FDLRS Child Find Intake Referral Form

To be completed by Child Find Staff Only # _____

First Contact/Referral Date: _____/_____/_____

Appointment Date: _____/_____/_____

County of Residence: **Martin** ◯ **St. Lucie** ◯ **Indian Riv** ◯ **Okeechobee** ◯

Child's Name: _____ _____ _____

*** (First name)** *** (Middle)** *** (Last)**

Birth Place: _____ DOB _____/_____/_____ Sex: M ☐ F ☐

(City, County & State)

Address: _____ _____ Zip: _____

Mother/**Legal Guardian**: _____ Ph#: _____

Father/**Legal Guardian**: _____ Ph#: _____

Work/Cell # **mothers** _____ **fathers** _____

E-Mail Address: _____

Preschool/Childcare currently attending: _____

Language proficiency: **English** ☐ **Spanish** ☐ **Creole** ☐ **Other** _____

Is there a 2nd language spoken in the home: **YES** ☐ **No** ☐ **Other language spoken:** _____ **%** ____

Ethnic Origin: **White** ☐ **Black** ☐ **Hispanic** ☐ **Am Indian/Alaska Native** ☐ **Asian** ☐

☐ **Pacific Islander/Nat Hawaiian** **Other** _____

Reason for referral: (☑ one or more that may apply)

☐ **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**

Referring Source : **Parent** ☐ **Relative** ☐ **Friend** ☐ **Physician** ☐ **Headstart** ☐ **Child Care** ☐

Soc.Serv. ☐ **VPK** ☐ **(ELC) Early Learning Co.** ☐ **Other not listed** _____

Prior evaluations or therapies: **NO** ☐ **YES** ☐ **(e.g. Speech/Language therapy, occupational/physical therapy)**

Who evaluated: _____ **Eval Outcome: DNQ** _____ **Child's age start of services:** _____

Services/therapy provided by: _____

Medical Diagnoses: _____ **Approx. date:** _____

Specialist's Name: _____ **Age child started seeing specialist:** _____

Can reports be provided? **Parent Faxing Report/Records** ☐ **Parent having Report/Records faxed by provider** ☐

Fax over to Katherine Wall at 772-429-3622 or Call 772-429-4601 or 800-358-8525 (Spanish 772-219-1610 ext 38250)

SUBMIT