**NYC**

Health **NYC EARLY INTERVENTION PROGRAM**

**REQUEST FOR SUPPLEMENTAL EVALUATION**

Child’s EI ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Child’s DOB:\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

Name of Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Last First MI*

Name of SC: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SC ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone#: (718) 882-2111 ext. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax: (718) 882-2117

Dear Early Intervention Official Designee:

I am requesting the following supplemental evaluation (one request per form):

( ) Audiological ( ) Occupational Therapy ( ) Psychological

( ) Special Instruction ( ) Physical Therapy ( ) Speech Therapy

( ) Other (specify):

I give consent to the use of the above evaluation to plan for my child’s services within NYC Early Intervention Program.

I understand that I will be involved in all aspects of my child’s evaluations and IFSP planning and that I am entitled to receive the results of all evaluations.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_

Signature of Parent/Guardian

***Parent Reason for Request (When request is not being made by the interventionist on the child’s Team, please write below)***

NYC BEI Request for Supplemental Evaluation 10/24