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:*			Session Notes Use for Notes in regard to Session Information and Description. Include all applicable notes for each service rendered.	
			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											1	
2											2	
3											3	
4											4	
5											5	
6											6	
7											7	
8											8	
9											9	
10											10	

Direct Medical Services and Health Evaluations

	Evaluation for Occupational Therapy **(97165)**	Measurement of Range of Motion **(95851)**	Self-Care or Home Management **(97535)**	OT using exercise to develop strength, endurance, range of motion and flexibility **(97110)**			Neuromuscular Reeducation **(97112)**		Therapy Procedure in a Group Setting **(97150)**		Community/Work Reintegration Training, Individual, 15 minutes **(97537)**	OT Activities, Individual, use of dynamic activities to improve functional perf. **(97530)**		Assistive Technology Assessment **(97755)**	OT Sensory Integrative Techniques - Individual **(97533)**			**Non-Billable Services**			**Comments Section**	
Session Number	OT Evaluation	Range of motion measurements/evaluation	Activities of Daily Living	Developmental	Handwriting Skills	Fine Motor Skills	Feeding/Oral Motor Training	Neuromuscular Development	Social Skills	Other	Prevocational	Organizational Skills	Play Skills	Technological Use/Support - Student present	Visual Motor	Visual Perceptual	Sensorimotor	Student not present	Service Provider not present	Other	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																					1	
2																					2	
3																					3	
4																					4	
5																					5	
6																					6	
7																					7	
8																					8	
9																					9	
10																					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: