Early Childhood Services MHMR Tarrant
HOPES / LAUNCH Referral Form

Phone #: 1-844-NTX-KIDS (1-844-689-5437)
Email: ECSNTXKids@mhmrtc.org
Fax #: 817-810-3999

☐ Referral to HOPES ☐ ECI Transition to HOPES ☐ Referral to Community Partner

Child Referral Information: *Please Type or Print Clearly*

Local ID:

Child's First Name: Child's Last Name: DOB:

Gender: ☐ Male ☐ Female Language: ☐ English ☐ Spanish Translator Needed: ☐ Yes ☐ No

List Other:

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

Ethnicity: Hispanic/Latino/Spanish? ☐ Yes ☐ No

Parent/Guardian #1: Foster? ☐ Yes ☐ No

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

Ethnicity: Hispanic/Latino/Spanish? ☐ Yes ☐ No

Parent/Guardian #2: Foster? ☐ Yes ☐ No

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

Ethnicity: Hispanic/Latino/Spanish? ☐ Yes ☐ No

Address: City: Zip: County:

Cell #1: Cell #2: Home: Work:

Physician Name: Phone: Fax:

Address: City: Zip: County:

Contact Name/Title:

Are you a HOPES/LAUNCH Coalition member or Community Partner? ☐ Yes ☐ No

Are you an ECI provider for the family? ☐ Yes ☐ No Contact Name: Phone:

Are you actively involved with the family? ☐ Yes ☐ No

Do you want to be invited to the initial appointment? ☐ Yes ☐ No Contact Name: Phone:

Reason for Referral: *(check all that apply)*

☐ Stress Factors Present for the Family:

☐ Need for family to be connected to resources or supports:
- ☐ Parent Support Programs such as Parent Café or Incredible Years
- ☐ Other Community Supports:

☐ Suspected developmental delay in the following area(s) –

☐ Other:

Screening Results: ASQ-3: ASQ-SE: M-CHAT: Other *(specify)*:

Authorization to Release Referral Status to Referral Source or Physician

☐ Parent Declined Evaluation
☐ Eligible for ECS Services – parent accepted services
☐ Eligible for ECS Services – parent declined services
☐ Not eligible for ECS Services
☐ Unable to establish contact with the parent (consent not required to release this information)

I authorize the Early Childhood Services MHMR Tarrant to provide to the referral source or physician identified on this form the applicable information about the referral indicated above. I understand that before sending this information to the referral source or physician that ECS will reconfirm my consent and give me the opportunity to withdraw my consent to provide this information to the referral source or physician.

Parent or Legal Guardian's Signature Printed Name Date