



Child Find Intake Referral Form

Child is ____ . ____ yrs old

To Be Completed By Child Find Staff Only # _____

First Contact/Referral Date: ____/____/____



Appointment Date: ____/____/____ Time ____:

Location of Screening/Rec Rev: _____

Child's Name: _____
* (First name) * (Middle) * (Last)

Birth Place: _____ (City, County & State) DOB ____/____/____ Sex: M F
(circle one)

Address: _____ Zip: _____

Mother/Legal Guardian: _____ Ph#: _____

Father/Legal Guardian: _____ Ph#: _____

Work/Cell # mothers _____ fathers _____

E-Mail Address: _____

Preschool/Childcare currently attending: _____

Language proficiency: English _____ Percent %
Language spoken in the home Spanish _____
Creole _____
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 Is/Nat Hawaiian
B / W (circle one)

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

- | | |
|---|--|
| ☐ Speech (hard to understand, talking not clear) | ☐ Social Emotional (fearful, shy, plays alone) |
| ☐ Expressive Language (few words in vocabulary, doesn't put many words together in sentences) | ☐ Developmental Delay (difficulty learning, behind others his/her age) |
| ☐ Receptive Language (doesn't seem to understand, difficulty following directions) | ☐ Hearing ☐ Vision ☐ Motor |
| ☐ Other concerns: _____ | |

Referring Source (circle one): Parent Relative Friend Physician Head Start Child Care Soc. Serv. VPK ELC

Website Referral #: _____ FCHD HPS/2-1-1 Tykes & Teens Hibiscus PRE-VPK

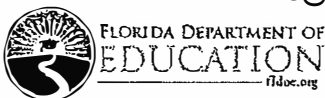
Prior evaluations or therapies: NO YES ☐ S/L ☐ OT/PT ☐ Behavior

Location of Services/Therapies: _____ Medical Diagnoses: _____

Mailed ASQ &/or P.P on: ____/____/____ Emailed Apt Reminder: ____/____/____

Att to Ct-L/M 4 R/C: ____/____/____ 2nd Att: ____/____/____ 3rd: ____/____/____

EMAIL: FDLRS@STLUCIESCHOOLS.ORG OR FAX: (772)429-3622 OR CALL (772)429-4601



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