Early Childhood Developmental Interagency Referral Communication Form

The information contained in this form is privileged and confidential information. If you are neither the intended recipient nor the employee or agent responsible for delivering this information to the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance on the content of this telecopied information is strictly prohibited. When sending this form, always attach the patient's current consent form.	Date: _____

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

CHILD INFORMATION

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

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

☐ Developmental Screening Tool Concern	Developmental tool used: _____
☐ Mental Health Screening Tool Concern	Mental Health tool used: _____
☐ Medical/Health/Growth Concern	(list) _____
☐ Suspected developmental delay or concern	☐ Motor/Physical ☐ Cognitive ☐ Vision ☐ Hearing ☐ Behavior/Adaptive ☐ Speech/Language ☐ Social Emotional ☐ Other _____
Other/ Comments: _____	
Identified automatic qualification condition for early childhood services? ☐ No ☐ 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: _____)

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

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

☐ Evaluation in process	☐ Parent declined	☐ No response from parent	☐ Client not seen within 60 days
Result of the assessment: Qualification ☐ Yes ☐ No		Date services started: _____	
If no, ongoing monitoring? ☐ Yes ☐ 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:

☐ Olmsted County Public Health	☐ School District (Place name) _____	☐ Head Start/School Readiness
☐ Early Childhood Screening (fax: 507-328-4015)	☐ Mayo Clinic	☐ Olmsted Medical Center
☐ Other Medical Provider _____		