



Early Childhood Intervention

An Affiliate of Texas Early Childhood Intervention

Phone: (915) 534-4324

Fax: (915) 496-0750

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: _____