



Children's Center - ECI A Division of LakesRegionalMHMRCenter
An Affiliate of Texas Early Childhood Intervention
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ECI THERAPY REPORT

SPEECH THERAPY **OCCUPATIONAL THERAPY** **PHYSICAL THERAPY**
 NUTRITIONAL THERAPY

Child's Name: Izaha [REDACTED]

Date of Evaluation: 11/27/2012

D.O.B.: 10/03/2002

Eligibility: Developmental Delay

Child ID # [REDACTED]

Therapist: Amelia K. [REDACTED], MEd., CCC-SLP

DEVELOPMENTAL SUMMARY:


Izaha is a 2 month-old male that was assessed due to concerns with oral-motor/feeding skills. Izaha currently is in foster care and little is known regarding prenatal care, delivery, and post-delivery history. Izaha was born at 40 weeks gestation, weighed 6 pounds, 6 ounces, and has a family medical history of Cerebral Palsy and Muscular Dystrophy. He has been diagnosed with reflux and is currently taking Prevacid. He sleeps on a wedge and is kept upright after each feeding. His foster parent reported a concern with leaking, choking, and gagging while drinking his bottle. An Infant Feeding Checklist from *The Source for Pediatric Dysphagia*, as well as clinical observation, and caregiver report were used to assess Izaha's oral-motor/feeding skills.

The results of the assessment are as follows:

Izaha is on a feeding schedule of every 3 hours during the day but no feedings during the night. Due to Izaha having eaten 1 hour prior to this assessment, most information regarding nutritive sucking was taken from caregiver report. He consumes 5 ounces of formula at each feeding and is in an active alert state prior to his mealtime. During the feeding he is in a quiet alert state and is able to consume the 5 ounces of formula in 15-20 minutes. His caregivers described excessive loss of fluids on the left side during his feedings with coughing and gagging observed during each feeding. While assessing Izaha's oral-motor strength and response to stimulation, he presented with decreased cheek strength on the left side. During the non-nutritive Sucking observation, Izaha had an initial burst cycle of 5-12 sucks before breathing and had a moderate decline in endurance due to labial weakness, suck strength weakness, and difficulty with cupping/grooving his tongue while sucking. His rooting reflex was present for the right side and at midline, but was absent on the left side. While Izaha was sucking on his pacifier, it was easy to gently pull on the pacifier and break the seal. Foster parent reports that they have tried external pacing by pulling the nipple away when Izaha begins to show signs of coughing or gagging. He also stated that the nipple is easy to remove. Izaha presents with dysphagia due to oral-motor weakness and incoordination.

Treatment Plan:

Based upon the results of the evaluation, it is recommended that Izaha receive speech therapy to improve oral-motor strength and coordination. It is recommended that he receive speech therapy 4 times per month to address feeding concerns.


Amelia K. Mitchell, MEd., CCC-SEP



Periodic Review of the IFSP
Children's Center ECI of Lakes Regional MHMR

Complete entire form for:
 Complete IFSP Review – No Changes
 Complete IFSP Review – With Changes
(Attach DARS4006, IFSP Services Pages.)

Partial IFSP Review for change of Service Coordinator, only
(Complete items 1 and 4, and attach DARS4006, IFSP Services Pages.)
 Partial IFSP Review (Complete items 1, 2, 3 and 5, and attach DARS4006, IFSP Services Pages.)

Child's Name: Kawa [redacted] Date of Birth: [redacted] Client ID: 35057
Date of Current IFSP: 11/15/12 Date of IFSP Review: 11/27/12
Start Time: 4:05 pm End Time: 4:15 pm

1. List IFSP team members in attendance (include names and disciplines): Tiffany [redacted], QUR
Amelia [redacted], SLP

2. List all team members who were not in attendance but were consulted and document their input:

3. Describe the child's progress toward achieving outcomes and the effectiveness of services: Newly enrolled in program (11/15/12). No services have been delivered due to pending oral/motor/feeding assessment. Completed assessment today. Amelia expressed oral/motor weakness and will address goal to stop choking/gagging.

4. Describe current needs of the child and family (include review of case management, transition planning, and any applicable late onset risk factors):

5. Describe reasons for any modification to the plan or describe the rationale for no changes: Added ST 4x mo x 45 min. to be provided by Amelia Mitchell, SLP.

[Signature]
Service Coordinator's Signature/Interpreter Signature

11/27/12
Date



Division for Early Childhood Intervention Services
IFSP Services Pages

Services and supports are determined following the development of functional IFSP outcomes. They are designed to enhance the capacity of the family in supporting the child's development and to promote the child's learning and development through functional participation in family and community activities.

Child's name: Hallak [REDACTED] Client ID: [REDACTED]

ECL program: Children's Center ECL of Lakes Regional MHR Center

Services key:
 AI—Audiological Services
 BI—Behavioral Intervention
 CO—Counseling
 CM—Case Management
 FE—Family Education
 NS—Nursing Services
 NU—Nutrition Services
 OT—Occupational Therapy
 PT—Physical Therapy
 PS—Psychological Services
 RA—Reassessment
 SST—Specialized Skills Training
 ST—Speech Therapy
 SW—Social Work Services
 VI—Vision Services

Service Information

Service	Discipline of Provider	Expected Frequency	Expected Intensity	Total Authorized Visits	Location*	Method	Start Date	End Date	Provider Outside ECL**
CM	Service Coordinator's Name: <u>Cooper EIS</u>	Ongoing	As Needed	Not Applicable	<input checked="" type="checkbox"/> Home <input checked="" type="checkbox"/> Community <input type="checkbox"/> Other Specify other:	Not Applicable	<u>11/21/12</u>	<u>11/15/13</u>	<input type="checkbox"/>
ST	<u>SJP</u>	<u>4x mo</u>	<u>45 min</u>	<u>48</u>	<input checked="" type="checkbox"/> Home <input checked="" type="checkbox"/> Community <input type="checkbox"/> Other Specify other:	<input checked="" type="checkbox"/> Individual <input type="checkbox"/> Group	<u>↓</u>	<u>↑</u>	<input type="checkbox"/>
					<input type="checkbox"/> Home <input type="checkbox"/> Community <input type="checkbox"/> Other Specify other:	<input type="checkbox"/> Individual <input type="checkbox"/> Group			<input type="checkbox"/>
					<input type="checkbox"/> Home <input type="checkbox"/> Community <input type="checkbox"/> Other Specify other:	<input type="checkbox"/> Individual <input type="checkbox"/> Group			<input type="checkbox"/>
					<input type="checkbox"/> Home <input type="checkbox"/> Community <input type="checkbox"/> Other Specify other:	<input type="checkbox"/> Individual <input type="checkbox"/> Group			<input type="checkbox"/>

*Describe how and why the IFSP team determined the location if services are not provided in the child's natural environment, and how these services will be generalized to support the child's ability to function in his or her natural environment.

**Mark if the provider is outside the ECL system, service is arranged and paid by the family or their insurance, and the team recommends the service.