



Referral to ECI of North Central Texas



TEXAS
Health and Human
Services

Early Childhood
Intervention

Serving Cooke, Denton, Ellis, Erath, Hood, Johnson, Navarro, Palo Pinto, Parker, Somervell Tarrant & Wise Counties

Completed by ECI	<input type="checkbox"/> Referral for Screening 21-day deadline:	ECI #:
	<input type="checkbox"/> Referral for Enrollment 45-day deadline:	T-KIDS #: Case #:
	<input type="checkbox"/> Re-Open D/C Date: Code: Unit:	Referral Date:
	<input type="checkbox"/> Transfer (check one): <input type="checkbox"/> In State <input type="checkbox"/> Out of State Office:	Referral Received by: <input type="checkbox"/> Email <input type="checkbox"/> Fax <input type="checkbox"/> Mail <input type="checkbox"/> Phone

Child's Name:

First Middle Last

Male Female DOB: Place of Birth: SS#:

Gestational Age: Birth Weight: APGAR: Current Age: Current Weight: Current Length:

Mother's Name: **Father's Name:**

Cell Phone: Permission to text? Yes No Home Phone: Work Phone:

Permission to email: Yes No Email Address:

Parent/Guardian's Address: Zip:

Apt. #: Gate Code: Complex Name: County:

Mobile Home Lot #: Mobile Home Park Name:

Race: American Indian / Alaska Native Asian Black Caucasian/White Pacific Islander More than 1 race (Check which two)

Ethnicity: Hispanic / Latino Yes No **Language Spoken at Home:**

Do you have an interpreter? Yes No If Yes, Who?

Legal Status: Natural Parent Joint Custody: Adoptive Parent Guardian:

Alternate Contact / Child Care: Email: Phone:

Reason(s) for Referral:

<input type="checkbox"/> Adaptive / Self Help	<input type="checkbox"/> Cognitive	<input type="checkbox"/> Global (5 or more of these)	<input type="checkbox"/> Hearing	<input type="checkbox"/> Medical (explain below)
<input type="checkbox"/> Physical / Motor	<input type="checkbox"/> Social / Emotional	<input type="checkbox"/> Speech / Language	<input type="checkbox"/> Vision	<input type="checkbox"/> Mental Health

Medical Reasons or Concerns:

Person Completing this Form (Name, Address, Phone, Email & Fax):

How did you learn about ECI?

Primary Physician's Name:

Address:

Phone #: Fax #:

Family's Insurance (if known):

Private Insurance Children's Health Insurance Program (CHIP) Medicaid Supplemental Security Income (SSI)