TEXAS Health and Human Services | Early Childhood Intervention

Early Childhood Intervention Physician Referral and Feedback

Child's Information

Name DOB

Parent's Name(s)

Address

Phone Language

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Pacific Islander ☐ White ☐ Hispanic/Latino

Physician's Information

Name Phone

Contact Name/Title Fax

Reason for Referral

1. Suspected developmental delay in the following area(s): ☐ Cognitive ☐ Motor

☐ Communication ☐ Adaptive/Self-Help ☐ Social-Emotional

☐ Other (specify)

2. Medically diagnosed condition(s), if applicable, including ICD-9 code(s) - LIST ALL:

3. Sensory Impairment: ☐ Auditory ☐ Visual

4. Screening results, if applicable: ASQ PEDS M-CHAT

Other (specify)

▶ Physician's Signature _____

Authorization to Release Pertinent Medical Information to ECI

I authorize the physician named above to send to the ECI program any of my child's pertinent medical information that the physician determines would assist ECI in evaluation of, and determining service needs of my child.

▶ Parent or Legal Guardian's Signature _____ Date_____

For Physician: Prior to sending referral to ECI, indicate the information you want to receive from the ECI program by checking the appropriate boxes below AND obtain written parental consent if needed. ECI will send information only for those sections that are marked and have parental consent.

☐ **Section 1: Referral Status -** If Section 1 is checked, the ECI program will complete and return page 1 to the physician. ECI must confirm with parent that consent is given.

☐ Parent declined evaluation ☐ Eligible for services - parent accepted

☐ Not eligible for services ☐ Eligible for services - parent declined

☐ Unable to establish contact with parent (consent not required to release)

For Physician: Select information you want to receive 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 (FSP), please send me the following information:

☐ Initial FSP services pages, showing services the child and family will receive

☐ Other (explain):

I authorize the ECI program receiving this referral to provide the physician with 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 and all of this information to the physician.

▶ Parent or Legal Guardian's Signature _____ Date _____

This section to be completed by ECI provider

ECI has fully informed the parent or legal guardian of the information to be sent to the child's physician as requested in Sections 2 and 3 above and explained their right to revoke said consent.

▶ Initials of ECI staff member confirming consent _____ Date _____

After completing this form, please fax to Betty Hardwick Center ECI at: 325.670.4831

For any questions, you may call our office at 325.627.0908 or email us at eci@bettyhardwick.org