

PHYSICIAN'S ORDER  
FOR  
EVALUATIONS



**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:**

Requesting authorization for the following early intervention evaluations:

Occupational Therapy

Physical Therapy

Audiology

Speech/Language

Oral and Pharyngeal Swallowing Function

Developmental

Other (Please list here):

Anticipated Outcome:

**Referring Physician Information:**

**Provider Organization Name:**

**Provider's Printed Name:**

**Phone:**

**FAX:**

**Provider's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

(Must be physician or practitioner of the healing arts)

**\*DURATION OF PHYSICIAN'S ORDER:**

\*Orders must be updated every 6 months from the date of the physician's signature.

A copy of all evaluation reports and Individual Family Service Plan (IFSP) Summary of Services page will be sent to Physician.