**Notification of First Session Form**

Name of Therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Discipline: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_EI #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorized begin date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency of Services:\_\_\_\_\_\_\_\_\_\_\_\_\_

First Start Date of Service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Start Date of Family Training (is applicable):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If services did not begin within five (5) days from assignment, please check off reason

(must choose one):

\_\_\_ Family Problem Scheduling Appointment (please indicate dates you attempted to reach family)

1st Attempt: \_\_\_\_\_\_\_\_\_\_\_\_ 2nd Attempt: \_\_\_\_\_\_\_\_\_\_\_\_ 3rd Attempt: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Family missed/cancelled appointment

\_\_\_ Family delayed response/consent for appointment

\_\_\_ Weather/Other emergency reason(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Provider scheduling does not match parent schedule (need to re-staff)

Therapist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Once competed and signed, please fax or mail to Amerimed EIP.**

**Fax: 718-339-7203**

**If form is not received within (10) days of your assignment, case will be reassigned.**