Early Childhood Intervention Physician Referral and Feedback

Locate a local ECI program at <u>http://www.dars.state.tx.us/ecis/searchprogram.asp</u>. If more than one program serves the family's zip code, send the referral to any of them and it will be forwarded to the appropriate program.

Child Information			
Child's Name	DOB	Parent's Na	me(s)
Address		Phone	Language
Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Ethnicity: ☐ Hispanic/Latino/Spanish	☐ Black or African American ☐ 1	Native Hawaiian d	or Other Pacific Islander
Physician Information			
Physician's Name	Phone		Fax
Address		Contact Nar	ne/Title
Reason for Referral			
1. Suspected developmental delay in the follow	wing area(s): Cognitive	☐ Motor	☐ Communication
☐ Adaptive/Self-Help ☐ Social-Emotion	nal		
2. Medically diagnosed condition(s), if applical	ble, including ICD-10 code(s) – list all <u>:</u>	
3. Sensory Impairment: Auditory Visi	ual		
4. Screening results, if applicable: ASQ	PEDS	N	И-CHAT
other (specify)			
► Physician's Signature			Date
Authorization to R	elease Pertinent Medica	al Informatio	on to ECI
I authorize the physician named above to send physician determines would assist ECI in evaluation			
► Parent or Legal Guardian's Signature			Date
For Physician: Prior to sending referral to checking the appropriate boxes in Sections 1, Section 1. ECI will send information only for the	2, and 3 (below and on pa	age 2) <u>AND</u> o	otain written parental consent for
Section 1: Referral Status – If Section 1 is ECI must confirm w	s checked the ECI program vith parent their consent to s		
Authorization	to Release Referral Sta	tus to Physi	cian
Parent declined evaluation			
☐ Eligible for ECI services – parent accep	eted services		
☐ Eligible for ECI services – parent declin	ed services		
☐ Not eligible for ECI services			
Unable to establish contact with the par	rent (consent not required to	o release this	information)
I authorize the ECI program that receives this r information about the referral indicated in Secti that ECI will reconfirm my consent and give me physician.	ion 1. I understand that bef	ore sending th	nis information to the physician
► Parent or Legal Guardian's Signature			Date

For Physician: Indicate the information you want to receive from the ECI program by checking the appropriate boxes
Section 2: Eligibility Determination
Please send me a copy of the completed Eligibility Statement forms that show the basis for the determination of eligibility or any other information used to establish eligibility.
☐ Section 3: Request for Additional Information
After development of the child's Individualized Family Service Plan (IFSP), please send me the following information:
☐ Initial IFSP Services Pages showing services the child and family will receive from ECI
Other
I authorize the ECI program that receives this referral to provide the physician the information requested in Sections
2 and 3 above. I understand that before sending this information to the physician ECI will reconfirm my consent and give me the opportunity to revoke my consent to provide any or all of this information to the physician. Parent or Legal Guardian's Signature
give me the opportunity to revoke my consent to provide any or all of this information to the physician.
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