# Early Intervention / Early Childhood Special Education

Referral Results Form: Please return by fax to the student’s primary clinic.

**Student’s Name Gender M F DOB**

**Referral Source Referral Date**

**Clinic or Referral Source Fax # School District**

**Student’s Primary Clinic Date Faxed**

**EI/School District Contact Person Phone**

**Outcome of the Referral: Check as many as apply**

* **Team was unable to contact parent**

**IN ORDER TO REPORT BACK INFORMATION BELOW THIS LINE, CONSENT MUST BE OBTAINED FROM THE STUDENT’S FAMILY.**

* **Team contacted, but parent declined evaluation**
* **Team determined no evaluation was needed**
* **Team evaluated and student did NOT qualify**
* **Student qualified and family declined services**
* **Student qualified and family accepted services**
* **Team evaluated and student qualified for:** 
  + - **Developmental Delay (DD)**

***Delays in following areas:* *Cognition* *Communication*  *Fine Motor*  *Gross Motor* *Social-Emotional* *Adaptive***

* **Speech/Language Impairment (SL)**

***Delays in following areas:* *Language* *Fluency*  *Voice*  *Articulation***

* **Autism Spectrum Disorder (ASD)**
* **Deaf/Hard of Hearing (DHH)**
* **Emotional/Behavioral Disorders (EBD)**
* **Other**

**Other Referrals Made (Mental Health Services, Dev. Disabilities, CPS, ECFE, PH Nursing, HeadStart, etc.)**