Rhode Island Early Intervention
Rhode Island Vision Specialists

Child's Last Name _____ **Child's First Name** _____ **MI** _____ **DOB:** _____/_____/_____

Parent's Full Name _____ **Child ID#:** _____

Service Date: _____/_____/____ **Service Coordinator:** _____ **EI Program** _____

Cancellation:	**Visit Participants:**	**Service Location:**	
❑ No Show		❑ H (Home)	❑ CB (Center Based)
❑ Cancel/Family Issue		❑ C (Community)	❑ EIGC.(EI Group in the Community
❑ Provider Cancel			❑ N/A (Not Applicable)

Outcomes addressed:

_____

Describe new skills, progress the child has made, or any updates from the family:

_____

_____

Visit description: ***Describe interaction between provider, parent(s)/caregiver(s) and child. Include observations, modeling, coaching and discussion highlights.***

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What will the parent(s)/caregiver(s) and/or EI provider will do in between visits?

_____

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_____

Plan for next session:

_____

_____

Provider/Signature	**Date:**	**Service Code:**	**Minutes:**
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____

NEXT VISIT: _____

TIME: _____