CHILD/PARENT CONTACT INFORMATION
Child's Name:
Parent/Guardian Name: Relationship to the Child:
Address:
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,
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
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 Personal Social  Gross Motor Other:  Clinician concerns (including vision and hearing) but not screened:
—————————————————————————————————————
Provider Signature:
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
El/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 □ El/ECSE will close referral on/