Indiana First Steps
Provider Summary of Service

Child Information		
Name of child	Child ID #	Date of birth (mm/dd/yyyy)
Date of IFSP (mm/dd/yyyy)	Diagnosis Code(s)	

Provider Information		
Name of provider	Discipline	Name of agency

Location Information		
Street address	City	Zip code
Location Type ☐Home ☐Child Care ☐Community Setting ☐Office/Clinic ☐Other:________________________________		Location code ☐Off-site ☐On-site

Visit Information				
Date of visit	Start time	End time	Time zone ☐Central ☐Eastern	Total # of units
CPT code(s) (code/units)		Delivery Method ☐In Person ☐Virtual – Audio Only ☐Virtual – Video		
Make-up session? ☐Yes ☐No	Date of original session	Reason for make-up session ☐Family Cancellation ☐Family No Show ☐Provider Cancellation		
Session participants ☐Child ☐Parent/Caregiver ☐Child Care Provider ☐Sibling ☐Interpreter ☐Other:________________________________				
Outcome(s) 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 relate back to IFSP outcome)
How did the family participate and what was modeled/taught/discussed? (Family Education and Involvement)
Parent/Caregiver/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/caregiver	Date (mm/dd/yyyy)
Signature of provider	Date (mm/dd/yyyy)
Signature of provider supervisor	Date (mm/dd/yyyy)