Clinic/Hospital: ______________________________ **Phone:** ________________________ **Fax:** _____________________ **Email:** ______________________

Physicians ☐ **I am referring this child for EI evaluation: Health Information & EI 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 "Prescription for EI" below and sign at bottom

☐ **Check if parents are aware of referral.** Note best time to reach them _______________.

☐ Parent consent to release information to referrer (including status of referral, evaluation, IFSP)
Parent Signature: ____________________________________ Date: __________________

Infant Toddler EI REFERRAL

Child (First, Last): ____________________________________ **Male** __ **Female** __ **Date of Birth:** ________________________
Address: ______________________________ **Zip Code:** _________________________ **MA #:** _______________________________
Parent/Guardian (First, Last): ____________________________________ **Phone #:** ____________________________
Primary Language: ______________________________ ☐ Check if Interpreter is needed **Alternate Phone #:** ___________________

Return to: Philadelphia Infant Toddler Early Intervention
701 Market Street, Philadelphia, PA, 19106 Birthto3EI@phila.gov Phone: (215) 685- 4646 Fax: (215) 685 - 4638

Health Appraisal (requesting: Information Pertinent to Developmental Needs)

- **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)?**

Prescription for EI Services and EI Therapies

I prescribe 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
- Physical Therapy if 1) checked and 2) only as indicated by child's MDE/IFSP (√)

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.
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: ______________)
☐ Confirmed abuse/neglect
☐ Elevated blood lead level (________)
☐ Chemical dependence/SA (mother/prenatal)

☐ Sensory Status/Neurological
☐ General Developmental Check
☐ Communication/language/speech
☐ Social/Emotional/Behavioral

☐ Medical diagnosis/condition
☐ Physical development
☐ Cognitive development/ Skill Acquisition

Check any areas that may need further evaluation:

___ Hearing Note: Did child pass PA Newborn Hearing Screening Test (___ Yes ___ No ___ Inconclusive)
___ Gross Motor ___ Fine Motor ___ Vision ___ Feeding/Nutrition concerns

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