NJ SBHS Service Log - Audiology Services 09/2024

Student Information

District Name: _____ **Dates of Service:** _____

Student Name: _____ **Student Date of Birth:** _____

Student ID: _____

Instructions

Please enter accurate information for each individually numbered session. This includes: **Session Information, Session Description, Direct Medical Services,** and **Non-Billable Services.** Provider **must** select from the choices listed for each category.

NOTE: All fields must be filled out electronically or by hand.

Session Information and Description

Session Keys	Enter the date service was rendered.	Enter the number of hours/mins service was delivered.	*Select 1:*		*Select 1:*			*Select 1:*		
			Size		**Progress**			**Location**		
Session Number	**Date of Service (MM / DD / YYYY)**	**Duration**	**Individual**	**Group**	**Progressed**	**Maintained**	**Regressed**	**In District**	**Out of District**	**Out of District at an NJ APSSD** (NJ Approved Private School for Students with Disabilities)
1										
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10										

Comments Section

Session Notes

Use for Notes in regard to Session Information and Description.

Include all applicable notes for each service rendered.

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Direct Medical Services and Health Evaluations

Session Number	Pure Tone Audiometry, air only **(92552)**	Central Auditory Function and Central Auditory Processing Eval **(92620)**	Ear Mold Impressions **(21086)**	In ear binaural hearing aid **(V5130)**	Treatment of Speech, Language, Voice - Individual **(92507)**	Treatment of Speech, Language, Voice - Group **(92508)**	Auditory Rehabilitation **(92630)**		Auditory Rehabilitation post lingual hearing loss **(92633)**	Acoustic Reflex Testing, Threshold **(92568)**	Acoustic Immittance Testing **(92570)**
	Pure tone hearing test air	Central Auditory Function and Central Auditory Processing Eval 1st Hour	Ear Mold Impressions	Hearing Aid	Auditory Training	Auditory Training	Aural Rehabilitation	Aud rehab pre-ling hear loss	Aud rehab postling hear loss	Acoustic reflex testing, threshold	Acoustic immittance testing
1											
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Non-Billable Services

Session Number	Student not present	Service Provider not present	Other
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Comments Section

Session Notes

Use this section for any additional notes in regard to Direct Medical Services and Health Evaluations.

Include all applicable notes for each service rendered.

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Service Provider Information

Provider Name (Printed):

Provider Name (Signature):

Date of Signature:

If providing the health related direct service "Under the Direction", the following information must be completed:

Supervisor Name:

Supervisor Signature:

Date of Signature: