Parent and Birth to 5 Service Provider Referral

Multnomah Early Childhood Program / *David Douglas School District*
5208 NE 122nd Ave. | Portland, Oregon 97230 | *Ph* 503-261-5535 | *Fax* 503-894-8229

CHILD / PARENT CONTACT INFORMATION

Child's name _____ Birth date ____ / ____ / ____ Gender ☐ M ☐ F

Parents / Guardian's name _____

Primary phone _____ Other Phone _____

Email _____

Address _____

City _____ State _____ Zip _____ County _____

Primary language _____ Secondary language _____ Interpreter needed Y / N

Child's ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Child's Race *(check all that apply)* ☐ American Indian / Alaska Native ☐ Asian ☐ Black / African American ☐ Native Hawaiian or Pacific Islander ☐ White

CONSENT FOR RELEASE OF MEDICAL AND EDUCATIONAL INFORMATION

I, _____ ***(print name of parent or guardian)***, give permission for my child's early childhood care and education 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.

Parent / Guardian Signature _____ **Date** _____

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

REFERRAL SOURCE AND REASON FOR REFERRAL

Name and Title of provider making referral _____ Date of referral _____

Phone _____ Fax _____ Address _____

Check all that apply: Areas of concern: ☐ Adaptive ☐ Cognitive ☐ Gross Motor ☐ Fine Motor ☐ Communication ☐ Speech (articulation/fluency) ☐ Social/Behavior ☐ Other

Please attach completed screening tool(s)

Screening information: ☐ ASQ ☐ ASQ - SE ☐ M - CHAT ☐ Other

Date of screening _____ Screening completed by _____

COMMUNITY RESOURCES / BIRTH to 5 SERVICES

Birth to 5 provider name _____ Agency _____
(may include Home Visitor / Child Care / Early Head Start / Head Start / Preschool / Teacher)

Address _____ Phone _____

Days child attends _____ Hours _____

DHS Involvement ☐ **Yes** ☐ **No** DHS caseworker name _____

Caseworker phone _____ Caseworker Fax _____

REFERRAL RESULTS AND FOLLOWUP

Requests from referral source ☐ Evaluation Report ☐ Eligibility Statement ☐ Invitation to IFSP meeting ☐ Copy of IFSP ☐ Contact to coordinate services

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

Date family contacted _____ Date child was evaluated _____ and was found to be:

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

EI/ECSE county contact _____ Phone _____

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