



# OUTCOME REVIEW

State Form 51838 (R / 3-05) / BCD 0110



Name of child	Date of birth (month, day, year)	County
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<input type="checkbox"/> Six month review <input type="checkbox"/> Other planned review	Date of IFSP (month, day, year)
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**OUTCOME REVIEW** (This page should be duplicated as needed, per review.)

A review of the IFSP must be conducted at least every six months, earlier if the family requests a review, to determine the degree of progress toward achieving outcomes and whether modification or revision of the outcomes or services is necessary. Parents and other participants must receive 10-day prior written notice of meetings.

**Statement regarding transition planning (for each review)**

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Outcome # _____ Progress Summary	<p style="text-align: center;"><b>MODIFICATIONS TO OUTCOME</b></p> <input type="checkbox"/> Achieved <input type="checkbox"/> Continue as written <input type="checkbox"/> New outcome written (see attached) <input type="checkbox"/> No longer a concern <input type="checkbox"/> Other _____	<p style="text-align: center;"><b>CHANGE IN STRATEGY TO BETTER MEET OUTCOMES</b></p> <input type="checkbox"/> New strategy written <input type="checkbox"/> Increase service <input type="checkbox"/> Decrease service <input type="checkbox"/> Other _____
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I / We participated in the IFSP review process and agree with the revisions reflected in this modification section. **An increase in an existing service or the addition of a new service will require the signature of my child's Primary Care Physician.**

Signature of parent	Date (month, day, year)	Signature of service coordinator
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