

Prescription Request

Child’s Name:

Date of Birth: EI #:

Dear

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 above named child is in need of the following services

|  |  |  |
| --- | --- | --- |
| **Discipline** | **Frequency** | **Effective Date** |
| Occupational Therapy |  |  |
| Physical Therapy |  |  |
| Feeding Therapy |  |  |
| Speech Therapy |  |  |
| Other |  |  |

ICD-10 Code: \_\_

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.

□ There are no restrictions.

□ There are restrictions (please attach specific medical clearance).

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Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s address and phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Physician’s signature/stamp