



ECI of North Central Texas
PROGRESS NOTE

ECI#: _____

Child's Name: _____

Medicaid # _____

Initial/Annual IFSP Date: _____		Orders Expire: _____	
Date: _____			
Time Start: _____		Stop: _____	Code: _____
Service: <input type="checkbox"/> DS <input type="checkbox"/> OT <input type="checkbox"/> PT <input type="checkbox"/> ST <input type="checkbox"/> Nursing			
Location: <input type="checkbox"/> HM <input type="checkbox"/> DC <input type="checkbox"/> Other <input type="checkbox"/> Translation <input type="checkbox"/> Consultation <input type="checkbox"/> Joint Visit			
Service Coordinator has verified Medicaid/CHIP/Private Insurance as: _____			
Present: _____			
What's New/Progress: _____			
Goals/Outcomes Addressed: _____			
Routines (summary, observation, assessment, plan): _____			
Recommendations: _____			
TCM Start: _____ Stop: _____ Service Coordination Start: _____ Stop: _____			
TCM to access: <input type="checkbox"/> Medical~01 <input type="checkbox"/> Social~02 <input type="checkbox"/> Educational~03 <input type="checkbox"/> Developmental~04			
<input type="checkbox"/> 6MR/AR <input type="checkbox"/> Transition <input type="checkbox"/> IFSP Change <input type="checkbox"/> Other:			
Date/Time of next visit _____ @ _____ am/pm			
Signature: _____ Discipline: _____			