

Provider Service Rendered
Alabama Department of Rehabilitation Services – Early Intervention

Child First Name: _____ **Child Last Name:** _____ **DOB:** _____

CaseID: _____ **Service Date:** _____ **Make Up Visit:** Yes; No

Service Location: Childcare; Clinic; Community; Home; Virtual Childcare; Virtual Community; Virtual Home

Cancellation: Not Cancelled; Family Cancellation In Past 24 Hours; Missed Appointment; Provider Cancelled

Cancellation Reason: _____

Timely Service Status: Untimely – Family Issue; Untimely Provider Issue

Untimely Service Justification: _____

Important Updates Since Last Visit:

Progress Toward IFSP Outcomes:

Provider Supported By:

- | | |
|---|---|
| <input type="checkbox"/> Reflecting/Discussing/Planning | <input type="checkbox"/> Demonstrating Activity to Parent/Caregiver |
| <input type="checkbox"/> Observing Parent/Caregiver/Child | <input type="checkbox"/> Providing Strategies/Information/Resources |
| <input type="checkbox"/> Other: Description: _____ | |

Parent/Caregiver Participated By:

- | | |
|---|---|
| <input type="checkbox"/> Reflecting/Discussing/Planning | <input type="checkbox"/> Practicing |
| <input type="checkbox"/> Observing | <input type="checkbox"/> Demonstrating Activity to Provider |
| <input type="checkbox"/> Other: Description: _____ | <input type="checkbox"/> Reviewing Strategies and Information |

Plan for Between Visits:

Plan for Next Visit:

Next Service Date: _____ **Family Travel:** Yes; No **Family Miles Traveled:** _____

Service Detail Lines Provided: _____

Name & Discipline for each SDL Provided: _____

Minutes Spent for each Name/Discipline: _____

Service Detail Lines Provided Virtually: _____

Provider Signature: _____ **Date:** _____

Provider Signature: _____ **Date:** _____

Caregiver/Guardian Signature: _____ **Date:** _____