Individual Supported: _____ Date: _____

Supporter I.D. #: _____

CCS Team Progress Report

Outcomes Area		*Improvement/Progress*				
		N/A	***None***	***Some***	***Good***	***Signifi-cant***
A.	**Implementation of the Support Needs and Treatments**					
	▪ G.I. & Bowel Management, Nutrition, Pain Management e.g.					
	▪ Brain Coherence & Inflammation Regulation i.e. Bouncing, Balancing Activities and Supplement Needs' Assessment/Treatment e.g. NAC e.g.					
	▪ Human Energy System – Building, Balancing, Prevention i.e. Exercise, Filters, Reduced Radiation e.g.					
	▪ Sensory Integration and Processing e.g.					
	▪ Mental Health e.g. Trauma Desensitisation, Improved Treatments for Anxiety, Sleep, OCD e.g.					
B.	**Supporter's Improved Competence and Compassion**					
	▪ Skilled Advocacy					
	▪ Need for less Direction and Support					
	▪ Improved Emotional Self Regulation					

Cont'd

	Outcomes Area	***Improvement/Progress***				
		N/A	***None***	***Some***	***Good***	***Signifi-cant***
C.	**Individual Supported Enhanced Body, Brain and Being Wellness**					
	▪ Fewer incidents of challenging behaviours					
	▪ More emotional self regulation					
	▪ Participation in enjoyable activities					
	▪ Cooperation					
	▪ Focus					
	▪ Participation in home maintenance activities					
	▪ Helping others					
	▪ Other					
D.	**Support Systems**					
	▪ Improved access to support from community professionals					
	▪ Reduced home safety risks					
	▪ More efficient allocation of staffing resources					
	▪ Reduced costs for support					
	▪ Enhanced Services Alignment with QAM					
	▪ Other					
E.	**Improved Leadership**					
	▪ Trust					
	▪ Improved Directional Skills					
	▪ Improved Support Skills					

Cont'd

Outcomes Area		
F.	**Moving Forward**	
	Continue:	
	Stop:	
	Start:	
G.	**Comments:**	