Infant & Toddler Connection of the Highlands

Early Intervention Referral Guide

Early Intervention providers observe and participate in families' daily routines and activities. They build on the things families do every day to support their child's learning and development.

Should I Refer My Patient for Early Intervention Services?

The list below includes many, but not all, conditions or concerns that may make a child eligible for Virginia's Early Intervention (EI) Services. These are all conditions or concerns that put a child at risk for developmental delays. Infants and toddlers with these conditions require close supervision and routine developmental screening, which can be provided through EI.

Qualifying Diagnoses & Eligibility

Admission Diagnosis

Gestational Age 28 Weeks or Less*

Effects of Intrauterine Toxic Exposure
Including FAS, NAS, and exposure to chronic maternal use of illicit substances, anticonvulsants, antineoplastics, and anticoagulants.

Hypoxic - Ischemic Encephalopathy

Chromosomal Abnormalities
Including Down Syndrome.

Major Congenital CNS Malformation
Including Meningomyleoceles and Microcephaly.

Cleft Lip or Palate

Other Conditions Impacting Development

Sensory-motor Problems
Such as abnormal muscle tone, limitations in joint range of motion, abnormal reflex orpostural reactions, poor quality of movement patterns, atypical articulation, or oral-motor skills dysfunction, including feeding difficulties.

Social-Emotional Problems
Delay or abnormality in achieving expected emotional milestones, persistent failure to initiate or respond to most social interactions, or fearfulness or other distress that does not respond to comforting by caregivers.

Speech/Language/Communication Delay

Congenital/Acquired Diagnosis

NICU stay of greater than or equal to 28 days

Symptomatic Congenital Infection
Including HSV, CMV, GBS Meningitis.

Seizures with Significant Encephalopathy

Grade 3 or Grade 4 Intraventricular Hemorrhage

Periventricular Leukomalacia

Inborn Errors of Metabolism

Congenital or Acquired Hearing Loss

Visual Disabilities

Brain or Spinal Cord Trauma
With abnormal neurologic exam at discharge.

Failure to Thrive

Endocrine Disorders
With a high probability of resulting in developmental delay.

Hemoglobinopathies
With a high probability of resulting in developmental delay.

**All preterm infants are at risk for developmental delays, consider all diagnoses and conditions listed.*

What's Next?

If you have a patient living in Washington Co. or the City of Bristol, Virginia with one or more of the above concerns or conditions, complete the referral form (attached or available at HighlandsCSB.org/EarlyIntervention) and submit to the Infant & Toddler Connection of the Highlands. Please include all records that will help us in the diagnosis and treatment of the patient, including birth records and discharge summaries.

For a complete listing of ITCVA localities, visit InfantVA.org/Documents/CITIES-COUNTIES-all.pdf or call the Virginia Statewide Central Directory at (800) 234-1448 for local contact information.

As always, if you have any questions, please feel free to contact us.

Serving Washington County and the City of Bristol, VA

Infant & Toddler Connection of the Highlands
276.619.2406
276.525.1764

In partnership with HCS Highlands Community Services

Infant & Toddler Connection of Virginia
1-800-234-1448
TTY/TDD 1-804-771-5877

Infant & Toddler Connection of the Highlands

Early Intervention Referral Form

Referral Date _____

FOR OFFICE USE ONLY

45 Day Deadline _____

CHILD INFORMATION

Child's Name _____

Date of Birth _____ Gender (circle) Female Male Race _____

Social Security Number _____ Physician's Name _____

Home Address _____

City _____ State _____ Zip _____

FAMILY INFORMATION

Legal Guardian's Name _____

Relationship to Child (circle) Mother Father Other (note relationship) _____

Mailing Addres (if different from child's address) _____

Phone Number _____ Work Number _____

Email Address _____

Insurance Type _____ Insurance Number _____

REFERRAL INFORMATION

Referral Contact Name _____

Referral Source (Agency, Affiliation, etc) _____

Phone Number _____ Alternate Phone Number _____

Fax Number _____ Email Address _____

Reason(s) for Referral _____

Directions to Family's Home (if applicable) _____

Upon completion, please return this referral form to:

Rebecca G. Thompson | Local System Manager
Infant & Toddler Connection of the Highlands
610 Campus Drive, Suite 273
Abingdon, VA 24210
Phone 276-619-2406 or 276-525-1764
Fax 276-525-1530

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Early Intervention Consent for Release of Protected Health Information

CHILD INFORMATION

Child's Name _____ Date of Birth _____

CONSENT DETAILS

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 contact name): _____
to disclose information to Infant & Toddler Connection of the Highlands, located at 610 Campus Drive, Suite 273Abingdon, VA 24210 (Phone: 276-619-2406 or 276-676-2879) (Fax: 276-525-1530).

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 Highlands Infant & Toddler Connection to disclose information to (referral source contact name, title, 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.

Legally Authorized Representative _____

Relationship to Child _____

Signature _____ Date _____

If not previously revoked, this authorization will expire in: ☐ 90 Days ☐ One Year ☐ On (specify date/event) _____

The information may be disclosed effective: ☐ Immediately ☐ On (specify date/event) _____