



Chester County Intermediate Unit

Student Services Division – Assessment & Clinical Services
HOME AND COMMUNITY SERVICES

BEHAVIORAL SPECIALIST CONSULTANT WEEKLY REPORT

Service Week: Saturday, _____ to Friday, _____

Page _____ of _____

Behavioral Specialist Consultant: _____

Client Name: _____

Hrs/Wk Authorized: _____ Hrs. Provided: _____ Total Travel Time: _____

Reason code(s) with time not provided and specific written reason(s) for each code:

Date of Consult(s): _____ (ONE DATE OF CONSULTATION PER PAGE)

Total Consultation Hrs. Provided this Date: _____ Total Travel Time this Date: _____

Consult #: _____

Start Time: _____ am/pm End Time: _____ am/pm Length of Consult: _____ Travel Time: _____

Type of Consult: _____ Face-to-Face _____ Phone _____ Treatment Plan _____ ITM _____ Observation
_____ Other (Please Explain) _____

Consulted with: (Specific names and location) _____

Signature of Parent/Teacher/Other: (Face-to-Face) _____

CLINICAL REPORT: Include Goals/needs addressed, strengths utilized, and plan of action. **Treatment Plans, Treatment Plan revisions/modifications, and all data collection from observations must be attached.**

Consult #: _____

Start Time: _____ am/pm End Time: _____ am/pm Length of Consult: _____ Travel Time: _____

Type of Consult: _____ Face-to-Face _____ Phone _____ Treatment Plan _____ ITM _____ Observation
_____ Other (Please Explain) _____

Consulted with: (Specific names and location) _____

Signature of Parent/Teacher/Other: (Face-to-Face) _____

CLINICAL REPORT: Include Goals/needs addressed, strengths utilized, and plan of action. **Treatment Plans, Treatment Plan revisions/modifications, and all data collection from observations must be attached.**

BSC Signature: _____ Date: _____