Early Intervention/Early Childhood Special Education (EI/ECSE) Referral Form for Providers* Birth to Age 5

CHILD/PARENT CONTACT INFORMATION

Child's Name: _____ Date of Birth: ____/____/____ Gender: ☐M ☐F ☐X

Type of Insurance: ☐ Private ☐OHP/Medicaid ☐TRICARE/Other Military Ins. ☐Other (Specify)_____ ☐ No Ins.

Parent/Guardian 1: Name: _____ Relationship to the Child: _____

Address: _____City: _____ State: _____ Zip: _____ County: _____

Primary Phone: _____ Secondary Phone: _____ E-mail:_____

Text acceptable: ☐Yes (☐ Primary Phone ☐ Secondary Phone) ☐ No Email acceptable: ☐Yes ☐ No

Parent/Guardian 2*:* Name: _____ Relationship to the Child: _____

Address: _____City: _____ State: _____ Zip: _____ County: _____

Primary Phone: _____ Secondary Phone: _____ E-mail:_____

Primary Language: _____ Interpreter Needed: ☐Yes ☐ No

Child's Doctor's Name, Location And Phone (if known): _____

PARENT CONSENT FOR RELEASE OF INFORMATION (more about this consent on page 4)

Consent for release of medical and educational information

I, _____ (print name of parent or guardian), give permission for my child's health provider _____ (print provider's name), to share any and all pertinent information regarding my child, _____ (print child's name), with Early Intervention/Early Childhood Special Education (EI/ECSE) services. I also give permission for EI/ECSE to share developmental and educational information regarding my child with the child health provider who referred my child to ensure they are informed of the results of the evaluation.

Parent/Guardian Signature: _____ **Date:** _____/_____/_____

Your consent is effective for a period of one year from the date of your signature on this release.

OFFICE USE ONLY BELOW:

Please fax or scan and send this Referral Form (front and back, if needed) to the EI/ECSE Services in the child's ***county of residence***

REASON FOR REFERRAL TO EI/ECSE SERVICES

Provider: Complete all that applies. Please attach completed screening tool.

Concerning screen: ☐ ASQ ☐ASQ:SE ☐ PEDS ☐PEDS:DM ☐M-CHAT ☐SWYC ☐Other:_____

Concerns for possible delays in the following areas (please check all areas of concern and provide scores, where applicable):

☐Speech/Language _____ ☐Gross Motor_____ ☐ Fine Motor _____

☐ Adaptive/Self-Help _____ ☐Hearing _____ ☐ Vision _____

☐ Cognitive/Problem-Solving _____ ☐Social-Emotional or Behavior_____ ☐Other: _____

☐ Clinician concerns but not screened: _____

☐ Family is aware of reason for referral.

Provider Signature: _____ **Date:** _____/_____/_____

If child has an identified condition or diagnosis known to have a high probability of resulting in significant delays in development, ***please complete the attached Physician Statement for Early Intervention Eligibility (on reverse) in addition to this referral form****. Only a physician licensed by a State Board of Medical Examiners may sign the Physician Statement.*

PROVIDER INFORMATION

Name and title of provider making referral: _____ Office Phone: _____ Office Fax: _____

Address: _____City: _____ State: _____ Zip: _____

Are you the child's Primary Care Physician (PCP)? Y___ N___ If not, please enter name of PCP if known: _____

EI/ECSE EVALUATION RESULTS TO REFERRING PROVIDER

EI/ESCE Services: ***please complete this portion, attach requested information, and return to the referral source above.***

☐Family contacted on _____/_____/_____ The child was evaluated on _____/_____/_____ and was found to be:

☐Eligible for services ☐Not eligible for services at this time, referred to: _____

EI/ECSE County Contact/Phone: _____ Notes:_____

Attachments as requested above: :_____

☐Unable to contact parent ☐ Unable to complete evaluation EI/ECSE will close referral on _____/_____/_____.

* The EI/ECSE Referral Form may be duplicated and downloaded at this Oregon Department of Education web page.