NASSAU COUNTY EARLY INTERVENTION PROGRAM
NASSAU COUNTY DEPARTMENT OF HEALTH

(Please print legibly-use black ink)

DAILY NOTES/ATTENDANCE SHEET

DOH EIOD: **Ongoing Service Coordinator**:

Child's Name: Date of Birth: / / Age:

IFSP Period: / / to / / Service:_____ _____ _____ _____
Type Location Frequency Duration

Authorized Sessions: Authorization #: ICD-9 Code:

Provider/Agency Name: Provider:
Name Professional Title

[Key] **C**= Clinician cancelled **FV**= Family Vacation **H**= Holiday **I**= IFSP meeting **M**= Make-up **N**= No one home
P= Parent cancelled **PV**= Provider Vacation **S**= Child sick/hospitalized **X**= Treatment session

DATE: / / **[ ]** IN:____OUT:____ ***Parent/Caregiver Signature**:__________________ **SESSION #:**___
Desired Outcome/Goals:
Makeup for: ___________
Session Content:
CPT CODES:

Provider Signature/License Initials:

DATE: / / **[ ]** IN:____OUT:____ ***Parent/Caregiver Signature**:__________________ **SESSION #:**___
Desired Outcome/Goals:
Makeup for: ___________
Session Content:
CPT CODES:

Provider Signature/License Initials:

DATE: / / **[ ]** IN:____OUT:____ ***Parent/Caregiver Signature**:__________________ **SESSION #:**___
Desired Outcome/Goals:
Makeup for: __________
Session Content:
CPT CODES:

Provider Signature/License Initials:

DATE: / / **[ ]** IN:____OUT:____ ***Parent/Caregiver Signature**:__________________ **SESSION #:**___
Desired Outcome/Goals:
Makeup for: __________
Session Content:
CPT CODES:

Provider Signature/License Initials:

Recommendations for support, education, and guidance for parents: (Complete)

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I certify that all the information listed above is correct to the best of my knowledge.

EI 5177.A 9/08 *Provider Signature/License Initials:*_________________________

 Child's Name:

DATE: / / **[ ]** IN:____OUT:____ ***Parent/Caregiver Signature**:__________________ **SESSION #:**___

Desired Outcome/Goals:

Makeup for: __________

Session Content:

CPT CODES:

Provider Signature/License Initials:

DATE: / / **[ ]** IN:____OUT:____ ***Parent/Caregiver Signature**:__________________ **SESSION #:**___

Desired Outcome/Goals:

Makeup for: __________

Session Content:

CPT CODES:

Provider Signature/License Initials:

DATE: / / **[ ]** IN:____OUT:____ ***Parent/Caregiver Signature**:__________________ **SESSION #:**___

Desired Outcome/Goals:

Makeup for: __________

Session Content:

CPT CODES:

Provider Signature/License Initials:

DATE: / / **[ ]** IN:____OUT:____ ***Parent/Caregiver Signature**:__________________ **SESSION #:**___

Desired Outcome/Goals:

Makeup for: __________

Session Content:

CPT CODES:

Provider Signature/License Initials:

***Confirms provider's attendance**

Recommendations for support, education, and guidance for parents: (Complete)

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SPECIFIC CONTACT AND COMMENTS BETWEEN TEAM MEMBERS, DOH, AND OTHERS (Doctors, etc.)

DATE	CODES	NOTES

Codes: **TC**: Telephone Contact **AV**: Agency Visit **HV**: Home Visit **IFSP**: Indiv Fam Svc Plan
TM: Team Meeting **CN**: Communications Notebook **PC**: Teacher/Therapist Consult

I certify that all the information listed above is correct to the best of my knowledge.

EI 5177.B 9/08 *Providers signature/License Initials*:__________________________