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										
2										
3										
4										
5										
6										
7										
8										
9										
10										

Comments Section

Session Notes

Use for Notes in regard to Session Information and Description.

Include all applicable notes for each service rendered.

1	
2	
3	
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9	
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Direct Medical Services and Health Evaluations

Session Number	Nursing Assessment/ Evaluation (T1001)		RN Services (T1002)												Personal Care Services (T1019)		LPN/LVN Services (T1003)	
	Nursing assessment/ evaluation		Nutrition Management	Blood Pressure Monitoring	Blood Sugar Monitoring	Catheterization	Chest Physiotherapy	Gastrostomy Tube Feeding	Medication Administration	Ostomy Care	Pain Management	Peak Flow Monitoring	Seizure Management	Tracheostomy	Ventilators	1:1 service during school day	1:1 service during transportation	Snack Administration	Transfers/ Ambulating
1																			
2																			
3																			
4																			
5																			
6																			
7																			
8																			
9																			
10																			

Non-Billable Services

Session Number	Student not present	Service Provider not present	Other
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

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.

1	
2	
3	
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6	
7	
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9	
10	

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: