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|  | **ECLIPSE Quarterly** **Progress Report** |

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| CHILD’S NAME | CHILD’S DATE OF BIRTH |
| MONTH(S) REFLECTED IN QUARTERLY REPORT  |  PROVIDER NAME |
| PROVIDER ADDRESS | PROVIDER CONTACT PERSON/PERSON COMPLETING REPORT |
| **Number of days child was absent this quarter:** |  |
| **How many times did parent meet with Child and Family Therapist?** |  |
| **PLEASE INDICATE IF PARENT(S) PARTICIPATED IN THE FOLLOWING:** |
| 1. Visited their child at the center in child’s treatment room? If so, how many times this quarter?
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| 1. Did parent(s) attend monthly facilitated parent support group? If so, how many times this quarter?
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| 1. Did parent(s) attend their child’s Multi-Disciplinary Team Meeting (MDT)? Date of last MDT?
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| 1. Child’s current treatment plan goals:
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| 1. Child’s progress toward meeting treatment plan goals:):
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| 1. Barriers to meeting child’s treatment plan goals:
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| 1. Summary of monthly home visits with parent(s) during this quarter:
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| Other child/case specific information you wish to share with referral source: |
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| PRINTED NAME OF PROVIDER STAFF COMPLETING QUARTERLY PROGRESS REPORT |
| PROVIDER STAFF’S SIGNATURE | DATE SIGNED |