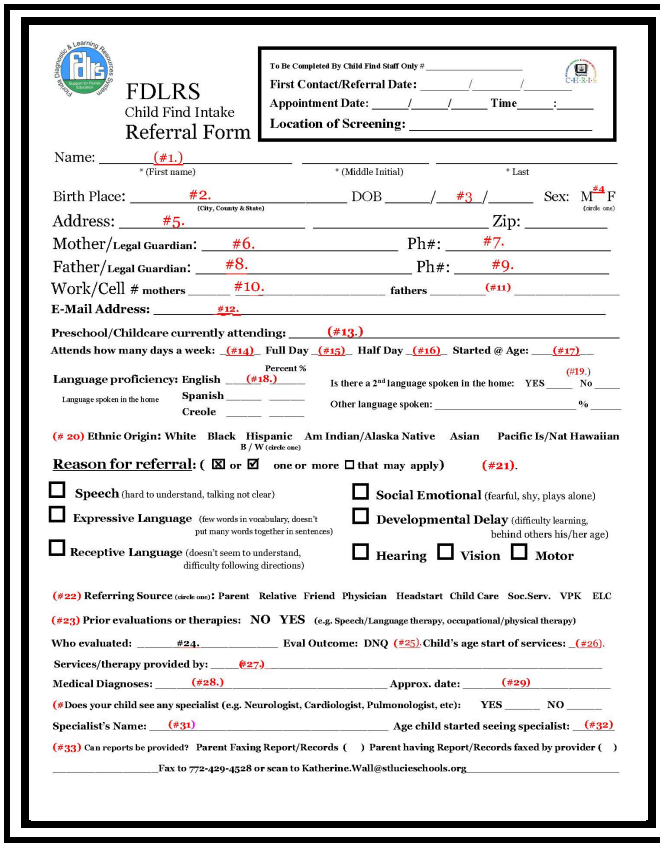
How to Complete A Child Find Referral Form

CHILD FIND provides free screenings for children, ages three to five who are not enrolled in the school system. These screenings measure a child's development in the areas of speech, language, cognitive, motor, auditory, and visual acuity. Here is a step by step on how to correctly complete a CHILD FIND referral form.

The BOX at the top of the form is for OFFICE USE ONLY. To be filled out by the Child Find Consultant or Data Specialist. Please leave this box empty.

This form can ONLY be printed out on line. Then faxed or mailed to the CHILD FIND office.



FDLRS
Child Find Intake
Referral Form

To Be Completed By Child Find Staff Only # _____
First Contact/Referral Date: ____/____/____
Appointment Date: ____/____/____ Time____:____
Location of Screening: _____

Name: (#1.) (First name) (Middle Initial) (Last)
Birth Place: #2. (City, County & State) DOB ____/#3./____ Sex: M #4 F (circle one)
Address: #5. Zip: _____
Mother/Legal Guardian: #6. Ph#: #7.
Father/Legal Guardian: #8. Ph#: #9.
Work/Cell # mothers #10. fathers (#11)
E-Mail Address: #12.
Preschool/Childcare currently attending: (#13.)
Attends how many days a week: (#14) Full Day (#15) Half Day (#16) Started @ Age: (#17)
Language proficiency: English (#18.) Percent %
Language spoken in the home: Spanish ____ ____ Creole ____ ____
Is there a 2nd language spoken in the home: YES ____ No ____ (#19.)
Other language spoken: _____ %
(# 20) Ethnic Origin: White Black Hispanic Am Indian/Alaska Native Asian Pacific Is/Nat Hawaiian B / W (circle one)
Reason for referral: (☒ or ☑ one or more ☐ that may apply) (#21).
☐ Speech (hard to understand, talking not clear)
☐ Expressive Language (few words in vocabulary, doesn't put many words together in sentences)
☐ Receptive Language (doesn't seem to understand, difficulty following directions)
☐ Social Emotional (fearful, shy, plays alone)
☐ Developmental Delay (difficulty learning, behind others his/her age)
☐ Hearing ☐ Vision ☐ Motor
(#22) Referring Source (circle one): Parent Relative Friend Physician Headstart Child Care Soc.Serv. VPK ELC
(#23) Prior evaluations or therapies: NO YES (e.g. Speech/Language therapy, occupational/physical therapy)
Who evaluated: #24. Eval Outcome: DNQ (#25) Child's age start of services: (#26).
Services/therapy provided by: (#27)
Medical Diagnoses: (#28.) Approx. date: (#29)
(#Does your child see any specialist (e.g. Neurologist, Cardiologist, Pulmonologist, etc): YES ____ NO ____
Specialist's Name: (#31) Age child started seeing specialist: (#32)
(#33) Can reports be provided? Parent Faxing Report/Records ( ) Parent having Report/Records faxed by provider ( )
Fax to 772-429-4528 or scan to Katherine.Wall@stlucieschools.org

1. Child's Name - Print clearly the first name, middle initial, and last name of **the child** you are referring to be screened**. Note: providing the middle initial helps separate children with same names like - John Smith/ Susan Williams etc....**

2. Birth Place - This is the ***county and state*** where the **child** you are referring was born.

3. DOB - Date Of Birth of the child being referred.

4. Sex - Circle either **M**-for male or **F** for female

5. Address - Child's current address - very important to list the city or county where the **child lives**. In order to mail an appointment reminder letter we must have a correct mailing address , apt.# & zip code. An appointment reminder letter if requested is mailed out prior to the scheduled appointment. There is also a map with directions provided on the back of the letter.

6. Mother - Name of child's mother **or legal guardian**

7. Ph# - Home phone number where parent/s can be reached

8. Father - Name of child's father **or legal guardian**

9. Ph# - Home phone number where parent/s can be reached

10. Work/Cell mother - mothers work or cell phone number

11. Fathers Work or Cell Number

12. E-Mail Address

13. Preschool/Child care attending - name if the preschool/child care where the child is currently enrolled.

14. How many days a week does the child attend Preschool/ daycare?

15. If child attends full day put a (X) here.

16. If child attends Half Day put a (X) here.

17. The child's age they started Preschool/daycare

18. Language Proficiency - check which language the child prominently speaks. If not listed beside **Other** indicate what language the child speaks.

19. Is there a 2nd language spoken in the home? - Circle YES or NO if yes write the 2nd language that is spoken on the line.

20. Ethnic Origin: What race is the child?

21. Reason for Referral - These are the 5 area's **CHILD FIND** does the initial screening. Mark the box for all concerns / reasons you are referring the child to be screened.

22. Referring Source: Circle the appropriate person/place that is referring the child to be screened - or where YOU the parent heard about FDLRS Child Find.

23. Prior Evaluations or Therapies Circle YES or NO

24. Who provided the prior evaluation?

25. Evaluation Outcome if Did Not Qualify mark and (X) here

26. If child qualified for service what age did services begin?

27. Services/Therapy provided by who?

28. Medical Diagnoses: If child was diagnosed list the diagnoses

29. Approx date of diagnoses goes here.

30. IF the child is seeing a Specialist: Indicate the name of the Specialist here.

31. Specialist Name

32. Age child started seeing the specialist?

33. Reports Provided: Mark and (X) if the parent is faxing over reports/records or if the parent is having the provider fax over the records/reports

Once the referral is complete please fax the referral to me at FDLRS Child Find @ 1-772-429-4528 or you can scan over the referral to my e-mail address Katherine.Wall@stlucieschools.org.
A call is required to confirm an appointment @ 1-772-429-4601. If you have any questions or concerns please feel free to call or e-mail me @ Katherine.Wall@stlucieschools.org
or visit our website for more information @ www.fdlrsgalaxy.org