AGENCY OR DOCTORS CHILD FIND REFERRAL (Children Ages 3 to 5 Years)

1531 Winthrop St. Jacksonville FL 32206
Phone (904) 346-4601 Option 1, www.fdlrscrown.org
FOR CLAY / DUVAL / NASSAU COUNTIES

Please e-mail this completed from to fdlrscrown@duvalschools.org

Referring Agency: ______________________________ **Phone:** __________________
Contact Person: ________________________________ **Phone:** __________________

COUNTY OF RESIDENCY ____________ **DATE SUBMITTED** ________________
CHILD'S LAST NAME _______________________ **FIRST** ________________ **MIDDLE** ____________
DOB ___________ ☐ **M** ☐ **F** **RACE** __________ **BIRTH (CITY/STATE)** ___________________________

This Information is Required to Process Referral

CHILD LIVES WITH: ☐ BOTH PARENTS ☐ MOTHER ☐ FATHER ☐ OTHER ___________________________
MOTHER'S NAME ________________________ FATHER'S NAME ________________________________
LEGAL GUARDIAN _________________________ RELATIONSHIP ________________________________
MAILING ADDRESS: ____
PHYSICAL ADDRESS: ____
HOME PHONE: __________________________ OTHER: ______________________________________
CELL (MOTHER): ________________ Text: ☐Yes ☐No CELL # (FATHER): _________________ Text: ☐ Yes ☐No
EMAIL: ____ MEMBER OF MILITARY ☐ YES ☐ NO

LANGUAGE(S) SPOKEN IN HOME IF OTHER THAN ENGLISH? ____________ INTERPRETER NEEDED: ☐ YES ☐ NO
IS THERE A CASEWORKER? IF YES, NAME: ______________________ PHONE: __________________________
ORGANIZATION: ____ EMAIL: ___________________________
PRESCHOOL/CHILD CARE PROVIDER: ____

REASON FOR REFERRAL (Mark all that apply):

☐ **SPEECH** (hard to understand, talking is 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** (interaction w/others, social skills)
☐ **DEVELOPMENT** (seems behind, difficulty retaining info.)
☐ **HEARING** ☐ **VISION**
☐ **FINE MOTOR SKILLS** (holding, drawing, grasping, picking up small objects)
☐ **GROSS MOTOR SKILLS** (clumsy, falls a lot, poor coordination, or balance)
☐ **BEHAVIOR** (aggressive, harms self or others, inattentive, active)
☐ **SELF HELP** (independent functioning, toileting, feeding, dressing)

PREVIOUS TESTING? ☐ **YES** ☐**NO: WHERE?** ____
MEDICAL DIAGNOSIS ☐ **YES** ☐ **NO SPECIFY:** ____
CURRENT SERVICES: ☐ **SPEECH/LANGUAGE** ☐ **OT** ☐ **PT** ☐ **BEHAVIOR** **LOCATION** __________________
OTHER: ____
____

(BELOW FOR FDLRS' USE ONLY)

Appointment Scheduled: ______________________________ **Intake By:** ______________
Place Date Time

DBNUM ____________________ **Assigned to:** ____________ **Date Entered in CHRIS:** _______ **Date Received:** ____________

NOTES: ____

CLOSED/INACTIVE DATE: ____________________ **REASON:** ______________________________________