

# Chester County EI Consultation Form

## Section 1 – Request for Consultation:

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Service Coordinator: \_\_\_\_\_  
Date of Request: \_\_\_\_\_ Date Faxed to Coordinator: \_\_\_\_\_  
EI team member requesting: \_\_\_\_\_ Agency/Discipline: \_\_\_\_\_  
Contact number: \_\_\_\_\_ Day/time of regular visit: \_\_\_\_\_  
Funding Source: MA      Waiver      County/Base  
Scheduling considerations: \_\_\_\_\_

Type of Consult requested: Communication    Motor    Sensory    Cognitive/Play Feeding  
Other: \_\_\_\_\_  
(please check which applies )

Can this agency provide this type of consultation? : YES      NO  
Which Discipline can provide the consultation? : OT    PT    ST    Special Instructor

Reason for Consultation/Information requested-

Date faxed to Service coordinator: \_\_\_\_\_

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## Section 2- to be completed at time of Consultation

Date of Consultation: \_\_\_\_\_ Person Completing Consultation: \_\_\_\_\_

Location of consult: \_\_\_\_\_ Agency: \_\_\_\_\_ Discipline: \_\_\_\_\_

Participants: \_\_\_\_\_

Additional/New Strategies/Suggestions for the Team:

\_ Please use back of page as needed

\*\*\*Session sheet with parent/caregiver signature must accompany this form when completed.

