An Affiliate of Texas Early Childhood Intervention
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325-643-1721
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ECI Staff Only

Case ID#_____

Medicaid#_____

SCREENING/EVALUATION COVER SHEET

☐ **Screening** ☐ **Evaluation/Assessment**

Child Name: **DOB:**

CONFIDENTIAL **Record Services Provided in the Space Below** **CONFIDENTIAL**

Screener/Evaluator	Date of Service MM DD YY	Start Time	End Time	Length of Time	Place of Service	Type of Contact	Appointment Code
					☐ Home ☐ Child Care ☐ Community	☐ Face-to-face ☐ Phone	☐ Scheduled ☐ No Show ☐ Parent Cancelled ☐ Staff Scheduled ☐ Unscheduled contact ☐ Unscheduled attempt

COMMENTS/NOTES:

Provider's Signature Date

Interpreter's Signature Date

ECI Staff Only

Case #/ID

TKIDS

Next Appointment:

☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri

☐ AM

☐ PM

Date: Time: