Provider Documentation Guidance and Expectations

In the medical world, if the service was not documented, it did not take place. When documenting the service, providers should ensure that these 5 questions are addressed in the documentation:

◆ Why did the student present for service/treatment?
◆ What kind of treatment did student receive?
◆ What was observed during the service/treatment?
◆ What was the outcome of the service/treatment?
◆ Is follow-up needed?

Relate documentation to goals and objectives in the IEP.

Format for Documentation

→ SOAP Format
  ◆ Subjective, Objective, Assessment, Plan
→ DAR Format
  ◆ Data, Action, Response

Notes can be written in a narrative paragraph. It is the provider’s professional responsibility to make sure that the note has sufficient specific detail and is well-written.

Examples of bad documentation as well as examples of good documentation should be studied carefully and always available to reference as you complete your services. Both types of examples follow on page 2.

Examples of Bad Documentation

→ OT – “FM/HW initials traced & copied”
→ PT – “balance and reaching for toy”
→ SLP – “instructions with prepositions”
→ SW/PSY – “anger management”
→ Nursing – “post seizure care”

Examples of Good Documentation

→ OT - “Fine motor/handwriting exercise. Traced initials 12X with 90% accuracy. Copied initials 18X, T legible, C is not. Will continue to work with student.”
→ PT - “Worked on standing balance by taking steps to the R & L to reach for a toy with minimal assistance. Able to ambulate 200’ by holding hands.”
→ SLP - “2-step instructions with prepositions: with in front of, behind, between, under, on top of, next to, with 80% accuracy.”
→ SW/PSY - “Anger management group. Focused on de-escalation techniques. Very agitated and unable to focus and participate.”
→ Nursing - “Emergency skilled nursing services required for post grand mal seizure observation. Teacher reported ... Moved to nurse’s office for observation. (Assessment). Home with mom at 13:10.”