Infant & Toddler Connection of Virginia Referral Form

Physicians: Please complete this form for referring a child to early intervention if you prefer to do so in writing. Also please indicate the feedback that you want to receive from the early intervention program in response to your referral.

Child Contact Information

Child Name: ______________________________Date of Birth: ____/____/____ Gender M F
Home Address: ______________________________City______________Virginia Zip______
Parent/Guardian__________________Relationship to Child: ______________________
Primary Language:________ Home Phone:________Other Phone:____________________

Reason for Referral and Referral Information

☐ Developmental Evaluation, which may include evaluations by special instructor and/or physical and/or occupational therapist and/or speech language pathologist.

Medical Information (Please check all that apply):

☐ Identified condition or diagnosis (e.g., spina bifida, Down syndrome): ______________________
☐ Suspected developmental delay or concern (Please circle areas of concern):
Motor/Physical Cognitive Social/Emotional Speech/Language Behavior Vision Hearing Other__________
☐ Assessment Method/Tool used to identify delay or concern:______________________________
☐ Other (Please Describe):______________________________________

Feedback Requested by the Referral Source

☐ Status of Initial Family Contact ☐ Services Being Provided to Child/Family ☐ Other:____________
☐ Developmental Evaluation Results ☐ Child Progress Report/Summary

Referral Source Contact Information

Person Making Referral:______________________________ Date of Referral:____/____/____
Address:____
Office Phone____/____-_____Office Fax:____/____-_____E-mail______________________
Signature:________________________________

Infant & Toddler Connection Information

Program Name: ____
Address: ______________________________City: ______________State: _____Zip:______
Telephone Number: ______________________Fax Number: ______________________
E-mail____

Consent for Release of Protected Health Information

Extent or nature of use/disclosure is limited to: (Check or list all that apply)

History and Physical, including vision and hearing_____ discharge summaries___ evaluation reports ____
IFSP___ Progress notes____ other____

Specified purpose or need for use/disclosure is: Intervention and Coordination of Care

Permission is hereby given to: ______________________ (Referral Source Name) to disclose information to: ____, (Local Early Intervention System Name, Street Address, City, State, Zip Phone/Fax #). I also authorize the recipient to use the information received pursuant to this authorization. As the person signing this authorization, I acknowledge that I am giving my permission to the above-named person/class of persons to disclose and use protected health information.

Permission is hereby given to: ______________________ (Local Early Intervention System Name) to disclose information to:____, (Referral Source name, title and organization, Street Address, City, State, Zip Phone/Fax #). I also authorize the recipient to use the information received pursuant to this authorization. As the person signing this authorization, I acknowledge that I am giving my permission to the above-named person/class of persons to disclose and use protected health information. I further acknowledge that:

This authorization ___does ___ does not extend to information placed in my record after the date I signed this form.

I acknowledge that I have read and understand the following.

- I may refuse to sign this authorization.
- The referral source and the early intervention system cannot condition the provision of treatment to me on my signing of this authorization.
- The original or a copy of this authorization shall be included with my original records.
- I have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance on it, by delivering the revocation in writing to the provider who is in possession of my health care records.
- There is a potential for any information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and, therefore, no longer protected by the provisions of the HIPAA Privacy Rule.

Signature of Individual (adult) or Legally Authorized Representative______________________
Relationship______________________ **Date Signed**______________________
If not previously revoked, this authorization will expire in: ___90 Days ___One Year ___On *(specify date or event)*__________
The information may be disclosed effective: ____Immediately ___*(specify date)*_______