Early Childhood Intervention

Physician Referral and Feedback

Locate a local ECI program at https://citysearch.hhsc.state.tx.us/. 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 Name(s) _____

Address _____ Phone _____ Language _____

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White
Ethnicity: ☐ Hispanic/Latino/Spanish

Physician Information

Physician's Name _____ Phone _____ Fax _____

Address _____ Contact Name/Title _____

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-10 code(s) – list all: _____
   _____
3. Sensory Impairment: ☐ Auditory ☐ Visual
4. Screening results, if applicable: ☐ ASQ _____ ☐ PEDS _____ ☐ M-CHAT _____
   ☐ other (specify) _____

▶ **Physician's Signature** _____ **Date** _____

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 in **Sections 1, 2, and 3 (below and on page 2)** AND obtain written parental consent for Section 1. ECI will send information only for those sections that are marked and after parental consent is obtained.

☐ **Section 1: Referral Status** – If Section 1 is checked the ECI program will complete and return page one to physician. ECI must confirm with parent their consent to send this information.

Authorization to Release Referral Status to Physician

☐ Parent declined evaluation

☐ Eligible for ECI services – parent accepted services

☐ Eligible for ECI services – parent declined services

☐ Not eligible for ECI services

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

I authorize the ECI program that receives this referral to provide to the physician identified on this form the applicable information about the referral indicated in Section 1. I understand that before sending this information to the physician that ECI will reconfirm my consent and give me the opportunity to withdraw my consent to provide this 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** _____ **Date** _____

For ECI Program: To be completed by ECI provider

Confirmation to Release Information to Physician

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 their consent.

▶ **Initials of the ECI staff member confirming consent** _____ **Date** _____