



TEXAS
Health and Human
Services

*Early Childhood
Intervention*

Betty Hardwick ECI Program Referral

This section for internal use only

CAPTA Referral?:

Date of Referral:

45-Day Timeline:

Previous ECI Services:

Transfer?:

Other Physicians Involved:

Child's Information

First Name:

Last Name:

Date of Birth:

SSN:

Ethnicity:

Gender:

Area(s) of dev. concern or medical diagnosis:

Primary Physician:

Physician Phone:

Physician Address:

Recent Testing and/or Services:

Referred with Sibling?:

Person/Agency Making Referral:

Phone:

Medicaid?:

Medicaid Number:

Name of Daycare:

Private Insurance (Private Insurance may require a referral from PCP)

Name of Insurance:

Policy/Group/ID #:

Address:

City:

State:

Zip:

Phone Number from Back of Insurance Card:

Primary Policyholder Name/Relationship:

Primary Policyholder's Date of Birth:

Parent/Guardian's Information

First Name:

Last Name:

Street Address:

City:

State:

Zip:

County:

Home Phone:

Cell Phone:

Work Phone:

Email:

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)

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

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