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/ESCE 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 ☐ 45 Day Due Date_____

☐Unable to contact parent ☐ Attempts_____ ☐ EI/ECSE will close referral on _____/_____/_____.