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| **Child’s Name: DOB: Sex: EI #: IFSP Mandate:**  |
| **Interventionist’s Name: Credentials/Discipline: National Provider ID #: Service Type:** |



**Westchester County Bureau of Early Intervention Session Notes (Home/Facility)-Important Steps, Inc.-ABA**

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| Session Date: IFSP Service Location: \_\_Home\_\_ DaycareTime: From AM PM To AM PM Intensity: \_\_Home/Ind\_\_ Daycare/Ind Session delivered: In-person Telehealth | Session Date: IFSP Service Location: \_\_Home\_\_ DaycareTime: From AM PM To AM PM Intensity: \_\_Home/Ind\_ Daycare/Ind Session delivered: In-person Telehealth |
| Date Note Written: ICD-10 code: HCPCS Code (if applicable): 1st CPT Code: 2nd CPT Code: 3rd CPT Code: 4th CPT Code: | Date Note Written: ICD-10 code: HCPCS Code (if applicable): 1st CPT Code: 2nd CPT Code: 3rd CPT Code: 4th CPT Code: |
| Session cancelled - reason listed in #1. Session must be made up by: This is a make-up for a missed session on . (must be within 2 weeks)Session Participants: child parent/caregiver Other: |  | Session cancelled - reason listed in #1. Session must be made up by:  |
| This is a make-up for a missed session on . (must be within 2 weeks) Session Participants: child parent/caregiver Other: |
| **1.** IFSP Outcome(s) and developmental step(s) addressed during this session (include #): | **1.** IFSP Outcome(s) and developmental step(s) addressed during this session (include#): |
| **2.** Describe A) ***what happened during today’s session*** and the B) ***progress made*** toward the IFSP outcome(s). When available, include parent/caregiver feedback on how they incorporated the strategies between sessions.***C) Routine Activities used in this session***:\_\_ (ADL) \_\_\_Play/Social\_\_ Community/Errand Other(s):\_\_\_\_\_\_\_\_ ***Strategies used in this session:***\_\_\_ Modeling \_\_Verbal Cues \_\_\_Gesture & Verbal Cues\_\_ Physical Prompts \_\_Hand-over-hand \_ Modification of the social/physical environment \_\_Positioning \_\_\_Adaptation of Materials \_\_\_\_Assistive Technology\_\_ Other:\_\_\_\_\_**ABA**: \_\_Pairing \_\_ABA Program\_\_ DTT \_\_Parent Training \_\_Task Analysis \_\_Shaping | **2.** Describe A) ***what happened during today’s session*** and the B) ***progress made*** toward the IFSP outcome(s). When available, include parent/caregiver feedback on how they incorporated the strategies between sessions.***C) Routine Activities used in this session***:\_\_ (ADL) \_\_\_Play/Social\_\_ Community/Errand Other(s):\_\_\_\_\_\_\_\_ ***Strategies used in this session:***\_\_\_ Modeling \_\_Verbal Cues \_\_\_Gesture & Verbal Cues\_\_ Physical Prompts \_\_Hand-over-hand \_ Modification of the social/physical environment \_\_Positioning \_\_\_Adaptation of Materials \_\_\_\_Assistive Technology\_\_ Other:\_\_\_\_\_**ABA**: \_\_Pairing \_\_ABA Program\_\_ DTT \_\_Parent Training \_\_Task Analysis \_\_Shaping |
| **3.** How did you work with the parent/caregiver? Observed parent/caregiver and child during routines caregiver tried activity, feedback exchanged Demonstrated activity to parent/caregiver Reviewed communication tool with parent/caregiverOther:\_\_\_\_\_\_\_\_\_\_\_\_ | **3.** How did you work with the parent/caregiver? |  | Observed parent/caregiver and child |
| during routines Parent/caregiver tried activity, feedback exchanged Demonstratedactivity to parent/caregiver Reviewed communication tool with parent/caregiver Other: \_\_\_\_\_\_\_\_\_\_\_\_ |
| **4.** What strategies/activities did you and the parent/caregiver collaboratively agree to do to support their child’s learning and development between visits? ***Parent agreed to*** | **4.** What strategies/activities did you and the parent/caregiver collaboratively agree to do to support their child’s learning and development between visits? ***Parent agreed to*** |
| Parent/Caregiver Signature: Date: / / Relationship to child: | Parent/Caregiver Signature: Date: / / Relationship to child: |
| Interventionist Signature: Date: / / License/Certification#/Cred:  | Interventionist Signature: Date: / / License/Certification #/Cred:  |
| Supervising Clinician (COTA/CF): Date: / / License/Certification/Cred #: Sup-r: Sign: | Supervising Clinician (COTA/CF): Date: / / License/Certification #/Cred: Sup-r Sign: |

 WC Bureau of Early Intervention Session (Home/Facility) Note 9/1/2024

**IFSP Outcome(s) and developmental step(s):** Please include # s in Section 1 above: