NASSAU COUNTY EARLY INTERVENTION PROGRAM
NASSAU COUNTY DEPARTMENT OF HEALTH

APPENDIX 00.1

(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 Kids First Evaluation & Advocacy Center Inc. 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.

*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:

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:*______________________