

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 — providing ICD-10 code may speed up enrollment 🌟			
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/			
🌟 IMPORTANT NOTE: If the child has been identified as having a medically qualifying diagnosis, providing the ICD-10 code(s) could automatically qualify the child for ECI and may result in quicker enrollment.			
Functional /area(s) of concern:			
Cognitive	Communication	Motor	Hearing
Self-help	Social-emotional	Vision	
Other: _____			
* Attach the following: <ul style="list-style-type: none"> • any screenings (ASQ, M-CHAT, PEDS, or other) • hearing/vision results • the child's last well-child check • referral to specialists 			
Special instructions/contraindications:			
<div style="display: flex; justify-content: space-between; align-items: flex-end;"> <div style="width: 60%;"> <p>▶ _____</p> <p>Physician's Signature (no stamps please)</p> </div> <div style="width: 35%;"> <p>_____</p> <p>Date</p> </div> </div>			
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)			
<ul style="list-style-type: none"> • 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 mychild. • 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. 			
<div style="display: flex; justify-content: space-between; align-items: flex-end;"> <div style="width: 60%;"> <p>▶ _____</p> <p>Parent/Legal Guardian's Signature</p> </div> <div style="width: 35%;"> <p>_____</p> <p>Date</p> </div> </div>			
Printed Name:		Email:	
Phone:		Alternate Phone:	
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.



Physician's Signature (no stamps please)

Date

Printed Name: _____

REFERRAL STATUS — to be completed by ECI and returned to provider listed on page 1 with parental consent

Child's Name:	DOB:	Medicaid #:
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Parent/Guardian's Name:	Date Referral Received:
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Parent/Legal Guardian's consent has been obtained.

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 following ECI services have been recommended for the child and family:
 Specialized Skills Training (Developmental Therapy) — include frequency: _____
 Occupational Therapy — include frequency: _____
 Physical Therapy — include frequency: _____
 Speech Therapy — include frequency: _____
 Social Work/Counseling — include frequency: _____
 Other — include frequency: _____

3. An Individualized Family Service Plan (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 family's assigned Service Coordinator.

Service Coordinator's Name:	Phone Number :
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Fax Number:	Email:
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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: _____