Informed Clinical Opinion Guidelines

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Early Intervention/Infant Learning Program May 2017

Informed Clinical Opinion

1.0 What is Informed Clinical Opinion?

In general, informed clinical opinion (ICO) refers to the knowledgeable perceptions of caregivers and professionals who use qualitative and quantitative information regarding difficult-to-measure aspects of a child's development in order to make a decision about the child's Part C eligibility for Alaska EI/ILP programs.

Federal Regulations [34CFR§303.321(a)3(ii)].	**Alaska Policies and Procedures (2015)**
"Qualified personnel must use informed clinical opinion when conducting an evaluation and assessment of the child. In addition, the lead agency must ensure that informed clinical opinion may be used as an independent basis to establish a child's eligibility under this part even when other instruments do not establish eligibility; however in no event may informed clinical opinion be used to negate results of evaluation instruments *used to establish eligibility."* The regulations for Part C of the Individuals with Disabilities Education Act require the use of informed clinical opinion (ICO) as described below. 1. Qualified personnel must use ICO when conducting an evaluation and assessment of the child. 2. ICO may be used as an independent basis to establish a child's eligibility even when other instruments do not establish eligibility. 3. However, in no event may ICO be used to negate the results of evaluation instruments used to establish eligibility.	*Informed Clinical Opinion (34 CFR §303.321(a)(3)(ii)) may be used by an evaluation team to determine eligibility when the approved tool(s) or other domain-specific tool(s) are not able to establish a developmental level due to the age of the infant or the child's level of arousal and ability to participate at the time of the evaluation and assessment; or when there are inconsistencies in the child's performance or inconsistencies in the results of the evaluation, and the team determines that the child meets the eligibility criteria.* 1. Informed clinical opinion means the knowledgeable perceptions of the evaluation team who use qualitative and quantitative information regarding aspects of a child's development that are difficult to measure in order to make a decision about the child's eligibility for early intervention services under Part C. 2. Informed clinical opinion in accordance with these policies may be used if a clear developmental level cannot be gained through the use of the approved tool(s) or domain-specific tools; or when there are inconsistencies in the child's performance or inconsistencies in the results of the evaluation; and shall be documented as "developmentally delayed". In no event may informed clinical opinion be used to negate the results of evaluation instruments used to establish Part C eligibility.

2.0 How is Informed Clinical Opinion Used When Conducting an Evaluation and Assessment of a child?

In every Part C eligibility decision, informed clinical opinion is used throughout the process of evaluating and assessing an infant or toddler to yield a comprehensive and accurate description of the functional skills and behaviors a child uses to participate in routines and activities within his/her natural environments. It must be included in evaluation and assessment procedures, since it is a necessary safeguard against eligibility determination based upon isolated information or test scores alone (Shackelford, 2004). In addition, there are significant test inconsistencies and all tests lack precision.

> *"Test results make useful contributions to diagnosis, but in the end, practice diagnosis rests on the clinical skills and experience of the examiners. Test results are merely aids to clinical judgment."*
>
> REEL-3, Examiner's Manual, p. 21

When using informed clinical opinion in the evaluation process, practitioners draw upon clinical training and experience (i.e., what you personally bring with you to the evaluation through your professional education, specialized training, and experience), standardized instruments, as available and appropriate, recognized clinical assessment procedures (e.g., observation techniques, interviewing techniques; use of objective measurement techniques specific to the developmental problem or circumstances and concerns related to child and family, etc.); experience with children of different cultures and languages; and their ability to gather and include family perceptions about children's development. The knowledge and skill of early intervention multidisciplinary team, including the parents, constitute the basic foundation for the process of becoming "informed" about a child's developmental status within a socially valid context (Shackleford, 2004).

3.0 When Can Informed Clinical Opinion be Used as the Primary Procedure for Making an Eligibility Decision?

In rare cases informed clinical opinion is allowable as the primary procedure for determining that an infant or toddler is eligible for Part C. The use of informed clinical opinion and diagnostic procedures is particularly important when, due to the child's age, culture, language, and/or nature of the developmental problem or concern, standardized instruments are not available or appropriate. When used as the primary procedure for making an accurate eligibility decision, ICO requires careful attention to an alternative set of qualitative and quantitative procedures for gathering, summarizing, and interpreting information about subtle behaviors, and other aspects of early developmental status that are difficult to measure using standardized evaluation procedures.

Informed clinical opinion is a process, not a definition of eligibility, **and it is intended to be used as the deciding factor in eligibility determination only when there are truly unique circumstances that may not be captured by standardized test scores (Shackelford, 2002).** Informed clinical opinion is the outcome of a careful team process for reaching a well-informed consensus decision about a child's eligibility for Part C in certain situations including but not limited to the following examples:

- Traditional measures of eligibility evaluation have been attempted but cannot be administered according to standardized procedures, or do not yield reliable, valid scores for comparison to Alaska's eligibility criteria.

- There is no test that can be used because of the child's young age.
- Traditional measures and procedures are unavailable or yield invalid scores when used to evaluate the following areas:

1. Growth and Feeding:
    - Feeding problems
    - Gastrostomy for feeding
    - Severe growth delay
2. Sensory and Regulatory:
    - Chronic problems with sleep, attention, and/or eating
    - Sensory processing disorders
3. Social Emotional:
    - Atypical social interaction with caregivers and peers
    - Attachment, Temperament and Self-regulation
    - Approaches to learning and play
    - Delays or differences in ability to communicate emotional needs or achieve expected emotional milestones such as pleasurable interest in adults and peers.
4. Motor:
    - Asymmetrical movements
    - Atypical tone
    - Poor balance
    - Problems in motor planning
    - Abnormal reflexes or postural reactions
5. Communication:
    - Variant speech and language pattern
6. Hearing Loss (According to State of Alaska Guidelines: date unknown)

    Any type, degree, or configuration of hearing loss as documented by an audiologist (NOT Part C Medical Diagnosis eligible), some delay in the domains (NOT Part C Developmental delay eligible) or atypical development with one or more factors related to hearing loss (listed below) that is difficult to measure, and is determined by a team.

    Factors include but are not limited to:

    - Failed Newborn Hearing Screen
    - Failed OAE Screening
    - Any speech/language delay
    - Any cognitive/academic delay
    - Any perceptual/gross motor delay
    - Atypical tone/quality of voice
    - Atypical intelligibility
    - Atypical attention/focus
    - Atypical response or lack of response to sound
    - Atypical vestibular responses
    - Atypical balance/coordination
    - Use of assistive device (hearing aid, etc.)
    - Use of another language or communication mode

7. Significant/Progressive Vision Impairment
   Clinical opinion may be use when there is a high risk for a vision impairment diagnosis due to medical history (prematurity, birth injury, IVH, diagnosed syndrome, etc.) ***and*** visual skills less than expected for developmental age as assessed by a vision impairment educational specialist.

- Parents or professionals believe the standardized measures fail to capture important information about the child and have evidence that the child has a delay or may show a delay over time.
- More specific and accurate information is available via interviews, observations, and other qualitative measures rather than through traditional evaluation methods.
- Children are hospitalized or restricted to other settings not appropriate for testing, or behavior patterns interfere with administration protocols

4.0 How is Informed Clinical Opinion (ICO) used as the Primary Source for Eligibility Determination?

When conducted properly, ICO involves a rigorous and complex process that is often more lengthy and involved than administration of a standard sequence of evaluation and assessment measures. To develop qualitative and quantitative information, any or all of the following may be used to augment psychometric and diagnostic data when there are no standardized measures appropriate for a given age or developmental area. The specific evaluation procedures will vary for each child and family (Lucas & Shaw, 2012).

- Review of a child's developmental history
- Interviews with parents
- Parent reports
- Evaluation/observation of a child at play and in various settings
- Observation of parent-child interactions
- Information from family members, other care-givers, medical providers, social workers, and educators.
- Medical, sensory, and/or neurodevelopmental or other physical examinations.
- Appropriate sections of curriculum-based assessment (CBA) instruments
- Qualitative measures such as social emotional and/or social interaction scales.
- Instruments that provide a format for achieving team consensus, such as SPECS or COACH.

5.0 Process for Determining Eligibility Through the Use of Informed Clinical Opinion

When the results of the designated test protocol do not accurately represent the child's development and do not indicated a qualifying developmental delay, the multidisciplinary team must document corroborating evidence of a qualitative developmental delay. Using the *Process for Determining Informed Clinical Opinion* form, the team will complete the following:

1. Indicate the area and/or reason(s) the team would like to consider eligibility by informed clinical opinion. Provide an explanation of why the evaluation standards, procedures and tools, which are used with the majority of children, did not adequately measure the child's ability.

2. List how the information will be gathered and/or the tools that will be used in determining eligibility by informed clinical opinion. List the team members who will be gathering the information or administering the assessments. Two or more team members must be involved in gathering the assessment information. The assessment information should be gathered in multiple settings when appropriate.

3. Meet as a team to synthesize and interpret all available information.

4. Reach a consensus decision based on the available information and a rationale for concluding the child is or is not eligible for Part C early intervention service based on informed clinical opinion.

The Process for Determining Informed Clinical Opinion for must be filed in the child's records.

Process for Determining Informed Clinical Opinion
(with examples)

1. Indicate the area and or reason that you would like to consider Part C eligibility by informed clinical opinion. (See examples below)

Example: Results of the BDI-s show a 27% delay in the area of expressive communication which is not a qualifying score for Part C eligibility. The team observed a lack of sound development and eating difficulties. Child is not yet producing the b, p, and m sounds. She has trouble eating meals and prefers textures. She often overstuffs her mouth which causes coughing and gagging.

Examples

- Traditional measures of eligibility evaluation have been attempted but cannot be administered according to standardized procedures, or do not yield reliable, valid scores for comparison to Alaska's eligibility criteria.
- There is no test that can be used because of the child's young age.
- Traditional measures and procedures are unavailable or yield invalid scores when used to evaluate the following areas:
    1. Growth and Feeding:
        - Feeding problems
        - Gastrostomy for feeding
        - Severe growth delay
    2. Sensory and Regulatory:
        - Chronic problems with sleep, attention, and/or eating
        - Sensory processing disorders
    3. Social Emotional:
        - Atypical social interaction with caregivers and peers
        - Attachment, Temperament and Self-regulation
        - Approaches to learning and play
        - Delays or differences in ability to communicate emotional needs or achieve expected emotional milestones such as pleasurable interest in adults and peers.
    4. Motor
        - Asymmetrical movements
        - Atypical tone
        - Poor balance
        - Problems in motor planning
        - Abnormal reflexes or postural reactions
    5. Communication:
        - Variant speech and language pattern
    6. Hearing Loss (According to State of Alaska Guidelines: date unknown)
    7. Significant/Progressive Vision Impairment

       Clinical opinion may be use when there is a high risk for a vision impairment diagnosis due to medical history (prematurity, birth injury, IVH, diagnosed

syndrome, etc.) ***and*** visual skills less than expected for developmental age as assessed by a vision impairment educational specialist.

- Parents or professionals believe the standardized measures fail to capture important information about the child and have evidence that the child has a delay or may show a delay over time.
- More specific and accurate information is available via interviews, observations, and other qualitative measures rather than through traditional evaluation methods.
- Children are hospitalized or restricted to other settings not appropriate for testing, or behavior patterns interfere with administration protocols

8. Other:_____

2a. List how the information will be gathered and/ or the tools that will be or have been used in determining eligibility by informed clinical opinion. (See possible sources below)

Example: Observation of feeding at home and child care and appropriate sections of a curriculum based-assessment.

Possible sources:

- Review of a child's developmental history
- Interviews with parents/caregivers
- Parent/caregivers reports
- Evaluation/observation of a child at play and in various settings
- Observation of parent-child interactions
- Information from family members, other caregivers, medical providers, social workers, and educators.
- Medical, sensory, and/or neurodevelopmental or other physical examinations.
- Appropriate sections of curriculum-based assessment (CBA) instruments
- Qualitative measures such as social emotional and/or social interaction scales.
- Instruments that provide a format for achieving team consensus, such as SPECS or COACH.

2b. List the team members who will be gathering the information or administering the assessments. Two or more team members must be involved in gathering the assessment information. Assessments should be carried out in multiple settings if warranted.

Example:
OT- Observation of feeding during meal time in family's home and child care
Administration of the oral motor development subtests of the HELP
SLP- administration of the speech intelligibility portion of the HELP in family's home

3. Meet as a team to review assessment data and how it impacts a child's functional abilities. Record the results of the assessment:

Example: Completed the speech intelligibility and the oral motor development subtests of the HELP. She exhibits atypical speech sound development as she is not producing several sounds that she should for her age. She also exhibits some oral motor deficits as she avoids crunchy foods, lacks a rotary chew, and stuffs her mouth which results in coughing, choking and gagging.
Help Strands:

Communication (Intelligibility of Speech)

- *Strand LR 2.6 (Development of Sounds/Intelligibility)*

Communication (Oral/Motor/Feeding)

- *Strand 5.5 (Oral Motor Development)*

4. Reach a consensus decision based on the available information.

Example: Results of the HELP show that child is at 22 months for sound development and at 14 months for oral motor development. The child's oral motor delay is affecting the range and type of food the child can eat without choking and gagging. The team agrees that child demonstrates a qualitative and quantitative delay and is eligible for Part C ILP services based on Informed Clinical Opinion.

Signatures:

Team Member:_____ Date: _____

Team Member: _____ Date:_____

Team Member: _____ Date:_____

6. Second Level Review: I have reviewed the documentation and pertinent information, as well as the informed clinical opinion statement of the team and concur that the child meets Part C eligibility under informed clinical opinion. __Yes __No

Date: Name: Signature:

6.0 Documentation of Informed Clinical Opinion:

Along with filing the Process for Determining Informed Clinical Opinion Form in the child's record, a summary of the team's ICO must be documented on each infant or toddler's IFSP in section 3.1 ;Evaluation Determination Summary. The following information must be included in Section 3.1:

1) Explain why the evaluation standards, procedures and tools, which are used with the majority of children, did not adequately measure the child's abilities.

2) Indicate what objective data was used to conclude that the child has a developmental delay and is in need of early intervention services. Data may include test scores; parent input; childcare provider comments; observations of the child in his/her daily routine; use of behavior checklists or criterion-referenced measures: and other developmental data including current health status and medical history.

3) Summarize the information and describe the functioning of the child in each developmental area.

Section 3.1 – Eligibility Evaluation Summary (complete within 45 days of referral

Narrative Summary and Recommendations (Evaluation Notes) Date: _____*Results of the BDI-s show a 27% delay in the area of expressive communication which is not a qualifying score for Part C eligibility. The team observed a lack of sound development and eating difficulties. Child is not yet producing the b, p, and m sounds. She has trouble eating meals and prefers textures. She often overstuffs her mouth which causes coughing and gagging.*

A SLP and OT completed the speech intelligibility and the oral motor development subtests of the HELP. She exhibits atypical speech sound development as she is not producing several sounds that she should for her age. She also exhibits some oral motor deficits as she avoids crunchy foods, lacks a rotary chew, and stuffs her mouth which results in coughing, choking and gagging.

Help Strands:
Communication (Intelligibility of Speech)

- *Strand LR 2.6 (Development of Sounds/Intelligibility*

Communication (Oral/Motor/Feeding)

- *Strand 5.5 (Oral Motor Development)*

Results of the HELP show that child is at 22 months for sound development and at 14 months for oral motor development. The child's oral motor delay is affecting the range and type of food the child can eat without choking and gagging.

The team agrees that child demonstrates a qualitative and quantitative delay and is eligible for Part C ILP services based on Informed Clinical Opinion.

7.0 Approval: (New Mexico Family Infant Toddler Program, 2013)

In order to determine if the documentation sufficiently describes the areas listed above, a second level review and "sign off" on the evaluation report is required within the early intervention agency by someone who is of equal or higher certification or licensure and who was not part of the evaluation team.

Guidance for Second Level Reviewers

In reading and signing off on the report, the second level reviewer must be able to:

- Understand the rationale of the team in looking beyond information obtained through evaluation processes and tools and in moving towards Informed Clinical Opinion, i.e.-why where other evaluation tools and methods not sufficient in determining eligibility?
- Identify the evidence that the team used in reaching the decision to use Informed Clinical Opinion. Examples of "evidence" include:
    - Parent and other caregiver reports of ways in which daily activities are being impacted;
    - Professional observations during the evaluation session and perhaps in other settings/situations:
    - Criterion-based assessments
    - Description of the child's abilities/and or behaviors and how they differ from those of typical same age peers, etc.
- Upon review of the evidence, reach the same conclusion as the evaluation team, i.e., that the child exhibits at least a 50% delay or atypical development in one or more developmental domains that would qualify him/her for Part C by Informed Clinical Opinion.

  If the reviewer is not able to do all of the above, the child would not be considered eligible for Part C services under Informed Clinical Opinion.

Process for Determining Informed Clinical Opinion

1. Indicate the area and or reason that you would like to consider eligibility by informed clinical opinion. (See examples below)

Examples

- Traditional measures of eligibility evaluation have been attempted but cannot be administered according to standardized procedures, or do not yield reliable, valid scores for comparison to Alaska's eligibility criteria.
- There is no test that can be used because of the child's young age.
- Traditional measures and procedures are unavailable or yield invalid scores when used to evaluate the following areas:
    1. Growth and Feeding:
        - Feeding problems
        - Gastrostomy for feeding
        - Severe growth delay
    2. Sensory and Regulatory:
        - Chronic problems with sleep, attention, and/or eating
        - Sensory processing disorders
    3. Social Emotional:
        - Atypical social interaction with caregivers and peers
        - Attachment, Temperament and Self-regulation
        - Approaches to learning and play
        - Delays or differences in ability to communicate emotional needs or achieve expected emotional milestones such as pleasurable interest in adults and peers.
    4. Motor
        - Asymmetrical movements
        - Atypical tone
        - Poor balance
        - Problems in motor planning
        - Abnormal reflexes or postural reactions
    5. Communication:
        - Variant speech and language pattern
    6. Hearing Loss (According to State of Alaska Guidelines: date unknown)
    7. Significant/Progressive Vision Impairment

       Clinical opinion may be use when there is a high risk for a vision impairment diagnosis due to medical history (prematurity, birth injury, IVH, diagnosed

syndrome, etc.) ***and*** visual skills less than expected for developmental age as assessed by a vision impairment educational specialist.

8. Other:_____

2. List how the information will be gathered and/ or the tools that will be or have been used in determining eligibility by informed clinical opinion. (See possible sources below)

Possible sources:

- Review of a child's developmental history
- Interviews with parents/caregivers
- Parent/caregivers reports
- Evaluation/observation of a child at play and in various settings
- Observation of parent-child interactions
- Information from family members, other caregivers, medical providers, social workers, and educators.
- Medical, sensory, and/or neurodevelopmental or other physical examinations.
- Appropriate sections of curriculum-based assessment (CBA) instruments
- Qualitative measures such as social emotional and/or social interaction scales.
- Instruments that provide a format for achieving team consensus, such as SPECS or COACH.

3. List the team members who will be gathering the information or administering the assessments. Two or more team members must be involved in gathering the assessment information. Assessments should be carried out in multiple settings if warranted.

4. Meet as a team to review assessment data and how it impacts a child's functional abilities. Record the results of the assessment:

5. Reach a consensus decision based on the available information.

Signatures:
Team Member:_____ Date: _____

Team Member: _____ Date:_____

Team Member: _____ Date:_____

6. Second Level Review: I have reviewed the documentation and pertinent information, as well as the informed clinical opinion statement of the team and concur that the child meets Part C eligibility under informed clinical opinion. __Yes __No

Date: Name: Signature:

References:

Bagnato, S.J. (2006). Formalizing informed clinical opinion assessment procedures is more likely to yield accurate results. *Endpoints, 2*(3). Retrieved from: http://tracecenter.info/endpoints/endpoints_vol2_no3.pdf

Early Intervention Program for Infants and Toddlers with Disabilities Rule of 2011, 34 C.F.R. §303 (2011).

Evaluation, Eligibility Determination and Eligibility Categories (2013). New Mexico Family Infant Toddler Program Technical Assistance Document.

Lucas, A. & Shaw, E. (2012). Informed Clinical Opinion (NECTAC Notes no. 28). Chapel Hill: The University of North Carolina, FPG Child Development Institute.

Procedural Guidance: Screening, Evaluations and Assessments Policy (2014). North Carolina Infant-Toddler Program Technical Assistance Document.

Shackelford, J. (2002). *Informed clinical opinion* (NECTAC Notes No. 10). Chapel Hill: The University of North Carolina, FPG Child Development Institute, National Early Childhood Technical Assistance Center.

Resources:

Bagnato, S. J., Smith-Jones, J., Matesa, M., & Mckeating-Esterle, Eileen (2006). Research foundations for using clinical judgment (informed opinion) for early intervention eligibility determination. *Cornerstones*, Vol. *2*(3), 1-14.

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Informed Clinical Opinion (2013). Practice Guide: Early Support for Infants & Toddlers: Washington State Department of Early Learning. http://del.wa.gov/publications/esit/docs/ICOrevisedjuly2013.pdf

APPENDIX A

Examples of Informed Clinical Opinion

Example of Informed Clinical Opinion as a Primary Source of Determining Eligibility:
(New Mexico Family, Infant Toddler Program, 2013)

Phillip is an 18 month old who was evaluated with Infant Toddler Developmental Assessment (IDA) and, due to additional concerns, the PLS-4. Both the IDA and PLS-4 did not indicate a delay; however, the team had significant concerns regarding his language use. The team needs to write an eligibility statement that summarizes their ICO and demonstrates the Significant Atypical Development that Phillip is displaying.

SAMPLE ICO section on IFSP

Informed Clinical Opinion:

Team agrees that child is eligible based on Significant Atypical Development: ___Yes ___No

Statement of informed clinical opinion documenting eligibility, including the use of another other instruments utilized. *(Examples: quality of skills; performance of skills; Scatter of scores (including across domains); behavior significantly different for typical peers).*

Phillip displays significant differences in his language and communication skills. Based upon observations, evaluation tool results, and parent report, Phillip uses a combination of words, gestures, and other vocalizations to attempt to get his needs met but most of the words are generally out of context for the situation. For example, when he wanted his mother to give him the car they were playing with, he would say, “uh-oh!” and instead of saying “Thank you” when he was handed a desired object, he would say “Bless you!” He was, however, observed using “Bless you!” when someone in the room sneezed. Phillip’s overall communication consists of the use of occasional words such as “mama”, “dada”, “ball”, etc. but primarily involves isolated exclamation, usually out of context, to attempt to communicate his needs. This communication shows effort and understanding of the power of words but is not effective in getting his needs met nor does it align with typical development. As a result, the evaluation team has determined that Phillip is eligible for the Early Intervention Program due to “Significant Atypical Development” in the area of communication.

Second Level Review (If ICO is used to determine developmental delay)

I have reviewed the ICO statement of the team, and concur that the child meets eligibility under Significant Atypical Development.

Date: Name: Signature:

Example #2 (North Carolina Infant- Toddler Program)

James was referred to the NCITP by his mother who has concerns about his language development. At 2 ½, James has about 20 words which he uses consistently. He's good at naming pictures in familiar books and characters on his favorite TV shows. He tries to sing along with his favorite videos. However, James rarely uses words functionally during his daily routine. Usually he points and whines for what he wants. Sometimes when he wants juice, he will take his mother to the refrigerator and say "juice". He occasionally uses two word phrases but is not speaking in full sentences. Both James and his mother are often frustrated over his attempts to communicate about what he wants, and James's communication attempts often end up in temper tantrums. The team completed developmental testing to determine James's eligibility for the Infant Toddler Program. Results indicated that James's adaptive, cognitive and motor skills were developing appropriately for his age. His receptive language skills were also within age expectations. Standard scores on the social-emotional and expressive language domains were each 1.3 standard deviations below the mean. In addition to the instrument results, the evaluator's synthesized their knowledge of development for infant and toddlers, observation of the child, other sources of information from test administration, and parent interview information about the child's use of communication skills within the context of daily routines and natural environments. Although James's test results did not qualify him for the NC ITP, the evaluators used ICO to determine that the he does have a developmental delay that meets the NC ITP eligibility definition based on his lack of functional expressive language which appeared to be significantly interfering with daily communication and social interactions with his family.

Example 3:

Connor (9 months) was found eligible for Early Intervention services base on informed clinical opinion for the following reasons.

Connors gross motor SS was 69 and fine motor SS was 91. Combined Motor score of 80 does not accurately reflect gross motor concerns. He has a difference of 22 points between his gross motor and fine motor skills reflecting a clinical difference in his scores.

He has a diagnosis of low tone and is not yet moving with good quality. Weakness in his hips and core impact the way Connor moves and plays. The evaluators and family are concerned about low muscle tone preventing further progression of motor skills. Connor cannot access toys on elevated surfaces by pulling to stand or cruising and this impacts his ability to participate fully in play and impedes his growing independence. He does not like to put weight on his feet which affects his ability to progress with pre walking skills. The Informed Clinical Opinion of the team and family feel Connor would benefit from Early Intervention Services.

Example 4:

Charlotte (2 months) is eligible for Early Intervention services to support needs in motor development due to informed clinical opinion. Charlotte's tight neck muscle prevents her from turning to her left. This will impact her movement patterns as time moves forward causing a delay in play and motor development. At this time the DACY-2 testing protocol does not reflect the fact that Charlotte only turns to her left up to 35 degrees and tilts only five degrees. This limited range of motion places Charlotte at risk for an atypical head shape. At this time she prefers to look to her right. Charlotte presents with mild flattening to the back of her head. Her parents are concerned about Charlotte's head shape and hope to

reshape her head through positioning. They are interested in learning methods that will encourage Charlotte to look to her left. The family and team agree that Charlotte would benefit from Early Intervention services to address her needs in the area of motor development. They family is interested in learning methods that will help Charlotte enjoy belly time and be comfortable in all types of play positions