WEST CENTRAL EARLY STEPS

Early Intervention/Therapy Session

Child's Name: ______________________________ **DOB:** __/__/__ **Age:** ___ **yrs.** ___ **mos.**

Date of Session: ______________________

Time In: ____________ **Time Out**: ____________ **Units**: __ .25 units = 15 min
__ .50 units = 30 min
__ .75 units = 45 min
__ 1.0 units = 60 min
__ 1 evaluation

Procedure Code: __________________

Location: ____ Home____ Childcare Ctr. ____ Other: ____

Participants: ___ Mom / Dad present / participated
___ Grandparent present / participated
___ Sibling present / participated
___ Childcare provider present / participated
___ Other: _________________________

IFSP Outcomes/goals:

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____

Parent/Caregiver Update on child progress:

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Progress towards IFSP Goals:

___ Regression ___ No Improvement ___ Continuing Improvement ___ Significant Improvement

Session Notes:

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IFSP Outcomes/Goals Met: ____

Communicate with service coordinator due to the following concern(s): ___________________________________

Notes for Next Visit:

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Interventionist/Therapist Signature/credentials ____

Parent/Caregiver Signature: ____