



educational excellence through leadership, partnership, and innovation

- New Screening Referral
- Move In

EARLY INTERVENTION PRESCHOOL REFERRAL FORM

Child's Name: _____ Gender: _____

Birth Date: _____ SSN: _____

Child's Address: _____
(City) (State) (Zip code)

School District Where Child Lives: _____

What is the Child's Ethnicity? Hispanic Not Hispanic or Latino

What is the Child's Race? White Black or African American Asian Native Hawaiian or Other Pacific Islander
 American Indian or Alaska Native

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? Yes No Lives with child? Yes No

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 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? _____

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 _____ Diabetes _____ Chronic 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 prescribed _____ yes _____ no By whom _____

_____ Hearing Problems, have hearing aides been prescribed _____ yes _____ no By whom _____

_____ Allergies, if checked please describe _____

Other: _____

Is your child currently taking medication? Yes No (if yes please complete below)

Medication _____ Dosage _____

Medication _____ Dosage _____

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 directions

_____ **Pragmatic 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:

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: _____

Relationship to child: _____ Date: _____