Child Find Referral Form
(For Children age 3-5 years)

Child’s Information
Child’s Name (First, Middle, Last): ________________________________
DOB: ___ / ___ / _____ Child’s Race: ___________________________ Gender: □ Male □ Female
Parent / Guardian: _____________________________ Relation to Child: ____________________________
Address: _____________________________ Phone #1: __________________________ Best Time: ______
____________________________________ Phone #2: __________________________ Best Time: ______
Interpreter Needed: □ Yes □ No If Yes, Language: __________________________

School District or County of Residence: ____________________________
Referring Provider: _____________________________ Phone: __________________________
Address: _____________________________ Fax: __________________________
Reason for referral: __________________________

Date of ASQ or other developmental screening ___ / ___ / _____ Date of Hearing Screen ___ / ___ / _____ Date of Vision Screen ___ / ___ / _____ (Please include copy of the entire developmental screening tool, such as the ASQ, as well as results of any hearing and vision screening. This will avoid duplication of efforts and allow for a more timely and appropriate evaluation.)

Referral and Consent to Share Information
I am requesting that my child be referred to Child Find to determine eligibility for preschool special education services. I authorize my child’s provider _____________________________ to release the results of developmental screening and any pertinent medical history of _____________________________(name of child) DOB ___ / ___ / _____ to _____________________________(Child Find Coordinator/School District) to be considered in determining whether the child is a child with an educational disability.
Signed: _____________________________ Relation to Child: _____________________________ Date: ___ / ___ / _____

Furthermore, I authorize _____________________________(Child Find coordinator/school district) to share the results of the evaluation with _____________________________(child’s provider).
Signed: _____________________________ Relation to Child: _____________________________ Date: ___ / ___ / _____

Update from Child Find to Referral Source (Child Find to Fax to Referral Source if listed above)
□ Child Find completed developmental screening of this child on ___ / ___ / ______
□ The child was evaluated on ___ / ___ / ______ and is...
   □ Eligible for preschool special education and (circle all):
      SPL PT OT Behavioral Other: _____________________________
   □ Not eligible for preschool special education at this time, further developmental evaluation may be indicated. Follow up with medical provider recommended.
□ The child has not been in for screening or evaluation
□ The child did not qualify for special education but a developmental delay was confirmed. Follow up with medical provider recommended.
□ Please call me for more information regarding this child’s screening/evaluation
Completed by: _____________________________ Phone: _____________________________
Signature: _____________________________ Date: ___ / ___ / _____

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