DISABILITIES - SUMMARY OF SERVICES

CHILD'S NAME_______________________________________

DATE	PROGRESS NOTE #	SERVICE

D1. POTENTIAL DEVELOPMENTAL CONCERN

____________ Concern identified (source of concern)

____

____________ Concern Discussed with Parent

____________ Internal Referral

____________ Internal Observation (by Head Start)

____________ Release of Information from Parent obtained

D2. PARENT/PROGRAM REFERRAL TO ESD

____________ Referral Date (by Education/Disabilities Director or parent directly to the ESD)

____________ Observations/Evaluations by ESD

____________ Qualified for services Not Qualified for services

D3. DISABILITY DOCUMENTATION

____________ Referral/Summary Form or Letter from ESD (check to see if in file)

____________ IFSP Eligibility Meeting (MDT DATE)

____________ Disability

Primary ______________Secondary______________(Only If Documented)

D4. IFSP DATES

Initial IFSP ___________ Current IFSP ___________

6 Mo Review___________ Annual ___________

Kindergarten Transition mtg __________

D5. SERVICES PROVIDED BY ESD CONSULTANTS/SPECIALISTS

	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July
Monthly Observation/ feedback												