

o Move In

educational excellence through leadership, partnership, and innovation

EARLY INTERVENTION PRESCHOOL REFERRAL FORM

Child's Name:	Gender:
Birth Date: SSN:	
Child's Address:	
School District Where Child Lives:	(City) (State) (Zip code)
What is the Child's Ethnicity? Hispanic Not His	spanic or Latino
What is the Child's Race? White Black or African Indian or	ican American Asian Native Hawaiian or Other Alaska Native Pacific Islander
Mother's name:	Father's name:
Home Phone:	Home phone:
Cell phone:	Cell phone:
Work phone:	Work phone:
E-mail:	E-mail:
Lives with child?	Lives with child?
If No list address	If No list address
What languages are spoken in the home:	
Dialect:	
Interpreter needed for parents: Yes No	(*An interpreter will be provided in your child's native language.)
To be completed only if this child has a legal s	guardian/foster parents:
Legal Guardian/Foster Parent's name (s):	(Please provide a copy of your legal documents)
Relationship:	
Guardian/Foster Parent's home phone:	
Guardian/Foster Parent's cell phone:	
Guardian/Foster Parent's work phone:	
Guardian/Foster Parent's E-mail	
Who has education rights?	

Please list any brothers and sisters below: Name <u>Sex</u> Age Live in the child's home? What concerns do you have about your child's development? _____ How did you learn about the CAIU Preschool Program? Does your child attend any of the following? _____ Day Care Center _____ Pre-K Counts ____ Nursery School ____Head Start _____ Day Care in a home If you checked any of the above, please tell us: Where_____ _____ What time_____ What days **DEVELOPMENTAL HISTORY** Did you have any difficulties: _____Before _____During _____ After the birth of this child? Check any of the following that apply: ___ Required Oxygen ____ Ventilator support _____Intraventricular hemorrhage (Brain Bleed) _____ PreEclampsia _____Other: _____ Exposure to toxic substances: _____ Drugs ____ Alcohol Did your child require special medical care following birth? Yes No _____NICU Treatment Number of days _____ Length of Pregnancy: ______ weeks Birth Weight: _____lbs. ____ oz (s) GROSS MOTOR: How old was your child when he/she began: Sitting _____ Crawling _____ Walking Child can: ____ walk ___ run ____ climb up steps/ stairs ____ go down steps/stairs Alternates feet when climbing Yes No TOILETING: _____ Fully toilet trained _____ Partially toilet trained _____ Not toilet trained

COMMUNICATION. How old was your skild when he/she began. Using single words

COMMUNICATION: How old was your child when he/she began: Using single words_______
Phrases _______
Sentences

Sentences
My Child does not talk yet

If your child does not use words or uses very few words, how does he/she let you know what he/she wants? gestures/pointing whining/crying taking you to it making sounds
How much of what your child says can you /family members understand?100% (all)75% (most)50% (some)25% (little)0% (none)
How much of what your child says can others understand?100% (all)75% (most)50% (some)25% (little)0% (none)
Once your child began using words did he/she ever stop talking? Yes No
If yes please describe:
My child can: follow 1 step directions follow 2 step directions not yet follow directions
Does your child usually play: alone near other children with other children (sharing or turn taking)
MEDICAL and PSYCHOSOCIAL HISTORY
Does your Child have a Medical Assistance (MA) card? If yes, please list the card number:
Name of Child's Physician:
Physician's address and/or phone:
Name of any other Physicians who are caring for your child, if any:
Describe any significant medical problems past or current: Surgeries:
Hospitalizations:
Serious Illnesses:
If your child has been given a diagnosis, please check and provide a copy of any reports (related to that diagnosis) that you may have in your possession.
Seizures Asthma DiabetesChronic Ear Infections
Attention Deficit Hyperactive Disorder (ADHD), By whom
Pervasive Developmental Disorder (PDD), By whom
Autism Spectrum Disorder, By whom
Obsessive Compulsive Disorder (OCD), By whom
Oppositional Defiant Disorder (ODD), By whom
Sensory Integration Dysfunction, By whom
Lead Poisoning, By whom
Vision Problems, have glasses been prescribedyesno By whom
Hearing Problems, have hearing aides been prescribed yesno By whom
Allergies, if checked please describe
Other

Is your child currently taking medication?
MedicationDosage
MedicationDosage
Place a check next to any of the following that describes concerns you have about your child
Developmental Delays: needs a lot of help to learn new skills, does not seem to be learning at an average rate, delayed in accomplishing developmental milestones
Speech/Language:
Articulation: difficulty pronouncing words
Expressive Language: difficulty putting words together to form sentences, few words
Receptive language: difficulty answering questions, following directionsPragmatic language: difficulty using words to have wants/needs met, unable to carry on a conversation, talks about 1 topic only
Motor:
Gross motor: clumsy, difficulty running, balance, poor body control Fine motor: difficulty with holding crayons/pencils, drawing, stacking blocks completing puzzles
Sensory Integration: difficulty having hands dirty /sticky, sensitive to loud noises, seeks deep pressure sensitive to touch, difficulty with haircuts
Self-Help: toileting, feeding, dressing problems
Socialization: does not play well with other children, difficulty separating from parent, will not work in a group, is left out of peer group activities
Attention: short attention span, changes activities frequently, difficulty completing play/activities without help
Behavior: tantrums, is not able to accept limits, resists rules, difficulty calming his/her self
Emotional: sudden changes in mood, is a danger to self or others
Hearing: does not seem to hear sounds/words, asks you to repeat or talk louder, turns up volume on the TV or radio
Vision: eyes turn in or turn out, squints, gets close to objects /books to see
Comments:
Comments:
Who should we call to schedule an Appointment?
What phone number (s) can we call between 8:30 AM and 4:00PM Monday-Friday?
Form Completed by:

EI-PS Referral Form Page 4 Revised 6/7/17

Date:_

Relationship to child: __