Central Directory: 1 (800 234-1448
TTY/TTD 1(804) 771-5877

Infant & Toddler Connection of [Local System]

[Address]
[Address]
[City], Virginia [Zip]
[Phone (000) 000-0000]

Date:

Physician Name
Address
City, State, Zip Code

RE: ____ ________________
Child's Name Date of Birth

Dear Dr. ___________________:

A copy of the Individualized Family Service Plan (IFSP) developed for this child is attached. The following services recommended by the IFSP team require certification that they are medically necessary:

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Developmental Services
☐ Other (please specify: ____)

Please indicate your agreement with these IFSP services by signing and recording the date in the space provided.

I certify and approve that the services recommended above are medically necessary for this child. I have reviewed and agree with the attached IFSP.

____ ______________________

Physician Signature **Date**

Health Status Indicators
As the Medical Home/primary care provider for this child, please provide answers to the following questions so we can collaborate with you to promote the child's healthy development.

<u>Health Status Indicator Questions</u>

1. Is this child up to date (per CDC/ACIP guidelines for this year) on immunizations? __ Yes ___ No
2. What is the date of this child's most recent visit with you? ____/____/____.
3. What is the date of the most recent well child visit? ____/____/____.
4. What month/year should this child see you for the next well-child visit? ____/____.
5. Are there immunizations needed at time of next visit? ___Yes ____No
6. Does the child's record have any lead testing (either capillary or venous) results? ____ yes ____ no If yes, date service provided ____/____/____ and testing results: ___normal ___elevated

Please return this completed form to the address or fax number listed below.

Thank you,

____

Name/Title

Name, address, city/state/zip code, fax number