The Arc
Alliance Children's Services

PHYSICIAN PRESCRIPTION

CHILD'S NAME: _____ SERVICES EFFECTIVE DATE: _____

The above child is currently eligible for Early Intervention Services, in the area of feeding/oral motor.

In order for The Arc Alliance Children's Services to complete the delivery of this service a medical clearance must be completed in its entirety and signed by the child's physician. Please check all those items that apply to your patient.

1. This child is at risk for Respiratory Distress. YES or NO *(please circle)*

2. This child is at risk for Aspiration for any oral feeds. YES or NO *(please circle)*
   Please describe: _____
   _____

3. This child's primary method of nutrition is: *(please check)*
   Full Diet ___ Other ___ Supplemental Diet ___ IV Fluids ___ J Tube ___ G Tube ___ Peg Tube ___

   Please describe reasons for supplemental feeds and frequency of feeds:
   _____
   _____

4. Consistency or textures that are safe for this child:
   _____
   _____

5. Safety precautions for this child:
   _____
   _____

6. The child has anomalies that would prevent non-nutritive. YES or NO *(please circle)*

PHYSICIAN'S SIGNATURE: _____ DATE: _____

Print Physician's Name: _____

(PLEASE NOTE: Only a licensed physician can sign this form. The signature of a nurse practitioner cannot be accepted.)