This **Early Childhood Intervention** program works in association with **Texas Health and Human Services**

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