Infant & Toddler Connection of Virginia

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.

Health Status Indicator Questions

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