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