



District of Columbia Medicaid Referral Form

PATIENT CONTACT INFORMATION	
Patient Name: _____	
Date of Birth: ____/____/____ Patient Age (for child under 3 in months): _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F	
Home Address: _____	
City: _____ State: _____ Zip: _____	
Parent /Guardian Name: _____ Relationship to Patient: _____	
Primary Language: _____ Home Phone: _____ Other Phone: _____	
E-mail: _____	
INSURANCE: _____ INSURANCE ID#: _____	

REASONS FOR REFERRAL
Reason for referral (including all relevant clinical information): _____

ICD-9/CPT CODES:					
X	SPECIALTY	# visits	X	SPECIALTY	# visits
	Allergy			Neurosurgery	
	Cardiology			Nuclear Medicine	
	Cardiovascular Surgery			Nutrition	
	Dermatology			Occupational Therapy	
	Developmental Pediatrics			Ophthalmology	
	Early Intervention (ITDD) (fill out the back of the form)			Oral Surgery	
	Endocrinology			Orthopedic Surgery	
	Gastroenterology			Otolaryngology	
	General Surgery			Physical Medicine & Rehab	
	Genetics			Physical Therapy	
	Gynecology			Plastic Surgery	
	Hearing/Audiology			Psychiatry	
	Hematology and Oncology			Psychology	
	HIV/AIDS Specialist			Pulmonary	
	Immunology			Radiology	
	Infectious Disease			Rheumatology	
	Mental and Behavior Health			Speech Therapy	
	Neonatology			Substance Abuse	
	Nephrology			Urology	
	Neurology			Other (specify)	

REFERRAL SOURCE CONTACT INFORMATION	
Referring Provider: _____ Date of Referral: ____/____/____	
Address: _____	
Office Phone: ____/____ - ____ Office Fax: ____/____ - ____ E-mail: _____	
Signature: _____ Date: _____	

Fill out the authorization information below or attach a print out of a referral verification		
Provided by Plan/Carrier: DATE APPROVED:	DATE SPAN:	REFERENCE #:

Referral certification is not a guarantee of payment. Payment of benefits is subject to a member's eligibility on the date that the service is rendered and to any other contractual provisions of the plan/carrier.

See Carrier/Plan Manual for Specific Instructions

Early Intervention Disclosure Form

Please fax this form to the Infants and Toddlers with Disabilities Division (ITDD) at 202-724-7230

If you have any questions, please call 202-727-5785

I authorize, as the **parent** or **legal guardian** of _____ (child's name), a developmental screening and/or a multidisciplinary evaluation to be completed for my child, which will assess my child's development in the following areas:

- **Cognitive development** (thinking and learning skills)
- **Physical development** (moving, running, crawling, use of hands)
- **Communication development** (understanding and using sounds, gestures and words)
- **Social-Emotional development** (responding to and developing relationships with others)
- **Adaptive development** (taking care of one's self when doing things like feeding and dressing)
- **Sensory development** (hearing, seeing)

I also authorize _____ to release the following information (check all that applies):

- | | | | |
|---|---|--|---------------------------------------|
| <input type="checkbox"/> Referral Information | <input type="checkbox"/> Physical Therapy Evaluations | <input type="checkbox"/> Developmental Evaluation or Screening Results | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Admission Summary | <input type="checkbox"/> Occupational Therapy Evaluations | <input type="checkbox"/> Hearing Screen or Test Results | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Speech Therapy Evaluations | <input type="checkbox"/> Vision Screen or Test Results | <input type="checkbox"/> Other: _____ |

... to the following agencies and programs, and for the following reasons:

- Early Intervention Program at the DC Department of Human Services in order to establish my child's eligibility for early intervention services.
- For children who are 2 years, 6 months or older– DCPS responsible for my child in order to establish my child's eligibility for special education preschool services at three years of age.

I understand that once released, my information may be disclosed and may no longer be protected under the Health Insurance Portability and Accountability Act (HIPAA), but will not be re-disclosed by the DCPS, in accordance with the Family Educational Rights and Privacy Act (FERPA).

For more information, see 45 CFR (Code of Federal Regulations) 164.508 for HIPAA and 34 CFR Part 99 for FERPA.

I understand that signing this authorization is not a condition of receiving future medical treatment or early intervention services.

I understand that I may revoke (i.e., cancel) this authorization at any time by notifying the Early Intervention Program or DCPS in writing, and that any information shared prior to revoking this authorization will not be affected by a revocation.

I understand that before any specific services for my child are provided, I also have the right to prior authorize or decline those services.

This authorization expires _____ (expiration date or event).

Signed: _____ Date: _____ copy to parent or legal guardian
(child's parent or legal guardian)

Signed: _____ Date: _____
(referring provider)