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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 |