

Daily Progress Report Note

Location of Service: (Must Check One)	<input checked="" type="checkbox"/>	Fairfax, Virginia	11240 Waples Mill Rd, Suite # 101 22030	(Tel)	703-237-2219 F: 703-237-2729
	<input checked="" type="checkbox"/>	Woodbridge, Virginia	14130 Noblewood Plaza, Suite # 301 22193	(Tel)	571-402-7550 F: 703-237-2729



Patient:	First Name Last Name(s) - Child's FULL Name			Service Date:	00/00/00
DOB:	00/00/00	Start Time	Child's scheduled START time AM/PM	End Time	Child's scheduled END time AM/PM
Parent / Guardian Signature & Printed Name		Signature	Printed Name		
Therapist Name:	Therapist/Assistant Name and Credentials		Supervising Therapist Name:	ONLY complete if YOU are supervising an assistant	

← Circle AM/PM

SPEECH THERAPY SERVICES	CODE	UNITS	PHYSICAL THERAPY SERVICES	CODE	UNITS	OCCUPATIONAL THERAPY SERVICES	CODE	UNITS
Speech Feeding Evaluation	92610		Physical Therapy Evaluation			Occupational Therapy Evaluation		
Speech Fluency Evaluation	92521		Physical Therapy Evaluation- Low Complexity	97161		Occupational Therapy Evaluation- Low Complexity	97165	
Speech Sound Production Evaluation	92522		Physical Therapy Evaluation- Mod Complexity	97162		Occupational Therapy Evaluation- Mod Complexity	97166	
Speech Sound Production w/ Language Comprehension & Expression Evaluation	92523		Physical Therapy Evaluation- High Complexity	97163		Occupational Therapy Evaluation- High Complexity	97167	
Behavioral/Qualitative Analysis of Voice/Resonance	92524		Physical Therapy Treatment	97110		Occupational Therapy Treatment	97530	
Speech Therapy Treatment	92507							
Speech Feeding Treatment	92526							
OTHER							CODE	UNITS
						No Show	NS	1
						Child Absent	CA	1
						Therapist Absent	TA	1

Choose a reason

SUBJECTIVE: Makeup for cancellation on _____ (date) Cancellation: LESS than 24 hours in advance (Choose one cancellation reason)

Session Participants: n/a **Mood/Behavior:** n/a

Update since last session: Child - "Mom called and canceled today's session due to Sheryl being sick with a fever. Make up to be determined/Make up offered on / / . Make up declined due to family's schedule, etc. **Therapist -** PT/OT/SLP out sick today; PT/OT/SLP cancelled in advance due to vacation/medical leave/medical appointment. Make up to be determined/Make up offered on / / . Make up declined due to family's schedule, etc.

OBJECTIVE:

Goals Addressed: n/a **Strategies/Intervention Used:** n/a

ASSESSMENT:

n/a

PLAN:

Recommendations: n/a **Continue Services:** **Discharge Services:** _____

Decrease Services: _____ **Increase Services:** _____

Diagnosis/ICD-10	Code 1 <small>Treatment Code</small>	Code 2 <small>Treatment or Medical Code</small>	Place of Service: Office	Tax ID 26-1878085
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Therapist Signature and Credentials	YOUR (therapist or assistant) signature on file (Name and Credentials)	Parent/Caregiver Interaction During Therapy: (mark all that apply) <input type="checkbox"/> Discussed and showed session activity <input type="checkbox"/> Parent tried activity; Therapist assisted <input checked="" type="checkbox"/> N/A (Cancelled Session) Parent/Caregiver Communication: _____ _____ _____
Supervising Therapist Signature and Credentials	ONLY signed if YOU are supervising an assistant; If NOT leave blank.	