UTAH DEPARTMENT OF HEALTH
Baby Watch Early Intervention
Birth to Three Development

*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: _____