



Fax to ECI Child Find: 915 496-0750

Date faxed: _____ From: _____

ECI Fax Referral Form

Person Referring: _____ Agency: _____

Address: _____ Phone: _____

Physician: _____ Reason for Referral: _____

Child's Name: _____ DOB: _____ Race: _____

Parent/Guardian: _____ Primary Language: _____

Primary ph. /name: _____ Secondary Ph. /name: _____

Home Address: _____ Zip Code: _____

Mailing Address/P.O Box: _____ Zip Code: _____

Physical Exam and Prescription Form

Initial Renewal

Height: _____ Weight: _____ lbs. Diagnoses: _____

ICD 10 Code(s) _____ Date of Physical: _____

	N	ABN	Not Done	Comments		N	ABN	Comments
Musculoskeletal					Mouth			
Extremities					Throat(teeth)			
Lymphatic					Neck			
Skin					Lungs			
Head					Heart			
Hair					Abdomen			
Scalp					Hernia			
Eyes					Genitalia			
Ears					Reflexes			
Nose					Endocrinopathics			

I hereby authorize the following as needed to be provided for this individual:

- Physical Therapy
- Speech Therapy
- Occupational Therapy
- Nutrition Services
- Developmental Services

Comments/Indications/Contraindications:

Physician's Name _____ Physician's Signature _____ Date _____
(print)