

NEW YORK CITY DEPARTMENT OF EDUCATION DIST. 75 RELATED SERVICES PROGRESS NOTES

Student Name: _____	NYCID #: _____	Date Service started: ___/___/___
Related Service Type: ___OT ___PT	Therapist's Name: _____	

**STUDENT DAILY TREATMENT LOG AND PROGRESS:**

**Therapeutic Activities & Progress: Date:** \_\_\_/\_\_\_/\_\_\_ **Time:** \_\_\_am \_\_\_pm  Student Absent  Provider Absent  Session Cancelled (explain)

Make up Session for date: \_\_\_/\_\_\_/\_\_\_  Assessment (\_\_\_\_\_)

Gross Motor  Balance/Eq.  Postural Control  Mobility

ROM  Sensory Processing (\_\_\_\_\_)

Fine Motor  Bilateral Coordination  Visual/Perceptual  Prewriting/Handwriting

Behavior /Psychosocial  ADL(\_\_\_\_\_)

Oral Motor/Ther.Feeding  \_\_\_\_\_

**Progress:**

**Therapeutic Activities & Progress: Date:** \_\_\_/\_\_\_/\_\_\_ **Time:** \_\_\_am \_\_\_pm  Student Absent  Provider Absent  Session Cancelled (explain)

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**Progress:**

**Annual Goal** \_\_\_\_\_  Achieved  Partially Achieved  Goal Not Achieved

More Time needed

Explain: \_\_\_\_\_

**Annual Goal** \_\_\_\_\_  Achieved  Partially Achieved  Goal Not Achieved

**Therapist Signature:** \_\_\_\_\_ **State License#** \_\_\_\_\_ **Date:** \_\_\_\_\_