

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) _____