

NYC EARLY INTERVENTION PROGRAM

Provider Progress Note Page 1 (Circle 3, 6, 9, 12)

Complete this progress report and review with the parent. Submit the completed report to the service coordinator **no later than 2 weeks** prior to the 6 month (submit 3 and 6 month notes) or annual review (submit 9 & 12 month notes). All questions must be answered or the report will be returned. Use additional pages if needed. Typed reports are preferred. Illegible hand written reports will be returned.

Child's Name: _____ EI #: _____ DOB: ____/____/____

IFSP Period: From: _____ To: _____ Provider Agency Name: _____

Provider Agency ID #: _____ Print Name of Interventionist: _____

Discipline: _____ Service Type: _____ Interventionist's Phone Number: _____

Date reviewed with parent: _____ Parent's Signature: _____

Authorized Frequency? _____ Date you started working with this child: ____/____/____

Where have services been delivered? _____

Has the parent(s) been present for the sessions, if not, how have you communicated with the family?

If there have been any gaps in service delivery of more than three consecutive scheduled visits, describe the length and the reason(s).

List the child's medical diagnosis(es) (if any):

Is the child using assistive technologies? Yes No Is a new AT Device being requested? Yes No

If yes, identify the Functional Outcome (from the IFSP) and specify how the device is helping (or will help) to achieve the Outcome.

1. IFSP Functional Outcome 1: _____ **Rate Progress in This Time Period**

_____	No	Little	Moderate	Great Deal	Outcome
_____	Progress	Progress	Progress	of Progress	Achieved
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

1a. List the short-term objectives that are currently being worked on to achieve the IFSP Functional Outcome:

Check Y/N to indicate if the objective(s) was achieved in this time period. Check (E) to indicate if the skills related to the objective are emerging.			
1. Objective:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Emerging <input type="checkbox"/>
2. Objective:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Emerging <input type="checkbox"/>
3. Objective:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Emerging <input type="checkbox"/>
4. Objective:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Emerging <input type="checkbox"/>
5. Objective:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Emerging <input type="checkbox"/>

1b. State changes/modifications made to objectives in order to facilitate developmental progress. Be specific.

1c. What routine activities are you and the family/caregivers using to achieve **each** objective stated above (ex: mealtime, bath time, etc.)? Describe how interventions are being incorporated into the routine activities. Which family member(s) have you been working with?

1d. What changes were made if the routine activities or the strategies/methods approaches were ineffective (progress limited), or difficult for the family to incorporate into daily routines?

Child's Name: _____ IFSP Period: From: _____ To: _____

2. IFSP Functional Outcome 2: _____

Rate Progress in This Time Period

	No Progress	Little Progress	Moderate Progress	Great Deal of Progress	Outcome Achieved
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2a. List the short-term objectives that are currently being worked on to achieve the IFSP Functional Outcome:

Check Y/N to indicate if the objective(s) was achieved in this time period. Check (E) to indicate if the skills related to the objective are emerging.

Objective:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Emerging <input type="checkbox"/>
1. Objective:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Objective:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Objective:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Objective:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Objective:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2b. State changes/modifications made **to objectives** in order to facilitate developmental progress. Be specific.

2c. What routine activities are you and the family/caregivers using to achieve **each** objective stated above (ex: mealtime, bath time, etc.)? Describe how interventions are being incorporated into the routine activities. Which family member(s) have you been working with?

2d. What changes were made if the routine **activities or the strategies/methods approaches were** ineffective (progress limited), or difficult for the family to incorporate into daily routines?

Child's Name: _____ IFSP Period: From: _____ To: _____

3. IFSP Functional Outcome 3: _____

Rate Progress in This Time Period

	No Progress	Little Progress	Moderate Progress	Great Deal of Progress	Outcome Achieved
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3a. List the short-term objectives that are currently being worked on to achieve the IFSP Functional Outcome:

Check Y/N to indicate if the objective(s) was achieved in this time period. Check (E) to indicate if the skills related to the objective are emerging.

Objective:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Emerging <input type="checkbox"/>
1. Objective:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Objective:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Objective:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Objective:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Objective:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3b. State changes/modifications made to **objectives** in order to facilitate developmental progress.
Be specific.

3c. What routine activities are you and the family/caregivers using to achieve **each** objective stated above (ex: mealtime, bath time, etc.)? Describe how interventions are being incorporated into the routine activities? Which family member(s) have you been working with?

3d. What changes were made if the routine activities or the strategies/methods approaches were ineffective (progress limited), or difficult for the family to incorporate into daily routines?

Note: Questions 4, 5, and 6 do **NOT** need to be answered separately for each outcome

Child's Name: _____ IFSP Period: From: _____ To: _____

4. In addition, to working with the family, describe all collaborative efforts made to address the IFSP outcomes of this child. (Examples: Interactions with outside medical providers (with written parent permission), other EI therapists, day care staff, other caregivers, community resources).

5. Based on your ongoing assessment of the child's progress, what is the child's current level(s) of functioning?

In addition, for the 6 and 12 month progress note, please estimate the percentage of delay.

Percent Delay: _____

Provide an explanation of how the percentage delay was determined (e.g. standardized instrument and/or informed clinical opinion). If an instrument was administered, please report the results according to the instrument's manual.

6. What can the child do now, that he/she was previously unable to do (child's strengths). Address each functional outcome.

Note: If the interventionist has additional comments or observations, please attach additional documentation.

I certify that I have received & reviewed a copy of the child's IFSP and evaluation/progress notes prior to starting services, have provided services in accordance with the IFSP service's specified frequency and duration, and have worked towards addressing the relevant IFSP outcomes. I further certify that my responses in this report are an accurate representation of the child's current level of functioning.

Signature of therapist completing report: _____

***License number:** _____ **Print Name:** _____

Date Report Was Completed: ____/____/____

*If certified, write "certified" and do not indicate number.