LITTLE TREASURES NASSAU COUNTY DAILY SESSION NOTES

Child's Name: Date of Birth: / /

IFSP Period: / / to / / Service:____ ____ ____ ______
Type Location Frequency Duration

Authorized Sessions: Authorization #: ICD-9 Code:

Provider/Agency Name: Provider Name:
Cooper Kids Therapy Associates
Agency NPI # 1659529402
Provider NPI #: 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**:______________________ **Date:___/____/____**
AM PM AM PM

Desired Outcome/Goals:

Session #: ___________

Makeup for: ___________
Co-Visit (circle one): Yes No

Session Content:

CPT CODES:

Provider Signature/License Initials:

Date note written: ___/___/___

DATE: / / **[ ]** IN:____OUT:____ ***Parent/Caregiver Signature**:______________________ **Date:___/____/____**
AM PM AM PM

Desired Outcome/Goals:

Session #: ___________

Makeup for: ___________
Co-Visit (circle one): Yes No

Session Content:

CPT CODES:

Provider Signature/License Initials:

Date note written:___/___/___

DATE: / / **[ ]** IN:____OUT:____ ***Parent/Caregiver Signature**:______________________ **Date:___/____/____**
AM PM AM PM

Desired Outcome/Goals:

Session #: ___________

Makeup for: ___________
Co-Visit (circle one): Yes No

Session Content:

CPT CODES:

Provider Signature/License Initials:

Date note written: ___/___/___

Recommendations for support, education, and guidance for parents:

____

____

____

I certify that all the information listed above is correct to the best of my knowledge.

*Provider Signature/License Initials:*___________________________

Child's Name: Date of Birth: / /

IFSP Period: / / to / / Service:_____ _____ _____ _____
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Cooper Kids Therapy Associates Provider NPI #: Professional Title
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DATE: / / [ ] IN:____OUT:____ ***Parent/Caregiver Signature**:_____________________ **Date:___/____/____**
AM PM AM PM

Desired Outcome/Goals:

Session #: ___________

Makeup for: ___________
Co-Visit (circle one): Yes No

Session Content:

CPT CODES:

Provider Signature/License Initials: Date note written: ___/___/___

DATE: / / [ ] IN:____OUT:____ ***Parent/Caregiver Signature**:_____________________ **Date:___/____/____**
AM PM AM PM

Desired Outcome/Goals:

Session #: ___________

Makeup for: ___________
Co-Visit (circle one): Yes No

Session Content:

CPT CODES:

Provider Signature/License Initials: Date note written: ___/___/___

DATE: / / [ ] IN:____OUT:____ ***Parent/Caregiver Signature**:_____________________ **Date:___/____/____**
AM PM AM PM

Desired Outcome/Goals:

Session #: ___________

Makeup for: ___________
Co-Visit (circle one): Yes No

Session Content:

CPT CODES:

Provider Signature/License Initials: Date note written: ___/___/___

Recommendations for support, education, and guidance for parents: (Complete every 4 sessions)

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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 **TC**: Teacher/Therapist Consult

I certify that all the information listed above is correct to the best of my knowledge.

Providers signature/License Initials:_________________________