An Affiliate of Texas Early Childhood Intervention

www.dars.state.tx.us/ecis

For LEA Use Only:
Date Referral Received in LEA Office:

Little Lives ECI
1104 Henderson St
Sweetwater, TX 79556
325-236-6821
fax: 325-236-6112

Betty Hardwick ECI
765 Orange St
Abilene, TX 79601
325-627-0908
fax: 325-670-48310

Central Texas MHMR ECI
PO Box 250
Brownwood, TX 76801
325-643-1721
fax: 325-646-7627

AI/VI Referral

Child's Name: ____________________ DOB: ____________________

Parents' Name: ____________________ Phone: ____________________

Address: ____

Phone: ____________________

ECI Contact Person: ____________________ Email: ____________________

Language: ____________ Ethnicity: ____________ Gender: ☐ M ☐ F

Date of Initial Evaluation Service Periods: ____________________

Services Received: ☐ Speech ☐ PT ☐ OT ☐ Behavior ☐ Other:

Reasons for Referral

Auditory Concerns	Vision Concerns
☐The child has failed a diagnostic auditory brainstem response (ABR) or otoacoustic emissions (OAE) test, or other diagnostic evaluations. ☐The child's record includes an otological examination that reports the child has a serious hearing loss after corrective medical treatment. ☐The child uses amplification. ☐The child is being followed by an otologist. ☐The child has an audiological evaluation that indicates a hearing loss or a progressive condition resulting in hearing loss.	☐The child appears to have no vision. ☐The child has a serious visual loss after correction. ☐The child has a progressive visual condition

Records Attached: (please send all applicable records or reason not included)

☐Texas Eye Report

☐Hearing Eligibility, parts A, B, C

Service Location:

☐ Home

☐ School (Name , Address, & Phone)

☐ Child Care (Name, Address, & Phone)

☐ Other (Name, Address, & Phone)

These doctors have pertinent medical information about this child:

NAME:	NAME:
ADDRESS:	ADDRESS:
PHONE:	PHONE:
MEDICAL DIAGNOSIS:	DOCUMENTATION ATTACHED: ☐ Yes ☐ No

Other information: ______________________________

NAME:	NAME:
ADDRESS:	ADDRESS:
PHONE:	PHONE:
MEDICAL DIAGNOSIS:	DOCUMENTATION ATTACHED: ☐ Yes ☐ No

Other information: ______________________________