Eliot Early Intervention Program
Intake Form

Client ID #:	**Assessment Date and Time:**	**Referral Source:**
Date of Call/Referral:	**IFSP Date and Time:**	**PCP:**
Client Name:	**Interviewer(s):**	
Client Social Security Number:	**Client Address:**	**Phone Number(s):**
Gender: Male Female	**Family Service Requests/Constraints:**	**Primary Language:**
Date of Birth: Current Age:	**Guardian Name:**	**Secondary Language:**
	Guardian Address:	
Primary Insurance Provider: **Secondary Insurance Provider:** ****Copy of Insurance card required (front and back)**	**Insurance Card Number:** **MMIS #:** **Policy #:**	**Subscriber Name:**

Has client ever been in another EI Program? Yes/No?

If YES: If yes, when and where? Please specify state and dates in program. Please include dates/copies of the latest Assessment and Individual Family Service Plan as well.

Briefly state reason for referral:

Scores: Battelle

Adaptive _____ Personal-social_____ Communication _____ Motor _____

Cognition _____BDI-2 Total _____ ASQ/SE _____ Clinical Judgment based on _____

Service Coordinator_____ Date Assigned _____

Report Writer _____

DIAGNOSIS DSM IV: **AXIS I:_____CODE:_____** **Staff name and ID number: _____**	**Please fax referral to 781-393-6554. If you have any questions please call the Intake line at 781-306-4820.**