**Important Steps, Inc NASSAU COUNTY EARLY INTERVENTION PROGRAM**

**Page 1 of 2 (Please print legibly-use black ink)**

# DAILY NOTES/ATTENDANCE SHEET

**DOH EIOD**: **Ongoing Service Coordinator**:

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|  Child’s Name:  | Date of Birth:  |  Age:  |
|  IFSP Period: From: To:  |  Service Type: Location: \_\_Home\_\_Daycare  Frequency: Duration:\_\_\_30\_\_45\_\_\_60  |
|  Agency NPI: **1770727661** # of Auth Sessions:\_\_\_\_\_\_\_\_\_\_\_\_ Auth #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ICD10 Code: \_\_\_\_\_\_\_\_\_\_  |
|  Provider/Agency Name: **Important Steps, Inc.**   |  Provider’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Professional Title:\_\_\_\_\_\_\_ Provider’s NPI#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**[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

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|  AM (circle AM or PM for OUT time)DATE: / / **[ ]** IN:\_\_\_\_ OUT:\_\_\_\_ PM \***Parent/Caregiver Signature**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **SESSION #:\_\_\_**Make Up for:\_\_\_/\_\_\_\_/\_\_\_\_ Co-Visit:\_\_\_\_ CPT Codes: 1)\_\_\_\_\_\_\_\_\_2)\_\_\_\_\_\_\_\_\_3)\_\_\_\_\_\_\_\_\_4)\_\_\_\_\_\_\_\_\_\_\_\_\_ Desired IFSP Outcome/Goals:   Session Content :   Date Note Written : Provider Signature/License Initials: |
|  AM (circle AM or PM for OUT time)DATE: / / **[ ]** IN:\_\_\_\_ OUT:\_\_\_\_ PM \***Parent/Caregiver Signature**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **SESSION #:\_\_\_**Make Up for:\_\_\_/\_\_\_\_/\_\_\_\_ Co-Visit:\_\_\_\_ CPT Codes: 1)\_\_\_\_\_\_\_\_\_2)\_\_\_\_\_\_\_\_\_3)\_\_\_\_\_\_\_\_\_4)\_\_\_\_\_\_\_\_\_\_\_\_\_ Desired IFSP Outcome/Goals:   Session Content :   Date Note Written : Provider Signature/License Initials: |
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**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/Cred. Initials:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Important Steps, Inc.** Page 2 of 2 Child’s Name: Service Type:

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|  AM (circle AM or PM for OUT time)DATE: / / **[ ]** IN:\_\_\_\_ OUT:\_\_\_\_ PM \***Parent/Caregiver Signature**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **SESSION #:\_\_\_**Make Up for:\_\_\_/\_\_\_\_/\_\_\_\_ Co-Visit:\_\_\_\_ CPT Codes: 1)\_\_\_\_\_\_\_\_\_2)\_\_\_\_\_\_\_\_\_3)\_\_\_\_\_\_\_\_\_4)\_\_\_\_\_\_\_\_\_\_\_\_\_ Desired IFSP Outcome/Goals:   Session Content :   Date Note Written : Provider Signature/License Initials: |
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**\***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.)**

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| DATE | CODES | NOTES |
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**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.**

*Providers signature/License Cred Initials*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_