

PROVIDER PROGRESS NOTE

Page ___ of ___

(Circle One) 3, 6, 9, 12 month

Child's Name: _____ IFSP Period: From ___/___/___ To ___/___/___
 (Last) (First)
 D.O.B.: ___/___/___
 Provider Agency Name: _____ Name of Interventionist: _____
 License #/Certification/Designation: _____ Discipline: _____

Each Interventionist should receive a copy of this child's IFSP and evaluations immediately upon assignment to work with the child. It is the joint responsibility of the Service Coordinator and the service agency supervisor to ensure prompt delivery of these documents to the interventionist, and it is the responsibility of the interventionist to follow up with his/her agency supervisor if the documents are not received within two weeks of assignment.

Service Type/Frequency/Duration: _____ Therapist's Service Start Date: ___/___/___

If there are any gaps in service delivery (i.e., 3 or more consecutively scheduled visits), describe length and reason for gap in service delivery. _____

IFSP OUTCOME(S): _____

RATE OF 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"/>

How did you work with the family to help the child reach this outcome? _____

IFSP OUTCOME(S): _____

RATE OF 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"/>

How did you work with the family to help the child reach this outcome? _____

IFSP OUTCOME(S): _____

RATE OF 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"/>

How did you work with the family to help the child reach this outcome? _____

PROVIDER PROGRESS NOTE

(Circle One) 3, 6, 9, 12 month

Child's Name: _____ IFSP Period: From ___/___/___ To ___/___/___ (Last) (First)
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1. For the 3 and 9 month report, provide a description of child's progress and current level of functioning. For the 6 and 12 month report, provide the description of progress; in addition, please estimate the percentage of delay at the end of the 6 month and 12 month period and state how that was determined, e.g., criterion referenced instrument, developmental checklist, or clinical opinion. (Standard deviation scores or formal evaluations are not required.)
2. List any factors that limit the collaboration between parent and interventionist. How have you addressed these factors? Be specific.
3. How have you used feedback from the family to help you modify how you work with the family? Be specific and provide examples.
4. Recommendations (include here any new IFSP outcomes, or changes in strategies and activities):

I certify that I have received a copy of the child's IFSP (and evaluation if available). I have provided the services described above in accordance with the frequency and duration mandated by IFSP, and have worked toward addressing the relevant outcomes set forth in the IFSP. I further certify that my responses in this report are an accurate representation of the child's current level of functioning.

Signature of Interventionist completing report: _____ Date: ___/___/___

License #/Certification/Designation _____

Dated 7/09

(Circle One) 3, 6, 9, 12 month

Child's Name: _____ (Last) (First)	D.O.B.: ____/____/____
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For Parent/Caregiver to Complete with Service Coordinator:

Service: _____

- | | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Have you seen changes in your child's skills - Development as a result of EI services?

_____ | No
Progress | Little
Progress | Moderate
Progress | Great
Progress | Reached
Goal |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you been given an opportunity to participate in your child's IFSP? Have you been taught skills, or given ways to help support your child's growth?

_____ | Never | A Few Times | Half the Time | Most of
the Time | Every Week |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you and the therapist/teacher review which activities are working well and which are not working well? Do you and the therapist/teacher review the IFSP outcomes?

_____ | Never | A Few Times | Half the Time | Most of
the Time | Every Week |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. <u>For home/community based services:</u>
Were the therapists or teachers flexible about scheduling services for you and your child? If you were not routinely available during your child's session, did the therapist arrange a time to enable you to participate in a session?

<u>For facility toddler groups:</u>
Did the teacher or therapist keep in touch with you? How did the teacher/therapist communicate with you? (e.g. communication book, your visit to center, phone call)

_____ | No | Little | Some | Great Deal | |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5. What are your current concerns/priorities about your child? Are there new skills you would like to learn?

_____ | | | | | |

Comments: _____

Signature of Parent/Caregiver: _____ Date: ____/____/____

Signature of Service Coordinator: _____ Date: ____/____/____