Physician Referral and Orders for Early Childhood Intervention (ECI)

To locate a local ECI program visit 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.

Physical, occupational, speech, feeding and nutrition evaluations and services may be provided, as determined appropriate by the ECI Interdisciplinary Team, based on information provided in this referral and the outcome of any assessments conducted by ECI.

Date:	**Child's Name:**	**Medicaid #:**
DOB:	**Preferred Language:**	**Race/Ethnicity:**

REFERRAL AND ORDERS — to be completed by physician

Child's diagnosis:

ICD-10 code(s) —

A searchable list of medically qualifying diagnoses (by name or diagnosis code) is available at: https://diagsearch.hhsc.state.tx.us/

Functional/areas of concern: (cognitive, motor, communication, self-help, social-emotional, hearing, vision, other)

* **Attach the following:**

- **any screenings (e.g. ASQ, M-CHAT, PEDS, or other)**
- **the child's last well-child check**
- **hearing/vision results**
- **referral to specialists**

Special instructions/contraindications:

► ______________________________ ______________

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

Physician's Printed Name:		National Provider Identifier (NPI):	
Address:	City:	State:	Zip:
Contact Name/Title:	Phone:	Fax:	

REQUIRED AUTHORIZATIONS FROM PARENT/LEGAL GUARDIAN

(signature must be obtained to allow ECI to release information about the child back to physician)

- I authorize the physician named above to send to Early Childhood Intervention (ECI) any of my child's pertinent medical information that the physician determines would assist ECI in evaluation and determination of service needs for my child.
- I authorize ECI to provide to the physician named above information about my child's evaluation and eligibility for services, percent of delay, information on recommended services, services to be delivered, and transition information. ECI will reconfirm my consent and give me an opportunity to revoke my consent at any time.
- I understand that if ECI staff are not able to contact me, ECI can notify the physician.

► ______________________________ ______________

Parent / Legal Guardian's Signature ***Date:***

Printed Name:	Phone:	Fax:	
Alternate Phone Number:			
Address:	City:	State:	Zip:

REVIEWS — to be completed by Early Childhood Intervention (ECI)

- I have reviewed these medical records/referral/orders.
- I have informed the family of the records to be sent to the physician.
- I have reminded the family of their right to revoke consent at any time.

► ______________________________ ______________

ECI Staff Member's Signature ***Date***

Printed Name:

REFERRAL STATUS — to be completed by ECI and returned to provider listed on page 1		
Child's Name:	DOB:	Medicaid #:
Parent/Guardian Name:	Date Referral Received:	

☐ **Parent/Legal Guardian consent has been acquired.**

1. The family was contacted on (date): and the following occurred:
   - ☐ The child has been evaluated and found to be **not eligible** for services at this time (skip to #4)
   - ☐ The child has been evaluated and found to be **eligible** for services based on the following:
     - ☐ 25% or greater developmental delay in 1 or more areas of development (social emotional, self-help, communication, motor function or cognitive skills) or 33% delay in expressive language development
     - ☐ Qualifying diagnosis of:
     - ☐ Other:

2. The child and family have been recommended to receive the following ECI services:
   - ☐ Developmental Therapy; frequency:
   - ☐ Occupational Therapy; frequency:
   - ☐ Physical Therapy; frequency:
   - ☐ Speech Therapy; frequency:
   - ☐ Social Work/Counseling; frequency:
   - ☐ Other: (include frequency)

3. An IFSP was/will be developed for the child and family. The IFSP Summary Report will be released to the provider identified on page 1. Authorization to release additional information can be obtained through contact with the Service Coordinator assigned.

Name	Phone Number
Fax Number	Email

4. The child and family received referrals to the following non-ECI services:

5. The evaluation/assessment and services planning process have not been completed because:
   - ☐ After attempts we were not able to reach the family
   - ☐ The family declined ECI services
   - ☐ Other: