To be faxed to the Medical Home at completion of child's assessment

EARLY INTERVENTION FEEDBACK TO THE MEDICAL HOME

To be completed by the Medical Home

Child's Name_____ Medical Home/PCP: Benson Area Medical Center Fax: 919-894-7645

Child's DOB _____Parent /Guardian_____

Address _____Phone: _____

CDSA/Preschool Contact: _____Phone:_____

Date of referral (CDSA)/date of notification (preschool program)_____

To be completed by the CDSA

Why the medical home referred?

At-risk score(s):

- ○ ASQ/PEDS
- ○ MCHAT
- ○ ASQ-SE

Established Condition
(Specify below):

- ○ Congenital Anomaly/Genetic Disorder/Inborn Errors of Metabolism
- ○ TORCH (Congenital Infections)
- ○ Autism
- ○ Reactive Attachment Deprivation/Maltreatment Disorder of Infancy
- ○ Hearing Loss
- ○ Visual Impairment
- ○ Neurologic Disease
- ○ Neonatal Conditions (<27 weeks, ELBW, IVH, seizures, stroke, meningitis, etc.

Parent Concern_____

Entry Evaluation Date:_____

To be completed by the EC Preschool Program

Why the medical home sent the notification?

At-risk score(s):

- ○ ASQ/PEDS
- ○ MCHAT
- ○ ASQ-SE

Condition that adversely impacts educational performance.
(Specify below):

- ○ Speech and Language Impairment
- ○ Developmental Delay/Atypical Behavior
- ○ Autism
- ○ ADHD
- ○ Orthopedically Impairment
- ○ Visually Impairment
- ○ Hearing Impairment
- ○ Other

School System Screening date:_____

***CDSA/EC Preschool Program - results from above**: (check all that apply)*

_____ Eligible (based on): _____

_____ Ineligible (note reason): _____

_____ *No Evaluation Done: Parent unreachable*_____, *Did Not Keep Appointment*_____, *Declined Services*_____

Services on IFSP_____ or IEP_____:

- ○ Service coordination (IFSP)
- ○ Specialized Instruction on the IFSP or IEP
- ○ Speech and Language Therapy
- ○ Physical Therapy (PT)
- ○ Occupational Therapy (OT)
- ○ Other (specify)_____

Recommended additional community services:

- ○ CC4C
- ○ Family Support Network (FSN)
- ○ Head Start
- ○ NC PreK Program
- ○ Parents as Teachers
- ○ Other (specify):_____