

# CPS Referral to ECI

ECI Referral FAX: (      )  
ECI Referral Telephone: (      )

## 1. General Information

Referral Date:	Child's Name:	Date of Birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Child's Current Address:	City:	State:	ZIP Code:
Child's Medicaid Number:	CHIP Number:	Weight:	Height:

## 2. Caregiver Information

Child is placed with: <input type="checkbox"/> Biological Parent(s) <input type="checkbox"/> Foster Parent(s) <input type="checkbox"/> Adoptive Parent(s) <input type="checkbox"/> Relative <input type="checkbox"/> Other			
Caregiver:	Cell Number: (      )	Home Number: (      )	
Address:	City:	State:	ZIP Code:

## 3. Referral Concerns

<input type="checkbox"/> No Concerns (referred for screening)
<input type="checkbox"/> Medical Diagnosis:
Suspected developmental delay – in what area(s):
<input type="checkbox"/> Self-feeding, dressing, etc. <input type="checkbox"/> Speech/Language <input type="checkbox"/> Vision/Hearing <input type="checkbox"/> Other
<input type="checkbox"/> Playing and learning <input type="checkbox"/> Physical/Motor <input type="checkbox"/> Social/Emotional
Explanations:

## 4. CPS Information

CPS Case Worker Name:	FAX Number: (      )	Phone: (      )
Address:	Email Address:	
Supervisor's Name:	Phone: (      )	
Is this the child that was abused or neglected? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Status: <input type="checkbox"/> Investigative <input type="checkbox"/> FBSS <input type="checkbox"/> Substitute Care (e.g. foster, shelter, kinship)		

## 5. Medical Information

<input type="checkbox"/> Unknown	Child's Primary Physician:	Phone: (      )
Medical Conditions (include injuries, genetic/developmental problems (e.g., Down syndrome), feeding/nutrition, sensory issues, major illnesses)		
1. Who saw child in the past for sick visits, well child visits, immunizations?		
2. Name of hospital (if admitted) and physician(s) name(s) treating child, if different from above.		
Insurance:	<input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP <input type="checkbox"/> SSI <input type="checkbox"/> Unknown	

**X**

Worker's Signature

Date