REFERRAL

Easterseals Rio Grande Valley
Phone: (956) 631-9171 Fax: (956)291-7600
Email: referrals@easterseals-rgv.org

NEW **Re-referral - Program ID:** ________________________ **Transfer:** ________________________

Referral Taken by: ____ Date:_________________________

How did you hear about the ECI program? ____

Child's Name: ____ **M** **F** **DOB:** _______________________

Parent/Legal Guardian's Name: ____

Area of Concern: ____

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Language Preference: English Spanish

Physical Address: ______________________________________City:_____________ State:_____ Zip Code: __________

Mailing Address: ______________________________________ City: _____________ State:_____ Zip Code: __________

Phone number: ____________________________________ Email Address: ____________________________________

Best time to call:____________________________________ AM PM

Referred By: ____ Phone: __________________________

If referred by CPS, who has custody of child/able to give consent: ____

Are Service court ordered? Yes No

Are Parents aware that this referral is being made to Easterseals - ECI program? Yes No

Primary care physician: ____ Phone: _________________________

Are service being provided at any other agency? If yes, where?: ____

Medicaid/CHIP: Yes No Medicaid/CHIP member ID: _________________________ Effective Date____________

Insurance: Yes No Policy number:_______________________ Group: ________________________________

Additional Information: ____

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IFSP to be held no later than 45 days: ________________________ ***Case Assigned to***_____________________

Case issued on: _______________________________ ***Referral date to Part B:*** ____________________