

REQUEST FOR MUSIC THERAPY SERVICES

Student Name:

DOB:

Request is for the Academic School Year (SY):
Request is for the Extended School Year (ESY):

MUSIC THERAPY EVALUATION

- Any previous music therapy reports
- Consent to evaluate form
- Current psychological report

INDICATE CSE
Date & Time if Known:

INITIAL

RE-EVALUATION

*For 1st Year Student in
BOCES Program*

MUSIC THERAPY DIRECT SERVICES

Individual

Frequency (number of sessions per month)
Duration (minutes per session)
Location

Group

Frequency (number of sessions per month)
Duration (minutes per session)
Location
Ratio

MUSIC THERAPY CONSULTATION

- Indicate number of hours per year:

To assist BOCES in fulfilling your request, please indicate:
Reason for Request or any additional information: