ALL ABOUT KIDS™

Evaluations & Therapy Services For All Children

www.allaboutkidsny.com

CPSE MEETING FORM

Child's Name: _____

CPSE Meeting Date: _____ Time: _____

Persons Present:
Chairperson: _____

All About Kids Representative: _____

Others: _____

Therapies Assigned	Frequency	Duration (time)	Provider	Location Of Therapy

Coordinator of Related Services: __Yes __No Name of Provider: _____

Duration (months): _____ 10 months _____ summer _____initiation date _____

PT/OT Prescriptions requested (if those therapies designated) _____

Family's preference for therapy services: Days _____ Times_____

Comments and/or recommendations: _____

Executive Office
Nassau
255 Executive Drive,
Suite LL 105/108
Plainview, NY 11803
516-576-2040
Fax: 516-576-2131

Suffolk
150 Vanderbilt Motor Pkwy,
Suite 401
Hauppauge, NY 11788
631-439-6860
Fax: 631-439-6861

Queens
Manhattan
37-11 35th Ave,
Suite 3C
Astoria, NY 11101
718-706-7500
Fax: 718-706-9595

Brooklyn
25 Chapel Street,
Suite 704
Brooklyn, NY 11201
718-522-7300
Fax: 718-522-5280

Bronx
3140B
E. Tremont Avenue
Bronx, NY 10461
718-239-4147
Fax: 718-239-4310

Westchester
145 Huguenot Street,
Suite 404
New Rochelle, NY 10801
914-251-0905
Fax: 914-251-1266