**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*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_