

## **Referral Form**

				Date Received: Date Assigned to Intake:				
Child Information				Date Acknow	rieage	ment Sent: _		
Child Information		l DOD			. —	Mala 🖂	Famala	
Name (last, first, middle):		DOB:			Ш	Male 📙	Female	
Home Address (City, State Zip Code):								
Family Information						_	_	
				Relationship: Mother Father				
Parent/Legal Guardian:				Other				
Mailing Address (if different from home address)				E-mail add	Iress			
Home Phone #: Work Phone #				Cell Phone #				
Native Language:	Is an interpre	eter needed?	Yes		No	1		
Reason For Referral What are your concerns about this child?								
What are the family's concerns about the child	?							
Is the family aware that this referral is being ma	ade?	Yes 🗌	No					
Referral Source Information								
Name:	Phone #			Fax #				
Mailing Address		, ,		E-mail Add	dress			
What is your role? Circle one: Parent/Friend/Relative/Doctor's Office/Discharge Plane		How did you f	elative/Do	ctor's Office/	Discha	arge Planner	rs in	
Hospital/DSS/Health Dept./Public Schools/Community Services Hospital/DSS/Health Department/Public schools/Community							nity	

See reverse of form for consent to exchange information.

Board Program/Central Directory/Other Early Intervention

Program/Head Start/Healthy Families/Day Care Provider

Please Mail or FAX to: (Insert local early intervention address, phone number and fax number)

Services Board Program/Central Directory/Other Early Intervention

Program/Head Start/Healthy Families/Day Care Provider

Advertising: TV/Radio/Billboard/Print/Other\_



## **Referral Form**

Consent for Release of Protected Health Information						
Child Information						
Name (last, first, middle):  DOB:						
Extent or nature of use/disclosure is limited to: (Check or list all that apply)  History and Physical, including vision and hearing discharge summaries evaluation reports  IFSP Progress notes other						
Specified purpose or need for use/disclosure is: Intervention and Coordination of Care  Permission is hereby given to:						
(Reierral Source Name)						
to disclose information to:						
I also authorize the recipient to use the information received pursuant to this authorization. As the person signing this authorization, I acknowledge that I am giving my permission to the above-named person/class of persons to disclose and use protected health information.						
Permission is hereby given to:						
(Local Early Intervention System Name)						
to disclose information to:						
(Referral Source name, title and organization, Street Address, City, State, Zip Phone/Fax #).						
I also authorize the recipient to use the information received pursuant to this authorization. As the person signing this authorization, I acknowledge that I am giving my permission to the above-named person/class of persons to disclose and use protected health information. I further acknowledge that: This authorizationdoes does not extend to information placed in my record after the date I signed this form.						
I acknowledge that I have read and understand the following.  • I may refuse to sign this authorization.  • The referral source and the early intervention system cannot condition the provision of treatment to me on my signing of this authorization.  • The original or a copy of this authorization shall be included with my original records.  • I have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance on it, by delivering the revocation in writing to the provider who is in possession of my health care records.  • There is a potential for any information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and, therefore, no longer protected by the provisions of the HIPAA Privacy Rule. I understand that under the Family Educational Rights and Privacy Act (FERPA), which the Individuals with Disabilities Education Act must adhere to, information, may not be re-disclosed by the recipient to another source without my written authorization.						
Signature of Individual (adult) or Legally Authorized Representative						
Relationship Date Signed						
If not previously revoked, this authorization will expire in:90 DaysOne YearOn (specify date or event) The information may be disclosed effective: Immediately (specify date)						