



NEW MEXICO

Early Childhood
Education & Care Department

Family Support and Early Intervention Division
FAMILY INFANT TODDLER (FIT) PROGRAM

Initial Evaluation (CME) Summary Form Page 1 of 2

Child's First Name: _____ Middle Initial: _____ Last Name: _____

DOB: _____ Chronological Age: _____ Adjusted Age (if applicable): _____

Evaluation Date: _____ Report Date: _____

Parent/Guardians' Name(s): _____

Evaluators' Names/Credentials: _____

Eligibility Information: Check all that apply and give specifics as indicated.

Developmental Delay - Specify area(s): _____

Established Condition - Specify Diagnosis: _____

At-Risk Biological/Medical Condition - Specify Diagnosis: _____

Environmental Risk Condition based on FIT Environmental Risk Assessment Tool

Child does not meet FIT eligibility requirements

Vision and Hearing Summary

Vision Date Tested: _____ Results: Pass Did Not Pass Unable to Screen Instruments

Used: NM Birth to Three Vision screening Other: _____

Tested by (Doctor or Agency): _____

Recommendations/Referral: _____

Hearing Date Tested: _____ Results: Pass Did Not Pass Unable to Screen Instruments

Used: OAE/Tympan Other: _____

Tested by (Doctor or Agency): _____

Recommendations/Referral: _____



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Child's Developmental Levels: Give age ranges or N/A when not appropriate.

Social: ____ Months

Emotional: ____ Months

Communication: ____ Months

Cognitive: ____ Months

Gross Motor: ____ Months

Fine Motor: ____ Months

Self-Help: ____ Months

Child's Strengths and Needs

Strengths

Needs or Next Steps

Recommended Strategies and Next Steps

Parent/Family should continue to:

1.

2.

3.

4.

5.

Parent/Family Approval and Signature:

I understand that I will receive a written evaluation report within 30 days of my evaluation date:

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

FSC Signature: _____ Date: _____