Utah Department of Health & Human Services
Family Health

Name: _____

DOB: ____/____/_____ *IFSP:* ____/____/_____

EARLY INTERVENTION SERVICE VISIT

Visit Date*: ___/___/_____ (mm-dd-yyyy) Time In: ___:___ ___ (hh:mm) Time Out: ___:___ ___ (hh:mm)

Visit Status*: (Check one)

☐ Appointment Kept ☐ Family Canceled-before 9 am ☐ Family Canceled-after 9 am ☐ No Show - Family ☐ Provider Canceled

Service Coordinator/Service Provider*: (If more than one service and service provider, enter a number by the service and the corresponding service provider.)

1._____ 2._____ 3._____

Services provided: Enter length of service in the "Minutes" column and service provider number in the "Number" column.

☐ Check if a simultaneous visit (A service visit in which more than one service is delivered simultaneously or concurrently to a child and family.)

Min	#	Service	Min	#	Service	Min	#	Service
		Special Instruction			PT			Nursing
		Family Training			Assistive Technology			Nutrition
		Service Coordination			Audiology			Psychological
		SLP			Health			Social Work
		OT			Medical			Other _____

Service Setting*: (check one) ☐ Home ☐ Community ☐ Virtual Home Visit ☐ Other Setting _____

Update (What has happened since we last met?):

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Today's visit (What we did today):

Plan (What we'll do next):

Next Appointment Date: ___/___/_____ Time: ___:___ ___

Parent/Guardian Signature: _____ Provider Signature: _____