

**Indiana First Steps
Six Month ED Team Review**

Child Name: _____	DOB: _____	Age: _____
IFSP Date: _____	6 m Review Date _____	SC: _____
Parent Name: _____	Phone: _____	
Address: _____	City: _____	Zip: _____

Service Coordinator:

Ongoing Providers:

<u>Name:</u>	<u>Discipline:</u>	<u>Frequency:</u>
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Summary of Progress Related to IFSP Outcomes:

Documentation of Communication:

Suggestions for other Resources not listed:

Recommendations of IFSP Outcomes/Strategies:

Time In: _____ **Time Out:** _____

___ I will attend the 6 month review. ___ I will not attend the 6 month review.

Signature of Lead ED Team Representative

Date