**CAPTA: (Y) (N)**

**Due Date** _____

*Jackson County Early Intervention/*
*Early Childhood Special Education Services*
**640 Superior Ct., Medford, OR 97504**
**Phone: (541) 494-7800 Fax #: (541) 494-7829**

**DESD**

**Child's name:** _____ **M/F / Date of Birth:** _____
(first) (Middle) (last)

**Child's physical address:** _____ **School district:** _____

**Parent 1:** _____ **Address:** _____ **Phone:** _____ **Relationship:** _____

**Parent 2:** _____ **Address:** _____ **Phone:** _____ **Relationship:** _____

**Are there legal restrictions limiting either parents' access to information? (N) (Y) (N/A)**

**Is there a custody arrangement:** _____

**DHS Case Worker Name:** _____ **Phone:** _____

**Foster Parent name:** _____ **Address:** _____ **Phone: (home)** _____

**Has child ever received EI/ECSE testing/services here or in another location?** _____ **If yes, where/when?** _____

**Physician:** _____ **Dr. aware of referral? Yes / No Has child been in high-risk follow up?** _____

**School:** _____ **Teacher:** _____ **Phone:** _____

**Child's Primary language:** _____ **Need interpreter for parent?** _____ **For child?** _____

**Referring party:** _____ **Phone:** _____ **Parent informed of referral: Yes** ☐ **No** ☐

**CHECK THE SPECIFIC AREA(S) OF CONCERN. Please give examples of skills in each area, and indicate which areas are of concern.**

**Cognitive Development (problem solving, remembering, and learning new skills):** _____

**Receptive Language (understanding of language):** _____

**Expressive Language (using words, sounds, gestures to express needs and wants):** _____

**Gross Motor (crawling, rolling, walking):** _____

**Fine Motor (fingers, hands, wrists):** _____

**Self-help (feeding, dressing, toileting):** _____

**Social, Emotional, Behavioral (interaction with others and processing feelings):** _____

**Hearing:** _____ **Vision:** _____

**Health Concerns:** _____

**Additional information:** _____

**Previous history** _____

_____ **Dx:** _____

**Medications:** _____

**FOR JACKSON COUNTY EI/ECSE OFFICE USE ONLY**

☐**Central Valley Team** ☐**North Valley Team**
☐**South Valley Team**

**Referral for:**

☐**ECSE, 3 years to kindergarten**
☐**Adding Eligibility**
☐**EI, birth to 3 years old**
☐**Disenrollment**
☐**Transfer**
☐**High Risk Follow-up**
☐**Autism**
☐ **Other** _____