

Clinic/Hospital: _____ Phone: _____ Fax: _____ Email: _____

Physicians I am referring this child for EI evaluation: Health Information, EI Medical Necessity Authorization & PT Prescription below.

NOTE: If you want to send us your own Health Form instead, simply attach to this page. Please fill in the information at top, add child's name/DOB, note "Medical Necessity Authorization for EI" below and sign at bottom

Check if parents are aware of referral. Note best time to reach them _____.

Parent signature below indicates their consent for the release of information to referrer about status of referral

Parent Signature: _____ Date: _____

Philadelphia Infant Toddler Early Intervention (EI) REFERRAL

PLEASE PRINT

Child (First, Last): _____ Male Female Date of Birth: _____

Address: _____ Zip Code: _____ MA #: _____

SSN (Last 4 Digits): XXX-XX-_____

Parent/Guardian (First, Last): _____ Best Phone #: _____

Primary Language: _____ Check if Interpreter is needed Alternate Phone #: _____

Send to: Philadelphia Infant Toddler Early Intervention

701 Market Street, Suite 5200, Philadelphia, PA, 19106 Birthto3EI@phila.gov Phone: (215) 685 - 4646 Fax: (215) 685 - 4638

Health Appraisal (Requesting Information Pertinent to Developmental Needs)

- Was ASQ done? Yes No If yes, attach score summary sheet.
- Developmental Concerns: Clinical Obs. Parent Report Screening Test (_____) Diagnoses: _____ ICD Code: _____
- Related Concerns (birth/medical history, neurological findings/ton, nutrition/growth, obesity, recommended follow-up for concerns)
- Precautions/Contra-indications/Emergencies (allergies, asthma, diabetes, seizure, equipment)
- Immunizations complete for age? Yes No Was child premature? Yes No
- Medications (impact on diet/ activities)?

Medical Necessity Authorization for EI Services and Prescription for Physical Therapy

I authorize Early Intervention (EI) for this child which will include

- Evaluation services such as developmental screening, Multi Disciplinary Evaluation (MDE)
- Service Coordination, At-Risk Monitoring if eligible
- Developmental therapies/services identified on child's Individualized Family Service Plan (IFSP), based on child's EI eligibility as determined by MDE

Early Intervention services will be individually determined by the EI team (which includes the family) and written consent on the IFSP. The IFSP and the child's continuing need for specific EI services will be re-evaluated as needed, at least quarterly and annually.

I prescribe Physical Therapy. If (✓) checked, provide as indicated by child's MDE/IFSP

Prescription effective from ____/____/____ until the child's 3rd birthday or until EI team assessment determines these EI services are no longer needed.

(EI intake will add date of child's initial EI intake call with parents)

Physician Check (✓) All concerns that apply

- | | | |
|--|---|--|
| <input type="checkbox"/> Low Birth Weight (_____lb/gr _____ hosp) | <input type="checkbox"/> Cognitive development/ Skill Acquisition | <input type="checkbox"/> Physical development |
| <input type="checkbox"/> NICU Care (Hosp: _____) | <input type="checkbox"/> Communication/language/speech | <input type="checkbox"/> Sensory Status/Neurological |
| <input type="checkbox"/> Chemical dependence/SA (mother/prenatal) | <input type="checkbox"/> General Development | <input type="checkbox"/> Social/Emotional/Behavioral |
| <input type="checkbox"/> Confirmed abuse/neglect | <input type="checkbox"/> Medical diagnosis/condition | |
| <input type="checkbox"/> Elevated blood lead level (_____) | Specify _____ | |
| <input type="checkbox"/> Experiencing Homelessness | | |

Check any areas that may need further evaluation:

Hearing Note: Did child pass PA Newborn Hearing Screening Test (Yes No Inconclusive)

Feeding/Nutrition concerns Fine Motor Gross Motor Vision

Today's Date:	Date of Next Appointment:	Physician's Name:	(Stamp: Name, Address, Lic. #)
Most Recent Exam Date:		Signature:	
		Check if PCP: <input type="checkbox"/>	