NYC EARLY INTERVENTION PROGRAM
REQUEST FOR PRESCRIPTION FOR SERVICES

Child's Name: _____ DOB: _____
EI #: _____ Date: _____

Dear Physician/Nurse Practitioner,

At the request of the parent, we are writing to inform you that your patient has been found eligible for the NYC Early Intervention Program (NYCEIP). The NYC Early Intervention Program provides educational and therapeutic services to children with developmental delays and disabilities and supports families/caregivers, using everyday routines to promote development.

The NYC EIP staff met with the family on (date) _____, and discussed the parents' concerns, priorities and resources in order to develop the Early Intervention Individualized Family Service Plan (IFSP).

Based on the IFSP meeting, your patient will receive the following services:

Speech Therapy: _____ (per week / month)
*Occupational Therapy: _____ (per week / month)
*Physical Therapy: _____ (per week / month)
*Feeding Therapy _____ (per week / month)
Special Education: _____ (per week / month)
Other: _____ (per week / month)

* Based on the New York State Practice Acts, Occupational Therapy (OT), Physical Therapy (PT), and Nursing services require a prescription. The prescription can specify the above frequency or say "As per the IFSP." A separate prescription is needed for OT and PT services. Please attach a prescription if you agree with the plan.

Are there any medical concerns about this child participating in a therapy program? If yes, please let us know of the limitations of his/her participation, (e.g., cardiac or respiratory disease, etc.).

☐ There are no restrictions ☐ There are restrictions **(Attach specific medical clearance)**

The service plan will be reviewed by the NYCEIP every six (6) months and adjustments to the plan will be made based on the child's progress. With parent permission, please keep us updated on any medical information or diagnoses that may impact his/her interventions within the NYCEIP.

If there are any questions about this request, please contact me at the below number/address:

Provider Contact (print name): _____ Title: _____
Address: _____
Phone: _____Fax: _____
Email (optional):_____
Signature: _____