INFANT LEARNING PROGRAM
213 Third Street ♦ Juneau, Alaska 99801 ♦ (907) 586-8228 ♦ Fax 1-907-782-4191 ♦ www.reachak.org

Referral from Medical Provider

Referred By: _____
Name Agency Phone

Today's Date: _____ ☐ **MEDICAL RECORDS INCLUDED**

Child Name (First, Middle, and Last)	**Child's DOB:**	**Gender:** ☐ **Female** ☐ **Male**
Primary Language in Home:	**Race:** ☐ White ☐ Hispanic ☐ African American ☐ Asian ☐ Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native	
Living Situation: ☐ Living with family ☐ CPS Living with family ☐ CPS Foster Care ☐ Homeless ☐ Unknown ☐ Other: _____		
Parent/Guardian Name(s):	**Parent/Guardian Relationship to Child:** ☐ Mother ☐ Father ☐ Foster Parent ☐ Grandparent ☐ CPS ☐ Other: _____	
Address: ☐**resides** ☐ **mailing**	**Phone Numbers:** Home: _____ Work: _____ Cell: _____ Other: _____	

Referral Reason: _____

_____

_____

Prescription for Infant Learning Program Assessment

Dx code(s): _____

Therapy services:
- ☐ Physical therapy
- ☐ Occupational therapy
- ☐ Speech/Language therapy

Recommendations:
- ☐ Assessment

Signature: _____

NPI #: _____

For ILP Office Use Only
Referral received by: _____ Referral Date: _____ 45 Day Timeline: _____