

Early Childhood Developmental Interagency Referral Communication Form

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Date: _____

TO: _____ (name, title) _____ (phone) _____ (fax) _____ (address) _____ (program / agency)	FROM: _____ (name, title) _____ (phone) _____ (fax) _____ (address) _____ (program / agency)
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CHILD INFORMATION

Child ID Number: _____	Child's Name: _____	DOB: _____	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Parent / Legal Guardian: _____		Relationship: _____	
Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Hmong <input type="checkbox"/> Somali <input type="checkbox"/> Other _____			Interpreter Needed: <input type="checkbox"/> Yes <input type="checkbox"/> No
Home Address: _____		Phone: _____	Insurance: _____
Known Pertinent Medical History: _____			

*****REASON FOR REFERRAL (please check all that apply)*****

<input type="checkbox"/> Developmental Screening Tool Concern	Developmental tool used: _____
<input type="checkbox"/> Mental Health Screening Tool Concern	Mental Health tool used: _____
<input type="checkbox"/> Medical/Health/Growth Concern	(list) _____
<input type="checkbox"/> Suspected developmental delay or concern	<input type="checkbox"/> Motor/Physical <input type="checkbox"/> Cognitive <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Behavior/Adaptive <input type="checkbox"/> Speech/Language <input type="checkbox"/> Social Emotional <input type="checkbox"/> Other _____
Other/ Comments: _____	
Identified automatic qualification condition for early childhood services? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, list) _____	

OTHER REFERRALS (In process = IP; Receiving Services = RS=)

Audiology: _____	Social Worker: _____	Home Care: _____
Medical Specialists: _____	Public Health Nursing: _____	Mental Health: _____
Private OT/PT/SLP: _____	Help Me Grow/direct website: _____	Other: _____

WHEN RETURNING THIS FORM, PLEASE INDICATE ATTACHED INFORMATION (Date: _____)

<input type="checkbox"/> *Consent form	<input type="checkbox"/> Developmental Screening, Assessment Information	<input type="checkbox"/> Mental Health Screening Assessment Information
<input type="checkbox"/> Individualized Education Plan / Individualized Family Service Plan		<input type="checkbox"/> Medical Reports, Diagnosis, Prescriptions
<input type="checkbox"/> Evaluation results / observations / progress report		<input type="checkbox"/> Other: _____
<input type="checkbox"/> Summary of presenting problems		

RETURN COMMUNICATION (expected within 45 days B-3, 90 days 3-5)

<input type="checkbox"/> Evaluation in process	<input type="checkbox"/> Parent declined	<input type="checkbox"/> No response from parent	<input type="checkbox"/> Client not seen within 60 days
Result of the assessment: Qualification <input type="checkbox"/> Yes <input type="checkbox"/> No		Date services started: _____	
If no, ongoing monitoring? <input type="checkbox"/> Yes <input type="checkbox"/> No; Follow-up plan _____			
If yes, describe plan of action/services provided (i.e. frequency, duration, location, and type of service): _____			
Other relevant details/comments: _____			
Recommendations to referral source: _____			

RETURN TO:

<input type="checkbox"/> _____ County Public Health	<input type="checkbox"/> Help Me Grow	<input type="checkbox"/> Head Start/ School Readiness
<input type="checkbox"/> Early Childhood Screening	<input type="checkbox"/> Medical Provider:	<input type="checkbox"/> Other