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

☐ Low Birth Weight (_____lb/gr _____ hosp)
☐ NICU Care (Hosp: _____)
☐ Chemical dependence/SA (mother/prenatal)
☐ Confirmed abuse/neglect
☐ Elevated blood lead level (_____)
☐ Experiencing Homelessness

☐ Cognitive development/ Skill Acquisition
☐ Communication/language/speech
☐ General Development
☐ Medical diagnosis/condition
Specify_____

☐ Physical development
☐ Sensory Status/Neurological
☐ Social/Emotional/Behavioral

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: Most Recent Exam Date:	Date of Next Appointment:	Physician's Name: Signature: Check if PCP: ___	(Stamp: Name, Address, Lic. #)