

Note Type: ☐ Weekly / Date Range: From _____ through _____

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|---|------------------|---|--------------|---|----------------------|---|-------|---|---|---|--|
| Organization Name: | | | | | Program Name: | | | | | | |
| Individual's Name (First / MI / Last): | | | | | | Record #: | | | DOB: | | |
| OASAS - Attendance Note | | | | | | | | | | | |
| Day | Duration | Type of Outpatient Rehabilitation Service (ORS) | | | | Base Service (Check One) | | | | | |
| Monday | | <input type="checkbox"/> Full Day (4+ Hours) | | <input type="checkbox"/> Partial Day (2-4 hours) | | <input type="checkbox"/> Individual (= or > 25 min.) | | | <input type="checkbox"/> Group (= or > 60 min.) | | |
| Tuesday | | <input type="checkbox"/> Full Day (4+ Hours) | | <input type="checkbox"/> Partial Day (2-4 hours) | | <input type="checkbox"/> Individual (= or > 25 min.) | | | <input type="checkbox"/> Group (= or > 60 min.) | | |
| Wednesday | | <input type="checkbox"/> Full Day (4+ Hours) | | <input type="checkbox"/> Partial Day (2-4 hours) | | <input type="checkbox"/> Individual (= or > 25 min.) | | | <input type="checkbox"/> Group (= or > 60 min.) | | |
| Thursday | | <input type="checkbox"/> Full Day (4+ Hours) | | <input type="checkbox"/> Partial Day (2-4 hours) | | <input type="checkbox"/> Individual (= or > 25 min.) | | | <input type="checkbox"/> Group (= or > 60 min.) | | |
| Friday | | <input type="checkbox"/> Full Day (4+ H) | | <input type="checkbox"/> Partial Day (2-4 hours) | | <input type="checkbox"/> Individual (= or > 25 min.) | | | <input type="checkbox"/> Group (= or > 60 min.) | | |
| Goal(s)/Objective(s) Addressed As Per Individual's Individualized Action Plan: Yes <input type="checkbox"/> / No <input type="checkbox"/> | | | | | | | | | | | |
| Goal ____ Objective ____ Objective ____ Objective ____ Objective ____ | | Goal ____ Objective ____ Objective ____ Objective ____ Objective ____ | | Goal ____ Objective ____ Objective ____ Objective ____ Objective ____ | | Goal ____ Objective ____ Objective ____ Objective ____ Objective ____ | | Goal ____ Objective ____ Objective ____ Objective ____ Objective ____ | | Goal ____ Objective ____ Objective ____ Objective ____ Objective ____ | |
| Summary of Services/ Interventions Provided During This Period: | | | | | | | | | | | |
| Response to Services, including a chronology of the individual's participation in services/ Intervention(s), and Progress Toward Goals and Objectives: | | | | | | | | | | | |
| Plan / Additional Information: | | | | | | | | | | | |
| Individual's Signature (Optional): | | | | | | | | | | Date: | |
| Completed By - Print Staff Name/Credentials: | | | | | | Staff Signature: | | | | Date: | |
| Supervisor - Print Name/Credentials (if applicable): | | | | | | Supervisor Signature: | | | | Date: | |
| Date of Service | Staff Identifier | Loc. Code | Service Code | Mod 1 | Mod 2 | Mod 3 | Mod 4 | Start Time | Stop Time | Duration in Minutes | |
| | | | | | | | | | | | |