Contact for Health Info: **Phone:**
Clinic/Hospital: **Fax:**

(Physicians) [√] **I am referring this child for ChildLink EI evaluation. Health Information & EI prescription below.**

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

[ ] **Check if parents are aware that you are referring. Note best time to reach them** _______________
[ ] **Check if you would like to be sent a summary of the results of the Multi-Disciplinary Evaluation**

City of Philadelphia – DBH/IdS
Early Intervention

EI REFERRAL for:

(service coordinator check)
Initial ___ Annual ___

Child: ________________________________ **Birth Date:** ______________
Address: ________________________________ **Zip** ______ **ChildLink #** ______________
Parent/Guardian ________________________________ **Phone #** ______________

Primary Language ________________ **Check if interpreter needed** [ ]
ChildLink Service Coordinator: **Phone #**

return to: CHILDLINK
PHMC/ChildLink, 260 S. Broad Street, 18th floor Philadelphia, PA 19102 Phone: (215) 731-2100 Fax: (215) 731-2025

HEALTH APPRAISAL

(requesting: Information Pertinent to Developmental Needs)

Developmental Concerns ___ Clinical Observ. ___ Parent Report ___ Screening Test (_____) **Diagnoses:**_________ ICD code (____)

[ ] **Check if attaching dev'l information/report**

Related Concerns (birth/medical history, neurological findings/ton, nutrition/growth, obesity, recommended follow-up on health concerns)

[ ] **Check if writing add'l information on back**

Precautions/Contra-indications/Emergencies (allergies, asthma, diabetes, seizure, equipment)

Immunizations complete for Age? **Yes__** **No__** **Was child prematur**e? Yes __ **No __** # wks ______

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 Services Plan (IFSP), based on child's EI eligibility as determined by MDE
- Physical Therapy if checked (√) (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 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 ___/___/___ (ChildLink will add date of child's initial EI intake call to ChildLink) **until child's 3rd birthday, or until early intervention team assessment determines these EI services are no longer needed.**

PHYSICIAN CHECK (√) ALL CONCERNS THAT APPLY

[ ] Low birth weight (_____ lb/gr _________hosp)	[ ] Sensory status/Neurological	[ ] Medical diagnosis/condition
[ ] NICU care (Hosp: ________________)	[ ] General developmental check	[ ] Physical development
[ ] Confirmed abuse/neglect	[ ] Communications/language/speech	[ ] Cognitive development/skill acquisition
[ ] Elevated blood lead level ( )	[ ] Social/Emotional/Behavioral	
[ ] Chemical dependence/SA (mother/prenatal)		

Also check any AREAS THAT MAY NEED FURTHER EVALUATION:

____ Hearing **NOTE: Did child pass PA Newborn Hearing Screening Test** (No _____ Yes ____ Inconclusive ____)

____ Gross Motor ____ Fine Motor ____ Vision _____ Feeding/Nutrition concerns

Today's Date **Most Recent Exam Date**	**Date of Next appointment**	**Physician Name:** **Signature:** **Check if PCP** ___	**(stamp: name, address phone, license #)**