

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 _____ Preferred Contact Phone _____ Text _____ 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 _____ Email _____ 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/hours child attends _____ Email _____

DHS Involvement Yes No DHS caseworker name _____

Caseworker Phone _____ Caseworker Email _____

REFERRAL RESULTS AND FOLLOWUP

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

EI/ECSE 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 referral on _____