Early Intervention Referral Form

Please complete this form for referring a child to early intervention if you prefer to do so in writing. Also please indicate the feedback that you want to receive from the early intervention program in response to your referral.

Child Contact Information

Child Name: ______________________________
Date of Birth: _____/_____/_____ Child Age (Months) _____ Gender M F
Home Address: ______________________________
City: __________________State:____________Zip:______________________
Parent/Guardian_______________Relationship to Child: ______________________
Primary Language:__________ Home Phone:________Other Phone:__________________
Signature:______________________________Date:______________________

Reasons(s) of Referral

Reason(s) for referral to early intervention (Please check all that apply):

- ☐ Identified condition or diagnosis (e.g., spina bifida, Down syndrome): ______________________
- ☐ Suspected developmental delay or concern (Please circle areas of concern):

Motor/Physical Cognitive Social/Emotional Speech/Language Behavior Other____________

- ☐ At Risk (Please describe risk factors): ______________________________
- ☐ Other (Please Describe):______________________________

Feedback Requested by the Referral Source

- ☐ Status of Initial Family Contact
- ☐ Services Being Provided to Child/Family
- ☐ Developmental Evaluation Results
- ☐ Child Progress Report/Summary
- ☐ Other (Please describe):______________________________

Referral Source Contact Information

Person Making Referral:______________________Date of Referral:_______/_______/_______
Address:______________________________
Office Phone_____/_____-_______Office Fax:_____/_____-_______E-mail__________________
Signature:______________________________Date:__________________

Early Intervention Program

Program Name: ______________________________
Address: ______________________City: ______________State: ______Zip:________
Telephone Number: ____________________Fax Number: ______________________
E-mail______________________________

Release of Information Consent

I,______________________(Print name of parent or guardian), give my permission for my pediatric health care provider, ____________________(print provider's name), to share any and all pertinent information regarding my child,____________________(print child's name), with the early intervention program.

Parent/Legal Guardian Signature______________________________ Date:_______/_______/_______