**Client Name:** Enter text. **DOB:** Enter a date. **ICD10:** Enter text.

**Service Coordinator:** Enter text. **EI Service:** Enter text.

**Provider Name:** Enter text. **Provider Agency:** Enter text.

**IFSP Service Frequency:** Enter text. **Service Location:** Enter text.

**Reason for Additional Time at Visit:** Choose an item. **Telehealth:**

**Date of Service:** Enter a date. **Start Time:** Enter text. **End Time:** Enter text.

**Funding Source: Medicaid  State General  Denver Health  Trust Fund  CHP+**

**Private Insurance:** Enter text.

Key for services with no CPT code: NS=No show PE=Parent Education 00000=Misc. Code

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Units** | **CPT Code** | **Outcomes/Session Plan** | **RMHS or Provider to bill** | **Total Session Duration (mins.)** |
| Enter text. | Enter text. | Enter text. | RMHS  Provider | Enter text. |

**Observations/Progress toward IFSP Goal(s):**

|  |
| --- |
| Enter text. |

**Recommendations/Strategies:**

|  |
| --- |
| Enter text. |

**Provider Signature:** Enter text. **Date:** Enter a date.

**Supervising Staff Signature (if applicable):** Enter text. **Date:** Enter a date.