early childhood services
MHMR TARRANT | WE CHANGE LIVES

TEXAS Health and Human Services | Early Childhood Intervention

ECI of NORTH CENTRAL TEXAS
PHYSICIAN REFERRAL AND FEEDBACK

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 Child's Gender: ☐ Male ☐ Female

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 *(no stamps please)* **Printed Physician's Name** **Date**

Authorization to Release Pertinent Medical Information to ECI

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

► Parent or Legal Guardian's Signature **Printed Name** **Date**

For Physician: Prior to sending referral to ECINCT, indicate the information you want to receive from the ECINCT 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. ECINCT 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, ECINCT will complete and return page one to physician. ECINCT 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 of North Central Texas program to provide to the physician identified on this form the applicable information about the referral indicated in Section1. I understand that before sending this information to the physician that ECINCT 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 **Printed Name** **Date**

ECI of NORTH CENTRAL TEXAS

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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 Service Pages showing services the child and family will receive from ECI

☐ Other: _____

_____

I authorize the ECINCT 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 ECINCT 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 **Printed Name** **Date**

For ECINCT Program: To be completed by ECINCT:

Confirmation to Release Information to Physician

ECINCT 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 ECINCT staff member confirming consent: _____ **Date:** _____

PHYSICIAN'S ORDERS

Date: _____ Medicaid #: _____

Based on my evaluation of _____ (child's name), DOB: _____,
I refer this child to ECI of North Central Texas for the following services:

Physical, occupational, speech, feeding and nutrition evaluations and services can be provided as determined appropriate by the ECI Interdisciplinary Team.

Special instructions/contraindication: _____

_____

_____

_____

Physician's Signature *(no stamps please)*: _____ Date: _____

Physician's Printed Name: _____ Fax #: _____

DEA #: _____ Physician's Office Email Address: _____
to be used by ECI to send encyrpted communications