

**CPSE/CSE MEETING OUTCOME FORM**

**To Be Returned Immediately AFTER MEETING**

 **CHILD’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BIRTH DATE: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_**

 **SCHOOL DISTRICT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MEETING DATE: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ TIME START: \_\_\_\_\_\_\_ TIME END: \_\_\_\_\_\_\_**

 **CPSE**  **CSE** **ATTENDED IN-PERSON** **ATTENDED VIA VIDEO/TELECONFERENCE** **CHILD DECLASSIFIED AS OF \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **SUMMER SERVICES: IEP Start Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ End Dates: \_\_\_\_/\_\_\_\_/\_\_\_\_ AAK Coordinator of Services: ( ) YES ( ) NO**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Service** | **#Sessions** |  **Minutes** | **(Week/Month)** | **Ind.** | **Group** | **Grp Size** | **Location** | **Current Therapist's Name** |  **Will Continue** |
| **ABA/BIS** |   |   |   |   |   |   |   |   |  **Y / N** |
| **SEIT/Resource Room** |   |   |   |   |   |   |   |   |  **Y / N** |
| **SPEECH/LANG** |   |   |   |   |   |   |   |   |  **Y / N** |
| **OT** |   |   |   |   |   |   |   |   |  **Y / N** |
| **PT** |   |   |   |   |   |   |   |   |  **Y / N** |
| **COUNSELING** |   |   |   |   |   |   |   |   |  **Y / N** |
| **PARENT TRAINING** |   |   |   |   |   |   |   |   |  **Y / N** |

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **FALL SERVICES: IEP Start Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ End Dates: \_\_\_\_/\_\_\_\_/\_\_\_\_ AAK Coordinator of Services: ( ) YES ( ) NO**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Service** | **#Sessions** |  **Minutes** | **Week/Month** | **Ind.** | **Group** | **Grp Size** | **Location** | **Current Therapist's Name** | **Will Continue** |
| **ABA/BIS** |  |  |  |  |  |  |  |  |  **Y / N** |
| **SEIT/Resource Room** |  |  |  |  |  |  |  |  |  **Y / N** |
| **SPEECH/LANG** |  |  |  |  |  |  |  |  |  **Y / N** |
| **OT** |  |  |  |  |  |  |  |  |  **Y / N** |
| **PT** |  |  |  |  |  |  |  |  |  **Y / N** |
| **COUNSELING** |  |  |  |  |  |  |  |  |  **Y / N** |
| **PARENT TRAINING** |  |  |  |  |  |  |  |  |  **Y / N** |

 **SCHOOL Days:  M  T  W  TH  F TIMES: ­­­\_\_\_\_\_\_\_\_ AM/PM \_\_\_\_\_\_\_\_ AM/­PM; SCHOOL NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **AAK Attending Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Chairperson/District Admin: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **NOTES:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**