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**	PT/OT (45 min) SLP (30 min) (AM)/PM	**End Time**	PT/OT (45 min) SLP (30 min) 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	3	Occupational Therapy Treatment	97530	3
Speech Therapy Treatment	92507	1						
Speech Feeding Treatment	92526					**OTHER**	**CODE**	**UNITS**
						No Show	NS	
						Child Absent	CA	
						Therapist Absent	TA	

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

Session Participants: PT/OT/SLP, Child's name, parent/caregiver/nurse/aide (who came and/or was present during the session)

Mood/Behavior: happy, sad, frustrated, un/cooperative, distracted

Update since last session: Upcoming medical appointments; Has family been working on recommended activities (specify) from the last session. Requested cancellations in advance, schedule changes, etc.

OBJECTIVE:

Goals Addressed: Copy & Paste the goals you will work with the child during the session from the child's evaluation

Strategies/Intervention Used: Copy & Paste the strategies/intervention you will use during the session directly from the child's evaluation

ASSESSMENT:

How id the child participate and respond to the strategies/intervention used to work on the goals addressed? Note: If you will be using a chart to document trials/attempts using (+) or (-), you MUST also write a few sentences describing what the charts mean (i.e., improvements, observations, plateau in skills, no change since the last session, etc.)

PLAN:

Recommendations: Continue PT/OT/SLP __ time weekly (your recommended frequency and duration). What the family will work on this week. NOT just "Continue POC;" Should be different for each session.

Continue Services: __X__ **Discharge Services:** _____
Decrease Services: _____ **Increase Services:** _____

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

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

Parent/Caregiver Communication: __ex 1. PT/OT/SLP and parent/caregiver reviewed handout provided for leg stretches; ex 2. Parent recorded activities recommended with their phone to practice at home. _

SESSION Note Template
Updated 5/25/2017