NASSAU COUNTY DEPARTMENT OF HEALTH NASSAU COUNTY FARLY INTERVENTION LOG NOTE

NASSAU COUNTY EARLY INTERVENTION LOG NOTE Page of (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: ICD-10 Code: Authorization #: Provider/Agency Name: Kids First Evaluation **Provider Name: Professional Title:** Agency NPI # 1376699421 Provider NPI# C= Clinician cancelled **FV**= Family Vacation **H**= Holidav I= IFSP meeting M= Make-up N= No one home **S**= Child sick/hospitalized **X**= Treatment session P= Parent cancelled **PV**= Provider Vacation DATE: 1 IN: OUT: *Parent/Caregiver Signature: SESSION #: Desired Outcome/Goals: Makeup for: __ Session Content: **CPT CODES:** Date Note Written: / Provider Signature/License Initials: DATE: 1 IN: OUT: *Parent/Caregiver Signature: SESSION #: **Desired Outcome/Goals:** Makeup for: **CPT CODES**: Session Content: Date Note Written: / / Provider Signature/License Initials:] IN:_ OUT: *Parent/Caregiver Signature: DATE: SESSION #: Desired Outcome/Goals: Makeup for: ____ Session Content: **CPT CODES:** Provider Signature/License Initials: OUT: *Parent/Caregiver Signature: DATE:] IN:__ **SESSION #:** Desired Outcome/Goals: Makeup for: _ Session Content: **CPT CODES:** Date Note Written: / / Provider Signature/License Initials: Recommendations for support, education, and guidance for parents: (Complete)

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

Provider Signature/License Initials:

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l contitu	TM	: Team M	eeting	CN: Communications Notebook	PC: Teacher/Therapist Consult
I certify that all the information listed above is correct to the best of my knowledge.					
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