**NYC EARLY INTERVENTION PROGRAM Provider Progress Note Page 1 (**☐ **3** ☐ **6** ☐ **9** ☐ **12)**

Complete progress reports and review with the parent. Submit the completed report to the service coordinator **no later than 2 weeks prior to the**

**6‐Donth or Annual Review.** All questions must be answered. Illegible hand written reports will be returned. Use additional pages if needed. Typed reports are preferred. Parents should receive copies of session and progress notes.

**Child's Name**: **EI #**: **DOB**: / /

**IFSP Period**: From:

To: **Provider Agency Name:**  **Important Steps, Inc.**

**Provider Agency ID #:**  **15248**  **Print Name of Interventionist**:

**Discipline:** **Service Type:**  **Interventionist’s Phone Number**:

**Indicate the language(s) used during the sessions:**

**Date reviewed note with parent**: / /

**Parent’s Signature:**

\*Parent Progress Note is available if parent wants to fill it out.

**Authorized Frequency?**

**Date you started working with this child**: / /

**Where have services been delivered?**  ***Home/ Daycare /Facility /Other***

**Has the parent(s) been present for the sessions*:\_\_\_ Yes\_\_\_No***

**if not, how have you communicated with the family? *Indicate below:***

***\_\_\_Parents Contacted via phone \_\_\_\_per week/month***

***\_\_\_Communication Tool Is Used:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***\_\_\_Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**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): PDD**

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

**If yes, identify the type of device, and the Functional Outcome (from the IFSP) and specify how the device is helping (or will help)**

**to achieve the Outcome:**

**I. Below list all the functional outcomes and objectives. Indicate the progress for each:**

**IFSP Functional Outcome 1:**

**Rate Progress in This Time Period**

 No Little Moderate Great Deal Outcome

 Progress Progress Progress of Progress Achieved

|  |
| --- |
| **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.** |
| 1a. Objective: | Yes | No | Emerging |
| 1b. Objective: | Yes | No | Emerging |
| 1c. Objective: | Yes | No | Emerging |
| 1d. Objective: | Yes | No | Emerging |
| 1e. Objective: | Yes | No | Emerging |

**Was this functional outcome and objectives identified at the IFSP meeting? Yes No**

**If not, 1) the date it was changed:\_\_\_/\_\_\_/\_\_\_ and 2) the reason:**

**IFSP Functional Outcome 2:**

**Rate Progress in This Time Period**

No Little Moderate Great Deal Outcome

 Progress Progress Progress of Progress Achieved

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| --- |
| **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.** |
| 1a. Objective: | Yes | No | Emerging |
| 1b. Objective: | Yes | No | Emerging |
| 1c. Objective: | Yes | No | Emerging |
| 1d. Objective: | Yes | No | Emerging |
| 1e. Objective: | Yes | No | Emerging |

**Was this functional outcome and objectives identified at the IFSP meeting? Yes No**

**If not, 1) the date it was changed:\_\_\_/\_\_\_/\_\_\_ and 2) the reason:**

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**IFSP Functional Outcome 3:**

**Rate Progress in This Time Period**

No Little Moderate Great Deal Outcome

 Progress Progress Progress of Progress Achieved

|  |
| --- |
| **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.** |
| 1a. Objective: | Yes | No | Emerging |
| 1b. Objective: | Yes | No | Emerging |
| 1c. Objective: | Yes | No | Emerging |
| 1d. Objective: | Yes | No | Emerging |
| 1e. Objective: | Yes | No | Emerging |

**Was this functional outcome and objectives identified at the IFSP meeting? Yes No**

**If not, 1) the date it was changed:\_\_\_/\_\_\_/\_\_\_ and 2) the reason:**

**2. Describe the learning activities (strategies + routine activities) that were successful for the family and specify the functional outcomes and objectives related to these activities *(i.e., this question asks about the successes)*.**

***Describe in detail:***

* ***Types of strategies being integrated within specific routine-based activities the family used to achieve each objective/functional outcome.***
* ***Include the family’s feedback as to how well these learning activities worked when you were not present.***

**3. What changes were made to the coaching techniques or learning activities when they were ineffective for the family/caregiver *(i.e., if the child’s progress was limited or if it was difficult for the family to incorporate strategies into their daily routines)*?**

* ***Change(s) to an activity(s):***
* ***Change(s) to intervention approach:***

**When you modified the coaching techniques or learning activities; were they successful or if not, why? *\_\_\_\_\_\_ Yes \_\_\_\_\_\_ No* Please address each functional outcome and the relevant objectives as applicable.**

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**4. Describe all collaborative efforts made to address the IFSP outcomes (Examples: interaction with other therapists, day care staff, community resources, and medical providers (with written parent consent)). Please include the family members/caregivers you have been working with.**

* ***Did you communicate with the other EI therapists?: \_\_OT \_\_PT \_\_SLP \_\_SI \_\_SW \_\_ABA\_\_Other\_\_\_***
* ***How did you work with the above therapist(s) to achieve the functional outcomes?***
* ***Have you communicated with relevant medical providers (with parental consent)? \_\_\_\_\_ Yes \_\_\_\_\_ No***

***If “yes”, please describe:***

* ***Did you assist the family in finding other resources (e.g., books, articles, educational resources, etc.)? \_\_\_\_\_ Yes \_\_\_\_\_ No***

***If “yes”, please describe:***

* ***Have you communicated with day care staff, taught structured ABA techniques, specific prompting language to grandparents, nannies, etc. who are part of the child’s routine activities? \_\_\_\_\_ Yes \_\_\_\_\_ No***
* ***If “yes”, please describe:***

**5. Based on your on‐going assessment of the child, what is the overall progress in this child’s functional abilities? How was progress determined (e.g. standardized instrument & informed clinical opinion)?**

***Was the standardized test utilized? \_\_\_\_\_Yes \_\_\_\_\_ No***

* ***If “Yes”:***
1. ***Indicate name of the test (e.g., PDMS-2, AIMS, PLS-5, REEL-3, DAYC, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_***
2. ***Report results according to the instrument’s manual:***
* ***raw score(s):***
* ***standard score(s):***
* ***standard deviation:***
* ***If “No”:***
1. ***Indicate tool(s) used (e.g., NYS DOH Memorandum 2005-02 – Standards and Procedures for Evaluations, Evaluation Reimbursement and Eligibility; NYS DOH Clinical Practice Guidelines\_ Communication Disorders; NYS DOH Clinical Practice Guidelines\_ Motor Disorders; E-LAP; HELP Checklist; etc.):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***
2. ***Report functional level in each domain by age ranges:***

***Cognitive\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Language­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Physical \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Social-Emotional\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Self-Help\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**i. Describe the child’s current skills. Underline skills that have been achieved since the last progress note (or IFSP) (*i.e., in the last 3 months*).**

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**ii. Indicate if the child’s functional abilities are/are not within the normal developmental range. If this child’s skills are not within the normal range, what skills will you be working on in the next 3 months?**

***Are child’s functional abilities within the normal developmental range? \_\_\_\_\_ Yes \_\_\_\_\_ No***

* ***If “Yes”:***
1. ***Explain if continuation is recommended (e.g., diagnosed condition with high probability of delay)***

 ***OR***

1. ***Indicate if termination is recommended: \_\_\_ Yes \_\_\_ No (if “Yes”, please attach “Justification for Change in Frequency, Intensity or Method of Services requesting Termination of Service” Form)***
* ***If “No”, based on the child’s current skill level, list the skills that will be needed for the child to make progress in the next 3 months:***

**6. For** **6‐Month/Annual** **Progress** **Notes** **only: If the child is still eligible for early intervention services, are there new functional outcomes or objectives recommended? The functional outcomes must contain all 6 components and be written in parent friendly language. The new/revised functional outcomes or objectives must be discussed with the parent before submission to NYCEIP.**

***Are new Functional Outcomes and/or Objectives recommended? \_\_\_\_\_\_ Yes \_\_\_\_\_\_\_ No***

***If “Yes”, discuss with the parent/caregiver and indicate below:***

***IFSP Functional Outcome: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

|  |
| --- |
| ***1a. Objective:*** |
| ***1b. Objective:*** |
| ***1c. Objective:*** |
| ***1d. Objective:*** |
| ***1e. Objective:*** |

I certify that I have received and 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/credentials of therapist completing report**: **Print Name:**  **License number:**  **Date Report Was Completed:** / /

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