

# Indiana First Steps

## Provider Face to Face Visit Summary – Virtual Visit



Child Information					
Name of child		Child ID #		Date of birth (mm/dd/yyyy)	
Date of IFSP (mm/dd/yyyy)			Diagnosis Code(s)		
Child's Location Information					
Street address			City		Zip code
Location Type <input type="checkbox"/> Home <input type="checkbox"/> Childcare <input type="checkbox"/> Community Setting <input type="checkbox"/> Office/Clinic <input type="checkbox"/> Other: _____					Location code <input type="checkbox"/> Off-site <input type="checkbox"/> On-site
Completed as a virtual visit?*		How was virtual visit completed?		Name of video platform used for visit	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Phone <input type="checkbox"/> Video			
Provider Information					
Name of provider		Discipline		Name of agency	
Provider's Location Information					
Street address		City		Zip code	
Visit Information					
Date of visit	Start time	End time	Total # of units**	CPT code (code/units)	CPT code (code/units)
Make-up session? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of original session	Reason for make-up session <input type="checkbox"/> Family cancellation <input type="checkbox"/> Family no show <input type="checkbox"/> Provider cancellation <input type="checkbox"/> Provider no show			
Outcome addressed					
Outcome addressed					
Summary of Visit					
What has happened since the last visit? ( appointments, new skills, successes, new concerns, barriers )					
What activities happened during the visit? (Activities should related back to IFSP outcome)					
How did the family participate and what was modeled/taught/discussed? (Family Education and Involvement)					
Parent/Child Interactions (Provider Observation)					
Follow Up Needed- What needs to happen for next visit?					
Next Scheduled Visit					
Day of week	Date (mm/dd/yyyy)	Time		Location	
My signature verifies that I agree to the accuracy of the time reported for this activity.					
Signature of parent/guardian/caregiver				Date (mm/dd/yyyy)	
Signature of provider				Date (mm/dd/yyyy)	

A copy of this document must be sent via secure email or mail following each virtual visit.

\*Virtual visits are permissible for allowable services until May 31, 2020 or the Indiana public health emergency related to COVID-19 is lifted, whichever date is soonest.

\*\*One (1) unit is equal to 15 minutes of direct child treatment/parent education. Providers may not round up to the next unit if under 15 minute increment