

Child & Adolescent Developmental Assessment Cheat Sheet

Reviewed by the BastionGPT Clinical Advisory Board · July 2026

A child & adolescent developmental assessment documents developmental history and milestone attainment across motor, language, cognitive, social-emotional, and adaptive domains, then ties the findings to eligibility or diagnosis. Eligibility decisions, diagnoses, and service plans all build on it.

Identifying info & referral question the whole report answers it

Do: record identifiers, DOB and age (corrected if preterm), caregivers, clinician credentials, dates, and the referral source with the question asked.

Pitfall: a report that never states the referral question; reviewers read everything against it.

Sources & procedures records can carry eligibility

Do: name every record reviewed, informant, observation setting, and instrument; note the language or mode of assessment.

Pitfall: instruments listed but records unnamed; under Part C, existing records alone can establish eligibility.

Birth & early medical history close the alternatives

Do: cover pregnancy, delivery, gestational age, birth weight, NICU time, early illnesses, and dated hearing and vision screen results.

Pitfall: a language delay with an unchecked hearing screen invites the wrong conclusion.

Milestones by domain informant + basis + benchmark

Do: record attainment ages against expected ranges for all six domains, naming who reported each and on what basis.

Pitfall: "delayed" with no informant, date, or benchmark behind the word.

Family & social context a required finding, not color

Do: document household, languages, caregiving, family history, and the family's resources, priorities, and concerns (Part C requires them).

Pitfall: writing the section as demographics only.

Education & child care history what was tried, what happened

Do: list settings, supports in place, prior IFSP, IEP, or therapy services, and the child's response to them.

Pitfall: omitting the response to prior services; the next team inherits a plan with no evidence.

Behavioral observations where clinical opinion gets evidence

Do: describe engagement, attention, communication attempts, play, and caregiver-child interaction across settings.

Pitfall: observations that only restate scores.

Instruments, scores & interpretation screens are not testing

Do: name each instrument with scores, interpret in plain terms, add a validity statement, and label caregiver-report screens as screens.

Pitfall: a parent-report screen presented as administered testing; 96110 and 96112 are different services.

Impressions: eligibility & diagnosis synthesis, not a single score

Do: tie eligibility to the state's criteria or the diagnosis to its basis; use informed clinical opinion to integrate the record.

Pitfall: one score carrying the conclusion; opinion may establish eligibility but never negates instruments.

Recommendations, signatures & time the audit-visible close

Do: tie each recommendation to a finding, record testing start/stop, and close with dated, credentialed signatures plus any required parent signature.

Pitfall: missing assessor or parent signatures; a federal audit in Maine flagged exactly this.

Before you sign

- ☐ Referral question stated and answered
- ☐ Every milestone has informant and basis
- ☐ Hearing and vision status closed out
- ☐ Screen labeled screen, testing labeled testing
- ☐ Testing time start and stop recorded
- ☐ Eligibility tied to criteria and record
- ☐ Signed with credentials; parent signature if required

Drafting with AI

Capture 30 seconds of bullets after the visit: milestones by domain with informant, screen versus testing results, family priorities, impression, recommendations.

"Draft a developmental assessment from these bullets, 34-month-old referred after a below-cutoff 30-month screen, bilingual household, recommending an early intervention referral: ..."

Never paste child-identifying information into consumer AI tools. BastionGPT is HIPAA-compliant with a signed BAA on every plan.

500 to 1,500 words
typical length

60 to 120 min by hand
clinical team estimate

Screen, school, Part C
referral streams

Caregivers · programs ·
payers
who reads it

Full guide and sample note:

bastiongpt.com/template/developmental-assessment

BastionGPT drafts the assessment from your interview bullets. Free 7-day trial.

Child & Adolescent Developmental Assessment Template

Copy or print for your practice · Adapt fields to your organization's, payer's and jurisdiction's documentation requirements.

Child (initials): _____ DOB / age: _____ Corrected age: _____ Date(s): _____

Assessor(s) / credentials: _____ Referral source + question: _____ Testing start/stop: _____

Sources of information & procedures

Records reviewed by name; interviews; observation settings; instruments (screen vs. testing labeled); language/mode of assessment

Birth & early medical history

Pregnancy, delivery, gestational age, birth weight, NICU, early illnesses; hearing and vision screen results with dates; current health

Developmental milestones by domain

Gross motor, fine motor, language (receptive/expressive), cognitive/play, social-emotional, adaptive; age attained + informant and basis

Family & social context

Household, languages, caregiving; family history of developmental or learning conditions; family resources, priorities, concerns (Part C)

Education / child care history

Settings, attendance, supports in place; prior IFSP, IEP, or therapy services and the response to them

Behavioral observations

Across settings: engagement, attention, communication attempts, play, transitions, caregiver-child interaction

Instruments, scores & interpretation

Instrument / scores / plain-terms interpretation, repeated per instrument; validity of results statement

Impressions: eligibility / diagnosis

Synthesis across sources; informed clinical opinion where used; eligibility statement (state criteria) or DSM-5-TR / ICD-10-CM code

Recommendations & next steps

Each tied to a finding, prioritized; referrals; re-screen date; feedback session and plain-language summary

Parental consent documented: Y / N _____ Assessor signature(s) / credentials: _____ Date signed: _____