Early Childhood Treatment Center
3524 Torrance Blvd, Ste 104
Torrance, CA 90503
Ph. 310-540-1630/ Fax. 310-540-1610
www.PediatricMinds.com

ECTC REFERRAL FORM (FREE CONSULTATION)

DATE: _______________

☐ **ECTC evaluation / consultation with an IOP clinician (*No Charge*)**

Please Schedule):

☐ Urgent ☐ First Available Appointment

Referring Provider's Name:	**Phone:**	**Fax:**

PATIENT INFORMATION

Patient Full Legal Name:		**DOB:**
Parent Contact Name (pt. under 18 y.o.):		
Preferred Phone:	**Best time to call:**	
Patient Insurance Information (*optional*):		
Patient's Primary Care Provider:	**Phone:**	**Fax:**

GENERAL INFORMATION

Reason for Referral:

Patient aware of reason for referral? ☐ Yes ☐ No: Explain

ECTC REFERRAL CONFIRMATION (COMPLETED BY ECTC)

REFERRAL CONFIRMATION

Referral Accepted? ☐ Yes ☐ No: Explain

ECTC Consultation Scheduled Date:	**Time:**

☐ Patient refused scheduling:

☐ Patient prefers to contact ECTC to schedule at a later date

Request for additional supporting clinical information (please detail):

Person completing confirmation:	**Date of Confirmation:**