

**Your practice name,
address and phone as desired
Report Date:**

Name: Address:

D.O.B: Diagnosis:

Plan of Care Date: Clinician

Frequency/Intensity: Method: Ind. Grp. Location:

IFSP Date: Sessions attended: Physician:

***Key:** 1=Met 2=>80% 3= 60-79% 4= 40-59% 5= 20-39% 6= 1-19% 7= Not addressed or n/a

***Based on progress toward goals/outcomes during a 12 month plan of care**

Goals/Outcomes & Objectives	Date of update:	(date)	(date)	(date)	(date)
<p>I. To improve _____ skills as measured by progress on short-term objectives, parent/clinician observation and data.</p> <p>1. Comment:</p> <p>2. Comment:</p> <p>New objectives:</p>					
<p>II. To improve _____ skills as measured by progress on short term objectives, parent/clinician observation and data.</p> <p>1. Comment:</p> <p>2. Comment:</p> <p>New objectives:</p>					
<p>III. To improve _____ skills, as measured by progress on short term objectives, parent/clinician observation and data.</p> <p>1. Comment:</p> <p>2. Given 1 repetition, John will Comment:</p> <p>New objectives:</p>					

Given the level of progress, I recommend the ECT consider:

	Discharge		Re-Evaluation
	Continue Service		ECT Review of another area of concern
	Change in Service (frequency or type)		Other _____

Comments/ Recommendations:

Clinician/ Provider Signature: _____

CC: