



EARLY STEPS CHILD'S QUATERLY PROGRESS REPORT

AUTHORIZATION PERIOD: ----- **TO** -----

Patient: _____ DOB: _____

Clinician Name: _____ Case Worker Name _____

Goal	Status Date: _____
1.	
2.	
3.	
4.	
5.	
Comments:	Comments:

Recommended Treatment sessions:

It is recommended that the above-mentioned patient receive speech therapy to maximize functional abilities:
 Frequency: _____ times per week for _____ Weeks/Months.

___ Treatments Sessions 0-30 minutes

___ Treatments Sessions 0-60 minutes are medically necessary due to: _____

Recommended other therapy intervention: Occupational Therapy / Speech Therapy / Physical Therapy

Therapist Signature

Date