

**PHYSICIAN'S RECOMMENDATION for ASSESSMENT / EVALUATION**



**Patient Name:**

**Today's Date:**

**Patient's DOB:**

**Patient's Diagnosis:**

**Is Referred to:**

**Name of Provider:** Infant Toddler Program

**Attention Service Coordinator:**

**Address:**

**Phone:**

**FAX:**

For the following medically necessary early intervention assessments/evaluations:

Occupational Therapy

Physical Therapy

Audiology

Speech/Language

Oral and Pharyngeal Swallowing Function

Developmental

Other (Please list here):

Anticipated Outcome:

**PHYSICIAN INFORMATION**

**Physician Organization Name:**

**Physician's Printed Name:**

**Phone:**

**FAX:**

**Physician's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**DURATION OF PHYSICIAN'S RECOMMENDATION FOR ASSESSMENT(S)/EVALUATION(S):**