



Early Intervention/Therapy Session

Child's Name: _____ DOB: _____ / _____ / _____ Age: _____ mos.

Date of Session: _____ Procedure Code: _____ Diagnosis: _____

Time In: _____ Time Out: _____ Units: .25 units = 15 min
 .50 units = 30 min
 .75 units = 45 min
 1.0 units = 60 min
 1 evaluation

Travel Time (in minutes): _____

Location: Home Childcare Ctr. Other: _____

Participants: Mom / Dad present / participated
 Grandparent present / participated
 Sibling present / participated
 Childcare provider present / participated
 Other: _____

Goals: _____

Parent/Caregiver Update: _____

Progress Towards Goals:

Regression No Improvement Continuing Improvement Significant Improvement

Session Notes: _____

Goals Met: _____ Goals Ongoing: _____

Communicate with Service Coordinator NO YES
for the following concern(s): _____

Notes For Next Visit: _____

Interventionist/Therapist Signature: _____

Parent/Caregiver Signature: _____