



# Early Childhood Intervention

An Affiliate of Texas Early Childhood Intervention

Phone: (915) 534-4324

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NAME: \_\_\_\_\_ CASE NO: \_\_\_\_\_

D.O.B: \_\_\_\_\_ DIAGNOSES: \_\_\_\_\_

## PHYSICAL EXAM FORM

(Required only for initial entrance to ECI)

Height: \_\_\_\_\_ Weight \_\_\_\_\_ (lbs.)

Hematocrit: \_\_\_\_\_ Hemoglobin: \_\_\_\_\_

|                 | N | ABN | Not Done | Comments |                  | N | ABN | NOT DONE |
|-----------------|---|-----|----------|----------|------------------|---|-----|----------|
| MusculoSkeletal |   |     |          |          | Mouth            |   |     |          |
| Extremities     |   |     |          |          | Throat (teeth)   |   |     |          |
| Lymphatics      |   |     |          |          | Neck             |   |     |          |
| Skin            |   |     |          |          | Lungs            |   |     |          |
| Head            |   |     |          |          | Heart            |   |     |          |
| Hair            |   |     |          |          | Abdomen          |   |     |          |
| Scalp           |   |     |          |          | Hernia           |   |     |          |
| Eyes            |   |     |          |          | Genitalia        |   |     |          |
| Ears            |   |     |          |          | Reflexes         |   |     |          |
| Nose            |   |     |          |          | Endocrinopathics |   |     |          |

COMMENTS: \_\_\_\_\_

PHYSICIAN'S SIGNATURE: \_\_\_\_\_

DATE OF PHYSICAL: \_\_\_\_\_

## PRESCRIPTION

(Required once a year unless otherwise specified)

I hereby authorize:

- Physical therapy
- Speech therapy
- Occupational therapy
- Nutrition services
- Developmental services

as needed, to be provided for this individual.

INDICATIONS/CONTRAINDICATIONS: \_\_\_\_\_

PHYSICIAN'S NAME: (Please print) \_\_\_\_\_

PHYSICIAN'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_