MKSA LLC

NASSAU COUNTY EARLY INTERVENTION LOG NOTE

Page \_\_\_\_ of \_\_\_\_

**(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: / / to / / Service:\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_  Type Location Frequency Duration |
| # Authorized Sessions: Authorization #: ICD-10 Code: |
| **Provider/Agency Name: MKSA LLC Provider Name: Professional Title Provider NPI#**  **Agency NPI # 1700208709** |

**[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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| --- |
| DATE: / / **[ ]** IN:\_\_\_\_OUT:\_\_\_\_ \***Parent/Caregiver Signature**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **SESSION #:\_\_\_**  Desired Outcome/Goals:  Makeup for: \_\_\_\_\_\_\_\_\_\_\_    Session Content: **CPT CODES:**    Date Note Written: / / Provider Signature/License Initials: |
| DATE: / / **[ ]** IN:\_\_\_\_OUT:\_\_\_\_ \***Parent/Caregiver Signature**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **SESSION #:\_\_\_**  Desired Outcome/Goals:  Makeup for: \_\_\_\_\_\_\_\_\_\_\_  Session Content: **CPT CODES:**      Date Note Written: / / Provider Signature/License Initials: |
| DATE: / / **[ ]** IN:\_\_\_\_OUT:\_\_\_\_ \***Parent/Caregiver Signature**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **SESSION #:\_\_\_**  Desired Outcome/Goals:  Makeup for: \_\_\_\_\_\_\_\_\_\_    Session Content: **CPT CODES:**      Date Note Written: / / Provider Signature/License Initials: |
| DATE: / / **[ ]** IN:\_\_\_\_OUT:\_\_\_\_ \***Parent/Caregiver Signature**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **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:*

**Page \_\_\_\_ of \_\_\_\_** Child’s Name:

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| --- |
| DATE: / / **[ ]** IN:\_\_\_\_OUT:\_\_\_\_ \***Parent/Caregiver Signature**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **SESSION #:\_\_\_**  Desired Outcome/Goals:  Makeup for: \_\_\_\_\_\_\_\_\_\_  Session Content: **CPT CODES**:    Date Note Written: / / Provider Signature/License Initials: |
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| DATE: / / **[ ]** IN:\_\_\_\_OUT:\_\_\_\_ \***Parent/Caregiver Signature**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **SESSION #:\_\_\_**  Desired Outcome/Goals:  Makeup for: \_\_\_\_\_\_\_\_\_\_  Session Content: **CPT CODES**:    Date Note Written: / / 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.)**

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| DATE | CODES | NOTES |
|  |  |  |
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|  |  |  |
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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 Initials*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MKSA rev 9/15 jv EI Log note Nassau