EARLY CHILDHOOD TREATMENT CENTER
PEDIATRIC MINDS

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

ECTC SELF-REFERRAL FORM (FREE CONSULTATION)

DATE:

PATIENT INFORMATION

Patient Full Legal Name:		**DOB:**
Parent Contact Name (pt. under 18 y.o.):		
Preferred Phone:	**Best time to call:**	
Medical Insurance Plan Name: **(Please bring Insurance Card to visit)**	☐ **PPO** ☐ **HMO** ☐OTHER:_____	
Patient's Primary Care Provider:	**Phone:**	**Fax:**

Reason for Referral:

EXTERNAL SERVICES

Has the patient had any of the following services? :	**NO**	**YES: (Provide Facility Name)**
REGIONAL CENTER		
SCHOOL IEP		
ABA SERVICES		
SPEECH THERAPY		
OCCUPATIONAL THERAPY		
PYSHICAL THERAPY		

☐ **OTHER:**

If answered YES to any of the questions above, please bring documents to visit