SCHEDULE REQUEST

Please indicate possible evaluation (one-time event) and treatment times (recurring weekly) for your child. Provide multiple options so that a collaborative schedule can be obtained. **(This serves as a tentative platform for services and is subject to change based on availability of therapist, evaluation results, and recommendations for services).**

Evaluation

Please indicate best day(s) and time to perform evaluations.

- ☐ Monday
- ☐ Tuesday
- ☐ Wednesday
- ☐ Thursday
- ☐ Friday
- ☐ Other: ___________________________

- ☐ Mornings (7:30am- 12:00pm)
- ☐ Mid-day (12:00pm- 3:15pm)
- ☐ Evenings (3:15pm -7:00pm)

Treatment

Please indicate **tentative** frequency, duration and specific days of treatment:

How many times weekly?: _________________________________

How long should sessions be?: _____________________________

Requested days and times:

1st option: ___________________________@ _____________________

2nd option: __________________________ @ _____________________

3rd option: __________________________ @ _____________________