

First Steps Service Provider

Face to Face

Child's Name: _____ Date: _____

Child ID#: _____ Service Start Time: _____ Service End Time: _____

Location of Service: _____

Street address

City

Zip

IFSP Outcome to be addressed: _____

Results of Visit:

Results of Visit:

Follow-up Needed:

Family Education/involvement:

Family Education/involvement:

Next Scheduled Session: _____

Day

Date

Time

Location

Please note if there has been any cancelled sessions (and not rescheduled) in between this visit and your last visit.

Yes, the provider needed to cancel the session scheduled for _____.

Date

Yes, I (the parent) needed to cancel the last session scheduled for _____.

Date

My signature certifies that the activities identified above occurred at the time and location indicated and that _____ minutes/hour of direct service were provided to my child/family.

Parent Signature

Date

Telephone

Provider Signature

Date

Telephone

Note: The parent is to be provided with a copy of the completed form.