Infant & Toddler Connection of Virginia

Referral Form

Date Received: _____
Date Assigned to Intake: _____
Date Entered into ITOTS: _____
Date Acknowledgement Sent: _____

Child Information

Name (last, first, middle): | **DOB:** | ☐ Male ☐ Female

Home Address (City, State Zip Code):

Family Information

Parent/Legal Guardian:		Relationship: ☐ Mother ☐ Father ☐ Other _____
Mailing Address (if different from home address)		E-mail address
Home Phone #:	Work Phone #	Cell Phone #
Native Language:	Is an interpreter needed? ☐ Yes ☐ No	

Reason For Referral

What are your concerns about this child?

What are the family's concerns about the child?

Is the family aware that this referral is being made? ☐ Yes ☐ No

Referral Source Information

Name:	Phone # ☐ Work ( ) ☐ Cell ( )	Fax #
Mailing Address		E-mail Address

What is your role? Circle one: Parent/Friend/Relative/Doctor's Office/Discharge Planners in Hospital/DSS/Health Dept./Public Schools/Community Services Board Program/Central Directory/Other Early Intervention Program/Head Start/Healthy Families/Day Care Provider	**How did you find out about Early Intervention services?** Parent/Friend/Relative/Doctor's Office/ Discharge Planners in Hospital/DSS/Health Department/Public schools/Community Services Board Program/Central Directory/Other Early Intervention Program/Head Start/Healthy Families/Day Care Provider Advertising: TV/Radio/Billboard/Print/Other_____

See reverse of form for consent to exchange information.

Please Mail or FAX to: (Insert local early intervention address, phone number and fax number)

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Consent for Release of Protected Health Information

Child Information

Name (last, first, middle): **DOB:**

Extent or nature of use/disclosure is limited to: (Check or list all that apply)
History and Physical, including vision and hearing_____ discharge summaries___ evaluation reports ____
IFSP___ Progress notes____ other_____

Specified purpose or need for use/disclosure is: Intervention and Coordination of Care
Permission is hereby given to: _____
(Referral Source Name)

to disclose information to: _____,
(Local Early Intervention System Name, Street Address, City, State, Zip Phone/Fax #).

I also authorize the recipient to use the information received pursuant to this authorization. As the person signing this authorization, I acknowledge that I am giving my permission to the above-named person/class of persons to disclose and use protected health information.

Permission is hereby given to: _____
(Local Early Intervention System Name)

to disclose information to:_____,
(Referral Source name, title and organization, Street Address, City, State, Zip Phone/Fax #).

I also authorize the recipient to use the information received pursuant to this authorization. As the person signing this authorization, I acknowledge that I am giving my permission to the above-named person/class of persons to disclose and use protected health information. I further acknowledge that: This authorization ___does ___ does not extend to information placed in my record after the date I signed this form.

I acknowledge that I have read and understand the following.

- I may refuse to sign this authorization.
- The referral source and the early intervention system cannot condition the provision of treatment to me on my signing of this authorization.
- The original or a copy of this authorization shall be included with my original records.
- I have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance on it, by delivering the revocation in writing to the provider who is in possession of my health care records.
- There is a potential for any information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and, therefore, no longer protected by the provisions of the HIPAA Privacy Rule. I understand that under the Family Educational Rights and Privacy Act (FERPA), which the Individuals with Disabilities Education Act must adhere to, information, may not be re-disclosed by the recipient to another source without my written authorization.

Signature of Individual (adult) or Legally Authorized Representative_____

Relationship_____ Date Signed_____

If not previously revoked, this authorization will expire in: ___90 Days ___One Year ___On *(specify date or event)*_____
The information may be disclosed effective: ____Immediately ___*(specify date)*_____