Referral to the Infant & Toddler Connection of Virginia

Child Contact Information

Child's 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 (Please check all that apply) & Medical Information

☐ Suspected developmental delay or concern (Please circle area[s] of concern):
Motor/Physical Cognitive Social/Emotional Speech/Language Behavior Vision Hearing
Other____

☐ Atypical Development (Please circle area[s] of concern):
sensory-motor social-emotional behaviors social/communication with restricted and repetitive behaviors

☐ Assessment Method/Tool used to identify delay or concern: ______________________________
(Please attach copy of screening results)
Is the identified delay, in your professional judgment, 25% or greater? ☐ Yes ☐ No
Comments: ____

☐ Identified condition or diagnosis (e.g., spina bifida, Down syndrome): Please list:
____

☐ Other (Please describe):____

Physician Input into Individualized Family Service Plan (IFSP) if Child is Eligible for Early Intervention Services

☐ I would like to participate in the IFSP meeting ____in person or ____ by phone.

☐ Please consider the following information and/or recommendations as the IFSP is developed:

____

____

As the Referral Source, Please Indicate what Feedback You Would Like:

☐ Status of Initial Family Contact ☐ Services Being Provided to Child/Family ☐ Eligibility Determination
☐ Child Progress Report/Summary ☐ Other: ______________________________

Referral Source Contact Information

Person Making Referral:______________________________ Date of Referral:_______/_______/_______

Address:____

Office Phone_____/_____-_______Office Fax:_____/_____-_______E-mail______________________________

Signature:______________________________

Infant & Toddler Connection Information

Infant & Toddler Connection of: ______________________________Telephone Number:____________________

Address: ______________________________City: ______________State: ______Zip:________

Fax Number: ______________________________ E- mail______________________________

Consent for Release of Protected Health Information

I authorize ___________________________________(referral source) to release the following information:

☐ History and Physical, including vision and hearing ☐ discharge summaries ☐ screening and assessment reports

☐ Other (specify) ____

to the Infant & Toddler Connection of ____________________________________ in order to establish my child's eligibility for early intervention services and for coordination of care if my child is found eligible.

- I understand that signing this authorization is not a condition of receiving future medical treatment or early intervention services
- I understand that I may revoke (cancel) this authorization at any time
- I understand that before any specific service for my child are provided, I also have the right to authorize or decline those services
- I understand that once released, my information may be disclosed and may no longer be protected under the Health Insurance Portability and Accountability Act (HIPAA), but will not be re-disclosed by the Infant & Toddler Connection System in accordance with the Family Educational Rights and Privacy Act (FERPA).

This authorization expires on ______________________(expiration date not to exceed one year from signature date).

Signed: _______________________________________ Date: __________________ ☐ copy to parent(s) or legal guardian

(child's parent or legal guardian)

I authorize the Infant & Toddler Connection of ________________________________ to share the results of the early intervention eligibility determination process, assessment results and the type and frequency of early intervention services (as appropriate) to ____ (referring professional).

Signed: _______________________________________ Date: __________________ ☐ copy to parent(s) or legal guardian

(child's parent or legal guardian)

For children with suspected or diagnosed hearing loss:

I authorize the Infant & Toddler Connection of ________________________________ communicate with the Virginia Department of Health Early Hearing Detection and Intervention Follow Up Unit about my child's referral to and services through the Infant & Toddler Connection of ____.

Signed: _______________________________________ Date: __________________ ☐ copy to parent(s) or legal guardian

(child's parent or legal guardian)

Form date: 6-24-10