TEXAS Health and Human Services | Early Childhood Intervention

Region One EDUCATION SERVICE CENTER "Students First"

REFERRAL FORM FOR REGION ONE ECI SERVICES

Date: _____

Child's Name: _____

Child DOB: _____ **Sex: M or F** **Medicaid #**_____

Parent's Name(s): _____

Parent's Address : _____

City: _____ **Zip code:** _____ **Language:** _____

Phone# _____ **Alternate #:** _____

Parent's Email address: _____

How did hear about ECI? _____

Have the parents/guardian been informed of the referral? ☐**Yes** ☐**No**

Reason for Referral Required (check all that apply):

☐ **Global** ☐ **Speech/Language** ☐ **Social-emotional** ☐ **Cognition**

☐ **Adaptive/Self Help** ☐ **Physical/Motor** ☐ **Fine Motor** **Other:** _____

Diagnosis (if applicable): _____

Physician/ Pediatrician: _____

Referral Source Information

Agency: _____

Contact Person: _____

Address: _____ **City/Zip Code:** _____

Email address: _____

Phone #: _____ **Fax:** _____

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405 E. Levee St
Brownsville, TX 78521
Phone: (956) 504-9422
Fax: (956) 984-7664

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Edinburg, Texas 78541
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