

Early Intervention

(Ages Birth to 3rd Birthday)

School District Child Find

(Ages 3 to 5)

Referral and Release Form

Early Intervention or School District: _____ Fax: _____

Child's Name: _____ Male Female DOB: _____

Parent(s)/Legal Guardian: _____ Phone: _____

Family's Address: _____ County: _____

Family's E-mail: _____ Alt Phone: _____

Foster/Kinship Parent(s) (if applicable): _____ Phone: _____

Guardian ad Litem (GAL) Name: _____ Phone: _____

CAPTA? YES NO Assigned Caseworker: _____ Legal Status of Child: Parent Custody, rights intact

Foster Care, Biological rights intact Foster Care, Parent rights terminated Other, Explain: _____

Primary Language Spoken by Parent(s)/Legal Guardian/Foster Parents: English Spanish Other _____

Ethnicity: White, Non-Hispanic Hispanic or Latino Asian American Black or African American American Indian Other

Child Attends: Head Start School District Preschool Private Preschool Child Care N/A

Primary Care Physician (PCP): _____ PCP Phone: _____ Fax: _____

Referring Practice/ Agency: _____ Referring Person: _____

Referring Person Phone: _____ Fax: _____ Email: _____

Has a developmental screening been completed for this child? (ASQ, Peds, etc) NO YES, **send the screening results with the referral**

There are concerns for possible delays in development in the following area(s): _____

If applicable: Date of Vision Screen: ___/___/___ Date of Hearing Screen: ___/___/___ Established Condition: _____

Signed: _____ (referring person) Date of Referral: _____

For Children age 3 +: I am requesting that my child be referred to Child Find to determine eligibility for preschool special education services: _____ (Parent/Legal Guardian) Date: _____

Authorization to Release Information (optional)

I authorize the Community Centered Board Early Intervention Colorado Program or Administrative Unit/ School District to share the following information with the referring practice/agency listed above.

- Eligibility outcome information (eligible/not eligible)
- Evaluation/Assessment results (range of delay for each developmental domain)
- Ongoing Early Intervention Services included on the Individualized Family Service Plan; or Special Education Services on the Individualized Education Plan, for the purpose of care coordination.

I understand that I may withdraw this consent by written request to the Community Centered Board Early Intervention Colorado Program or Administrative Unit/ School District. If consent is revoked it does not apply to any actions that occurred before consent was revoked. I certify that this authorization to release this information has been given freely and voluntarily. Information collected related to early intervention services may not be shared unless the person who consented to sharing this information specifically consents to it and or the sharing this information is allowed by law. I understand I have a right to inspect and copy the information to be disclosed.

Signed: _____ *Date: _____

(child's parent or legal guardian)

*Authorization is effective for a period of 12 months from this date

Update to Referral Source for Children aged 3+. (Early Intervention will provide follow-up on children referred aged 0-3)

- Passed Developmental Screen Referred to Head Start or Colorado Preschool Program
- Family declined Child Find screening or evaluation
- No response from family after multiple attempts to contact
- Child evaluated on (date) _____

Outcome: Not Eligible for Preschool Special Education at this time

Eligible for Preschool Special Education; (Circle) PT OT ST Cognitive Social Emotional