CPS Referral to ECI

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

1. General Information

Referral Date:	Child's Name:	Date of Birth:	☐ Male ☐ Female
Child's Current Address:	City:	State:	ZIP Code:
Child's Medicaid Number:	CHIP Number:	Weight:	Height:

2. Caregiver Information

Child is placed with: ☐ Biological Parent(s) ☐ Foster Parent(s) ☐ Adoptive Parent(s) ☐ Relative ☐ Other

Caregiver:	Cell Number: ( )	Home Number: ( )

Address:	City:	State:	ZIP Code:

3. Referral Concerns

☐ No Concerns (referred for screening)

☐ Medical Diagnosis:

Suspected developmental delay – in what area(s):

☐ Self-feeding, dressing, etc. ☐ Speech/Language ☐ Vision/Hearing ☐ Other
☐ Playing and learning ☐ Physical/Motor ☐ 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? ☐ Yes ☐ No

Status: ☐ Investigative ☐ FBSS ☐ Substitute Care *(e.g. foster, shelter, kinship)*

5. Medical Information

☐ 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:	☐ Medicaid ☐ CHIP ☐ SSI ☐ Unknown

X

Worker's Signature **Date**