Referral form

BIRTH TO THREE PROGRAM

❑ **UNDER 36 months** — *Submit by fax to (509) 544-5798*

❑ **Over 36 months** — *Submit to Local School District*

Date: _____

Child's Name: _____ **DOB:** _____

Parent/Guardian(s) Name: _____ **Gender: M**____ **F**____ **Ethnicity:**_____

Language: ❑**English** ❑ **Spanish** ❑**Other** _____ **Interpreter Needed**: ❑**Yes** ❑ **N o**

Home Phone: _____ **Cell:** _____ **Email:**_____

Address: _____**City:** _____

Primary Care Provider:_____**Office Phone:** _____**Fax:**_____

Please Check Area(s) of Concern:

☐ Cognitive/Problem-Solving ☐ Social/Emotional/Behavior ☐ Gross Motor ☐ Fine Motor

☐ Speech/Language ☐ Adaptive/Self-Help ☐ Hearing ☐ Vision ☐ Other

If hearing and/or vision is a concern, please additionally refer to a medical specialist for further evaluation.

Specific Concerns/or Diagnosis:

_____

_____

Referral Source Information

Name/Agency: _____

Address: _____

City: _____ State:_____Zip: _____

Phone: _____ Fax: _____

****Please attach copy of developmental screen if completed****

For Office Use Only

Intake Scheduled: Date:_____ Contact Attempts:_____ Date Received:_____

Time:_____ _____ Received By: _____

FRC:_____ _____ _____

Calendar Invite Sent:_____ _____

Appt Text Sent:_____