NORTH HILLS SERVICES
CHILDREN'S DEVELOPMENTAL CENTER
207 FRED RAINS DRIVE
SHERWOOD, AR 72120
(501) 834-0217 OFFICE
(501) 833-0957 FAX

EPSDT/ PHYSICIAN MEDICAL INFORMATION

COMPLETE PHYSICAL REQUIRED

Before Habilitation and/or therapy services can be conducted the following information must be completed:

Date of Examination: _____
Name of Patient: _____ DOB: _____

_____
Primary Care Physician: _____Telephone:_____
Attending Physician:_____

Patient's Present Height:_____Weight:_____

Please indicate below if normal or abnormal by check mark:

	NORMAL	ABNORMAL
VISION		
HEARING		
SMELL		
TASTE		
TOUCH		
MOUTH, PALATE, THROAT		
TEETH		
NECK		
REFLEXES		
HEART		
LUNGS		
GENITALIA		
NEUROLOGICAL		
LYMPH NODES		
SKIN AND SCALP		
BLOOD		
URINE		
ABDOMEN		

If any of the above are abnormal, please explain:_____
_____
_____

Present health status: (general vitality, frequency and type of illness, allergies, convulsions etc)_____

When was the last time you saw this patient and for what reason? _____
_____
_____

Before habilitation or therapy services can be conducted the following information must be completed:

Please give a statement regarding diagnosis of Disability (ies), Handicap(s) and probable cause.

_____
_____

Has this child been diagnosed as having Cerebral Palsy, Epilepsy or Autism? _____
_____

Please designate. _____
_____

If the patient has ever had a seizure or there is current seizure activity, please give type and the medications needed. _____
_____
_____

Are there any precautions to be taken with this child? _____Yes _____
_____No
Please explain._____
_____

Do you believe this child is capable of participation in the program offered by NORTH HILLS SERVICES Birth – 5 year Preschool Program (8:00 a.m. – 3:00 p.m.) _____
_____Yes _____No

If no, please explain. _____
_____

Was an EPSDT conducted on this child today? _____Yes _____No
If not, indicate the last date one was completed:_____
_____

Please check the services for which you are referring this child.

_____Speech Eval/Therapy___Occupational Eval/Therapy _____Physical Eval/Therapy

_____Day Habilitation Training (Preschool services/Classroom instruction)

_____Targeted Case Management__Developmental Evaluation

_____

Prescription/Order from Physician for habilitation and/or therapy services and other services:

Please give any additional information you feel would be beneficial in helping our program at North Hills Children's Developmental Center most appropriately supply services to this particular child and family. List specifically speech, occupational and physical therapy order for the child to receive these therapies.

I certify that this child is medically needy of Preschool services.

_____

Signature of Physician

Arkansas Division of Medical Services

Occupational, Physical and Speech Therapy for Medicaid Eligible Beneficiaries Under Age 21
PRESCRIPTION/REFERRAL

The PCP or attending physician must use this form to prescribe medically necessary Medicaid therapy services or must use this form to make a referral for therapy services. The provider must check the appropriate box or boxes.

☐ Referral ☐ Treatment

EVALUATE/TREAT IS NOT A VALID PRESCRIPTION

Patient Name: _____ Medicaid ID #: _____

Date Child Was Last Seen In Office: _____

Primary Diagnosis or ICD-9 code: _____

Diagnosis as Related to Prescribed Treatment: _____

_____

_____

Complete this block if this form is a prescription		
Occupational Therapy (OT)	**Physical Therapy (PT)**	**Speech Therapy (ST)**
_____Minutes per week	_____Minutes per week	_____Minutes per week
_____Duration (months)	_____Duration (months)	_____Duration (months)
☐ Therapy Not Medically Necessary	☐ Therapy Not Medically Necessary	☐ Therapy Not Medically Necessary

Other Information: _____

_____

Note:

	OT	***PT***	***ST***
Expenditures for SFY12	****$36,228,982***	****$27,285,874***	****$58,703,120***
Average Units Per Beneficiary	***85.19***	***80.00***	***95.00***
Average Cost Per Beneficiary	***$1,732***	***$1,614***	***$1,872***
Total Beneficiaries Served	***20,912***	***16,910***	***31,363***

_____ _____

Primary Care Physician (PCP) Name *(Please Print)* Provider ID Number/Taxonomy Code

_____ _____

Attending Physician Name *(Please Print)* Provider ID Number/Taxonomy Code

By signing as the PCP or Attending Physician, I hereby certify that I have carefully reviewed each element of the therapy treatment plan, that the goals are reasonable and appropriate for this patient, and in the event that this prescription is for a continuing plan I have reviewed the patients progress and adjusted the plan for his or her meeting or failure to meet the plan goals.

Physician Signature *(PCP or attending Physician)* Date

DMS-640 (Rev. 09/12)