

PROVIDER PROGRESS NOTE

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6 month 12 month Amendment Discharge

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

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"/>

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"/>

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"/>

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

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1. Provide a 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.)

CHILD'S NAME: _____ DOB: _____

CURRENT IFSP PERIOD: _____ to _____

IFSP START DATE FOR NEW OUTCOMES: _____

Outcomes:

List desired outcomes of the early intervention services to include criteria and procedures that will be used to determine progress.

Provider's Name: _____ Date: _____