech MUST include TSHH certification information
If as noted above the signature of the Clinician providing Under the Direction of, or under the supervision of MUST complete and sign the following:

Type of License of clinician providing direction/supervision	**License #**	**Signature of Clinician providing direction/supervision**