ORANGE COUNTY DEPARTMENT OF HEALTH
EARLY INTERVENTION PROGRESS/DISCHARGE REPORT
DIRECTIONS FOR COMPLETION OF FORM

CHILD'S NAME: enter child's full name as it appears in NYEIS
DOB: enter child's date of birth
CHILD'S ADDRESS: enter child's complete address
NAME OF PROVIDER/ DISCIPLINE: enter provider name and credentials
NAME OF AGENCY (if applicable): enter name of agency if appropriate
EIOD: enter EIOD's name (please check in NYEIS for the correct EIOD name)
ONGOING SERVICE COORDINATOR/AGENCY: enter OSC name followed by the agency name
TYPE OF NOTE/DUE DATE: enter the date the report is due per the IFSP next to the line that identifies the type of note being submitted

5 Month: ____ Annual: _____ Discharge: _____

If this is a discharge note, reason for discharge: enter reason for discharge of this service
Discharge Date: enter date of discharge
DATES OF SERVICE: From: enter provider's first session date for the current IFSP period
To: enter the date of the last session held to date during the current IFSP period
SITE OF SERVICE: enter the location for the services provided (ie: home, daycare, etc.)
PHYSICIAN'S ORDERS (IF APPLICABLE) – START DATE: enter the date of the most recent medical orders for the service provided if that service type requires orders
DURING THE CURRENT IFSP PERIOD:
 # SESSIONS AUTHORIZED: enter total number of sessions authorized for this service in the current IFSP period
 # SESSIONS PROVIDED: enter total number of sessions held to date during the current IFSP period
 # CO-VISITS AUTHORIZED (if applicable): enter total number of sessions authorized as co-visits in current IFSP
 # CO-VISITS PROVIDED: enter total number of co-visits held to date during the current IFSP period

IFSP FUNCTIONAL OUTCOMES	ACHIEVED	MAKING PROGRESS	NOT YET ADDRESSING
Enter all IFSP functional outcomes identified in the current IFSP and all associated amendments to the current IFSP	Check this box if this IFSP outcome has been achieved	Check this box if child/family are making progress on this IFSP outcome, but it is not yet achieved	Check this box if this IFSP outcome is not yet being addressed

Family Activities/Strategies of IFSP – enter the activities/strategies you are working on with family/child care provider to address the current IFSP outcomes.

Describe the child's progress towards functional outcomes? (Strengths & Challenges): enter the progress being made toward achieving the outcomes, including the child's strengths and challenges

Summarize your "ongoing assessment" of the child's developmental status: enter observations/information shared by the parent, observations made by the provider, informed clinical opinion of the provider, professional judgment, information from other caregivers (if appropriate), results of any recent testing, etc.

Describe child's current level of functioning: enter your professional interpretation of your ongoing assessment of the child's developmental status (ie: continues to demonstrate a delay, demonstrating skills considered to be within normal limits, demonstrating skills above age expectancy)

Describe the collaborative activities that have occurred with IFSP team members and others related to the family activities/strategies you have worked on during this reporting period: enter information regarding co-visits, conversations, meetings, etc. with other IFSP team members including other providers, OSC and/or EIOD

Additional information and recommendation: enter any additional information that has not previously been documented in this note. Include a recommendation for the next IFSP period. Do not specify frequency or length of session in this section as those topics will be discussed as part of the IFSP review. *Provided the information contained within this note contains ALL of the information required in a Justification for Proposed IFSP Amendment (Form IF9),* including answers to all of the questions in the category covering the type of recommended change, as well as a listing of all IFSP team members who support and who do not support this proposed change and the date each person was consulted, the provider may suggest consideration of a change *to take place in the next IFSP period* – *(*Note: a written Justification for Proposed IFSP Amendment will be requested if any of the required information is missing or is incomplete.) *If requested change to the IFSP is recommended to take place prior to the next IFSP period, please follow the amendment process as outlined in the OCDOH Procedure Manual (IFSP 8) by submitting Form IF9 to the OSC..*

Signature: _____ Date: _____
License, Registration or Certification # : _____

For COTA, OTA, PTA and SLP in his/her 9 Months of Supervision:
Supervisor comments (optional): supervisor may enter any additional information he/she deems as appropriate

Supervisor Signature: _____ Date: _____
License, Registration or Certification #:_____

Provider is responsible for distributing copies of this note to the:
Parent / Guardian
IFSP Team Members
Others as designated in IFSP

In addition, the provider submits two copies of this note to the OSC by the date indicated in the IFSP. OSC submits to the EIOD a copy of this note along with his/her OSC note by the date indicated in the IFSP.