



DATE ____/____/____

Dear Dr. _____,

Your patient, _____,

Date of Birth _____/_____/_____,

Social Security Number _____-_____-_____,

and his/her family are being served by Alabama's Early Intervention System(AEIS). Each family develops an Individualized Family Service Plan, or IFSP, with other members of the eligible child's team. We welcome your input in the team's planning process. In addition to AEIS service coordination, the following services have been identified by family need and by other members of the multidisciplinary evaluation team:

- | | | |
|---|--|---|
| <input type="checkbox"/> Assistive Technology | <input type="checkbox"/> Family training/counseling | <input type="checkbox"/> Audiology |
| <input type="checkbox"/> Health Services | <input type="checkbox"/> Medical Services for Evaluation | <input type="checkbox"/> Nursing |
| <input type="checkbox"/> Nutrition Services | <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Psychological Services | <input type="checkbox"/> Social Work Services | <input type="checkbox"/> Vision |
| <input type="checkbox"/> Special Instruction | <input type="checkbox"/> Speech/Language Therapy | <input type="checkbox"/> Other(see below) |

In today's Individualized Family Service Plan meeting, the team also decided

Please contact me if you have any questions or if I can be of service.

AEIS Service Coordinator

PHONE (____) _____

El Service Coordinator: This form and current Permission to Release must be on file

A Division of the Alabama Department of Rehabilitation Services