**Child’s Name: DOB:**   **MMI:** Click here to enter text.

**Service Coordinator:**   **IFSP Auth. Dates:** Click here to enter text.

**Pediatrician:**   **Diagnosis:** Click here to enter text.

**BACKGROUND INFORMATION**

**Pertinent Medical History, Medications and Recent Updates:**

**Outcomes / Goals from IFSP (indicate if met/not met/ongoing/modified):**

**Summary of Daily Routines:**

**FUNCTIONAL ASSESSMENT**

**POSITIVE SOCIAL RELATIONSHIPS: (Social Emotional Skills and Relationships)**

* **Behavior at home and in the community**

**Things we do well:**

**Things we need help with:**

* **Relationship with family, caregiver and peers:**

**Things we do well:**

**Things we need help with:**

**ACQUISITION AND USE OF KNOWLEDGE AND SKILLS:**

* **How the child is communicating to get her/his needs met?**

**Things we do well:**

**Things we need help with:**

* **Understanding simple concepts and directions in the daily routines: (Combines receptive language and cognition)**

**Things we do well:**

**Things we need help with:**

**USE OF APPROPRIATE BEHAVIORS TO MEET THEIR NEEDS:**

* **Mobility, movement and ease of reaching for objects**

**Things we do well:**

**Things we need help with:**

* **Independence throughout the day:**

**Things we do well:**

**Things we need help with:**

**COMPREHENSIVE ANALYSIS:**

**ASSESSMENT TOOL SCORES:**

**INTERVENTION PLAN**

**Provider Signature: Date:** Click here to enter text.

**Provider Name:** Click here to enter text. **License #:** Click here to enter text.

**Parent Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **MT/JG 7/17**