

# Early Intervention/Early Childhood Special Education (EI/ECSE) Referral Form for Providers\* Birth to Age 5

## CHILD/PARENT CONTACT INFORMATION

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Parent/Guardian Name: \_\_\_\_\_ Relationship to the Child: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
County: \_\_\_\_\_ Primary Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Text Acceptable:  Yes  No Best Time to Contact: \_\_\_\_\_  
Primary Language: \_\_\_\_\_ Interpreter Needed:  Yes  No

## PARENT CONSENT FOR RELEASE OF INFORMATION (more about this consent on page 4)

### Consent for release of medical and educational information

I, \_\_\_\_\_ (print name of parent or guardian), give permission for my child's health provider \_\_\_\_\_ (print provider's name), to share any and all pertinent information regarding my child, \_\_\_\_\_ (print child's name), with Early Intervention/Early Childhood Special Education (EI/ECSE) services. I also give permission for EI/ECSE to share developmental and educational information regarding my child with the child health provider who referred my child to ensure they are informed of the results of the evaluation.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Your consent is effective for a period of one year from the date of your signature on this release.**

## OFFICE USE ONLY BELOW:

Please fax or scan and send this Referral Form (front and back, if needed) to the EI/ECSE Services in the child's county of residence

## REASON FOR REFERRAL TO EI/ECSE SERVICES

**Provider: Complete all that applies. Please attach completed screening tool.**

Concerning screen:  ASQ  ASQ:SE  PEDS  M-CHAT  Other: \_\_\_\_\_

Concerns for possible delays in the following areas (please check all areas of concern and provide scores, where applicable):

- Communication \_\_\_\_\_  Fine Motor \_\_\_\_\_  Personal Social \_\_\_\_\_  
 Gross Motor \_\_\_\_\_  Problem Solving \_\_\_\_\_  Other: \_\_\_\_\_  
 Clinician concerns (including vision and hearing) but not screened:  
\_\_\_\_\_  
\_\_\_\_\_

Family is aware of reason for referral.

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

If child has an identified condition or diagnosis known to have a high probability of resulting in significant delays in development, **please complete the attached Physician Statement for Early Intervention Eligibility (on reverse) in addition to this referral form.** Only a physician licensed by a State Board of Medical Examiners may sign the Physician Statement.

## PROVIDER INFORMATION AND REQUEST FOR REFERRAL RESULTS

Referring Provider Name: \_\_\_\_\_ Referral Contact Person: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_ Address: \_\_\_\_\_  
\_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_

**If the child is eligible, medical provider will receive a copy of the Service Summary.**

## EI/ECSE EVALUATION RESULTS TO REFERRING PROVIDER

**EI/ECSE Services: please complete this portion, attach requested information, and return to the referral source above.**

- Family contacted on \_\_\_\_/\_\_\_\_/\_\_\_\_ The child was evaluated on \_\_\_\_/\_\_\_\_/\_\_\_\_ and was found to be:  
 Eligible for services  Not eligible for services at this time, referred to: \_\_\_\_\_  
 Parent Declined Evaluation  Parent Does Not Have Concerns  
 Unable to contact parent  Attempts \_\_\_\_\_  EI/ECSE will close referral on \_\_\_\_/\_\_\_\_/\_\_\_\_.

\* The EI/ECSE Referral Form may be duplicated and downloaded at this Oregon Department of Education [web page](#).

## MEDICAL CONDITION STATEMENT FOR EARLY INTERVENTION ELIGIBILITY (BIRTH TO AGE 3)

Date: \_\_\_\_\_ Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

The State of Oregon, through the Oregon Department of Education (ODE), provides Early Intervention (EI) services to infants and young children ages birth to three with significant developmental delays. ODE recognizes that disabilities may not be evident in every young child, but without intervention, there is a strong likelihood a child with unrecognized disabilities may become developmentally delayed.

ODE is requesting your assistance in determining eligibility for Oregon EI services for the child named above. Under Oregon law, a physician, physician assistant, or nurse practitioner licensed in by the appropriate State Board can examine a child and make a determination as to whether he or she has a physical or mental condition that is likely to result in a developmental delay.

Please keep in mind that, while many children may benefit from Oregon's EI services, only those in whom significant developmental delays are evident or very likely to develop are eligible.

Thank you for your time and assistance with this matter.

**Medical Condition:**

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**Please indicate if this child has a:**

- Vision Impairment
- Hearing Impairment
- Orthopedic Impairment

**Comments:**

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<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>	<b>This child has a physical or mental condition that is likely to result in a developmental delay.</b>
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\_\_\_\_\_  
Physician/Physician Assistant/Nurse Practitioner

\_\_\_\_\_  
Date

Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**OREGON EI/ECSE CONTACTS**

<b>Baker County</b> Phone: 800.927.5847 Fax: 541.276.4252	<b>Douglas County</b> Phone: 541.440.4794 Fax: 541.440.4799	<b>Lake County</b> Phone: 541.947.3371 Fax: 541.947.3373	<b>Sherman County</b> Phone: 541.238.6988 Fax: 541.384.2752
<b>Benton County</b> Phone: 541.753.1202 x106 877.589.9751 Fax: 541.753.1139	<b>Gilliam County</b> Phone: 541.238.6988 Fax: 541.384.2752	<b>Lane County</b> Phone: 541.346.2578 Fax: 541.346.6189	<b>Tillamook County</b> Phone: 503.842.8423 Fax: 503.842.6272
<b>Clackamas County</b> Phone: 503.675.4097 Fax: 503.675.4205	<b>Grant County</b> Phone: 800.927.5847 Fax: 541.276.4252	<b>Lincoln County</b> Phone: 541.574.2240 x101 Fax: 541.265.6490	<b>Umatilla County</b> Phone: 800.927.5847 Fax: 541.276.4252
<b>Clatsop County</b> Phone: 503.338.3368 Fax: 503.325.1297	<b>Harney County</b> Phone: 541.573.6461 Fax: 541.573.1914	<b>Linn County</b> Phone: 541.753.1202 x106 877.589.9751 Fax: 541.753.1139	<b>Union County</b> Phone: 800.927.5847 Fax: 541.276.4252
<b>Columbia County</b> Phone: 503.366.4141 Fax: 503.397.0796	<b>Hood River County</b> Phone: 541.386.4919 Fax: 541.387.5041	<b>Malheur County</b> Phone: 541.372.2214 Fax: 541.473.3915	<b>Wallowa County</b> Phone: 541.927.5847 Fax: 541.276.4252
<b>Coos County</b> Phone: 541.269.4524 Fax: 541.269.4548	<b>Jackson County</b> Phone: 541.494.7800 Fax: 541.494.7829	<b>Marion County</b> Phone: 503.385.4714 888-560-4666 x4714 Fax: 503.540.2959	<b>Warm Springs</b> Phone: 541.553.3241 Fax: 541.553.3379
<b>Crook County</b> Phone: 541.693.5630 Fax: 541.693.5661	<b>Jefferson County</b> Phone: 541.693.5740 Fax: 541.475.5337	<b>Morrow County</b> Phone: 800.927.5847 Fax: 541.276.4252	<b>Wasco County</b> Phone: 541.296.1478 Fax: 541.296.3451
<b>Curry County</b> Phone: 541.269.4524 Fax: 541.269.4548	<b>Josephine County</b> Phone: 541.956.2059 Fax: 541.956.1704	<b>Multnomah County</b> Phone: 503.261.5535 Fax: 503.894.8229	<b>Washington County</b> English: 503.614.1446 Spanish: 503.614.1299 Fax: 503.614.1290
<b>Deschutes County</b> Phone: 541.312.1195 Fax: 541.693.5661	<b>Klamath County</b> Phone: 541.883.4748 Fax: 541.850.2770	<b>Polk County</b> Phone: 503.385.4714 888-560-4666 x4714 Fax: 503.540.2959	<b>Wheeler County</b> Phone: 541.238.6988 Fax: 541.384.2752
			<b>Yamhill County</b> Phone: 503.385.4714 888-560-4666 x4714 Fax: 503.540.2959

EI/ECSE contact information also available at this Oregon Department of Education [web page](#).

or please call 1-800-SafeNet

**SOUTHWEST WASHINGTON EI/ECSE CONTACTS**

(NOTE: EI/ECSE Program Requirements differ in each state; please contact these offices for Washington Requirements)

<b>Clark County</b> Phone: 360.896.9912 ext.170 Fax: 360.892.3209	<b>Cowlitz County</b> Phone: 360.425.9810 Fax: 360.425.1053	<b>Klickitat County</b> Phone: 360.921.2309 Fax: 509.493.2204	<b>Skamania County</b> Phone: 509.427.3865 Fax: 509.427.4430
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## Early Intervention/Early Childhood Special Education (EI/ECSE) Referral Form for Providers\* Birth to Age 5

### CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION BETWEEN HEALTHCARE PROVIDERS and EARLY INTERVENTION

#### **Information for Parents**

*This consent for release of information authorizes the disclosure and/or use of your child's health information from your child's health care provider to the Early Intervention/Early Childhood Special Education (EI/ECSE) program. This consent form also authorizes the disclosure of developmental and educational information from the Early Intervention/Early Childhood Special Education program to your child's health care provider.*

#### ***Why is this consent form important?***

Your child's health care provider sees your child at well-child screening visits and for medical treatment. Sometimes your child's health care provider may see the need for more information, like evaluation or follow up by other specialists, to identify your child's special health care needs. The Early Intervention/Early Childhood Special Education (EI/ECSE) program can be a resource to help identify your child's needs. The primary goal of this consent form is to allow communication between your child's health care provider and EI/ECSE programs so these providers can work together to help your child.

#### ***Why am I asked to sign a consent on this form?***

The consent allows your child's health care provider to share information about your child with EI/ECSE, and allows EI/ECSE to share information about your child with your health care provider. Your consent for the release of information allows your child's health care provider and EI/ECSE communicate with one another to ensure your child gets the care your child needs. However, as your child's parent or legal guardian you may refuse to give consent to this release of information.

#### ***How will this consent be used?***

This consent form will follow your child as he/she is screened and/or evaluated at EI/ECSE. The information generated by this release will become a part of your child's medical and educational records. Information will be shared with only individuals working at or with EI/ECSE or the office of your child's health care provider for the purpose of providing safe, appropriate and least restrictive educational settings and services and for coordinating appropriate health care.

#### ***How long is the consent good for?***

This consent is effective for a period of one year from the date of your signature on the release.

#### ***What are my rights?***

You have the following rights with respect to this consent:

- You may revoke this consent at anytime.
- You have the right to receive a copy of the Authorization.