Daily Progress Report Note

Location of Service: (Must Check One)					
	X	Fairfax , Virginia	11240 Waples Mill Rd, Suite # 101 22030	(Tel)	703-237-2219 F: 703-237-2729
	X	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	
						Child Absent	CA	
						Therapist Absent	TA	1

SUBJECTIVE: Makeup ☐ for cancellation on ____________(date) **Cancellation:** ____LESS than 24 hours __X__ in advance

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

Update since last session: Labor Day Holiday (Achieve Beyond closed)

OBJECTIVE:

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

ASSESSMENT:

n/a

PLAN:

Recommendations: n/a

Continue Services: __X__ **Discharge Services:** _____

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

Diagnosis/ICD-10	Code 1	Code 2	Place of Service:	Tax ID 26-1878085
	Treatment Code	Treatment or Medical Code	Office	

Therapist Signature and Credentials	YOUR (therapist or assistant) signature on file (Name and Credentials)
Supervising Therapist Signature and Credentials	ONLY signed if YOU are supervising an assistant; If NOT leave blank.

Parent/Caregiver Interaction During Therapy: ***(mark all that apply)***

☐ Discussed and showed session activity
☐ Parent tried activity; Therapist assisted
X N/A (Cancelled Session)

Parent/Caregiver Communication: ______________________________

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CANCELLATION - Holiday Template

Updated 5/24/2017