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 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