King County Early Support for Infants & Toddlers Referral Form

|  |
| --- |
| **Anyone can make a referral, including parents!**  **Diagnosis of a specific condition or disorder is not necessary for a referral.** Referrals may be sent to any **one** below to start the process. Check map for provider areas: <http://www5.kingcounty.gov/eiproviders/>  🞏 **Anywhere in King County**   * Any child/family--**WithinReach**: Call Christine Gray at 800-322-2588 /206-830-7641 or eFAX ESIT Referral to: 206-299-9146 * Deaf/Hard of Hearing child-- **Northwest Center D/HH Family Resource Coord.** Call 206-691-2585 or FAX 206-286-2301   🞏 OR **Specific Provider Intake**:   * **Birth to Three Developmental Center** (Federal Way/Auburn/South King) Call 253-874-5445 or FAX 253-874-0687 * **Boyer Children’s Clinic** (Seattle, Mercer Island, North King, Vashon) Call 206-325-8477 * **Childhaven** (Seattle--South of Ship Canal--and South King) Call 206-957-4841 or FAX 206-382-3303 * **Children’s Therapy Center** (South King—not Federal Way) Call 253-216-0804 or FAX 253-854-7025 * **ChildStrive** (North King: Northshore & Shoreline School Districts) Call 425-245-8377 or FAX 425-245-7108 * **Encompass** (East King: Snoqualmie, Riverview, Issaquah School Districts) Call 425-888-3347x2311 or FAX 425-888-3347 * **Experimental Education Unit** (Seattle) Call 206-616-1347 * **Kindering** (Bellevue, Mercer Island, Northshore, Issaquah, Renton, Sammamish) Call 425-653-4300 or FAX 425-747-1069 * **Northwest Center Kids** (All of Seattle, North Tukwila, North Burien, Skyway) Call 206-691-2598 or FAX 206-286-2301 * **Wonderland Developmental Center** (North King: Seattle, Shoreline, Bothell) Call 206-364-3777 or FAX 206-364-3999 |
| Parent/Child Contact Information |
| Child Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Child Age: (months) \_\_\_\_\_\_\_\_ Gender: 🞏 M 🞏 F  Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZipCode: \_\_\_\_\_\_\_\_\_\_\_  Parent/Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Primary Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Needs Interpreter? **Y N**  Phone: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other Phone: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Reason(s) for Referral |
| *Please check all that apply. Screening is not required, but if Ages and Stages Questionnaire or other tool has been completed, please attach.*  🞏 Any condition or diagnosis (e.g., hearing loss, Down syndrome): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  🞏 Possible concern or delay in development. **Please check areas of concern:** 🞏 \_\_\_\_\_\_\_\_\_NICU or Hospital with est. discharge:\_\_\_/\_\_\_/\_\_  🞏 Motor/Physical 🞏 Cognitive 🞏 Social/Emotional 🞏 Communicating 🞏 Behavior 🞏 Feeding  🞏 Other concerns (please describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Referral Source Contact Information—when someone other than parent is making referral |
| Person Making Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Role: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Referral: \_\_\_\_/\_\_\_\_/\_\_\_\_  Organization:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZipCode: \_\_\_\_\_\_\_\_\_\_  Phone: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  I am referring the child named above to 🞏 **WithinReach** (King County Central Intake) **OR** 🞏 Directly to a provider agency for a developmental evaluation to determine eligibility for Birth-to-Three (early intervention) services. 🞏 Time Sensitive/Urgent Referral/Please Call Referrer |
| **As a Referral Source I am requesting the following information be shared back, with the parent’s permission** *(check all that apply):*  🞏 Agency and Family Resource Coordinator Assigned 🞏Changes in Services Being Provided  🞏 Developmental Evaluation Results 🞏Periodic Progress Reports/Summaries  🞏 Services Provided to Child/Family, if Eligible 🞏Other (Describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Parent/Guardian Release of Information Consent |
| I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Print name of parent or guardian), give my permission for my child’s health care provider, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (print provider’s name), to share any and all pertinent information regarding my child, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (print child’s name), with the Birth to Three program(s) which will evaluate my child’s development to determine eligibility for services. If my child is eligible I may participate in creating an Individual Family Service Plan (IFSP).  Parent/Legal Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ |