Early Intervention Program Referral Form

The form may be faxed to CHAP at 206-282-0402 or you may phone them at 1-800-756-5437. Please indicate the feedback you want to receive from the Early Intervention Program in response to your referral. Diagnosis of a specific condition or disorder is not necessary for a referral.

Parent/Child Contact Information

Child Name:_____

Date of Birth:_____ Child Age (months):_____ Gender: ☐ M ☐ F

Home Address: _____

Parent/Guardian:_____ Relationship to Child:_____

Primary Language:_____ Needs Interpreter:_____ Home Phone:_____

Other Phone:_____

Reason(s) for Referral to Early Intervention

(Please check all that apply)

☐ Identified condition or diagnosis (e.g., spina bifida, Down syndrome):_____

☐ Suspected developmental delay or concern. **Please check areas of concern:**

☐ Motor/Physical ☐ Cognitive ☐ Social/Emotional ☐ Speech/Language ☐ Behavior ☐ Feeding

☐ Other (Describe):_____

Referral Source Contact Information

Person Making Referral:_____ Date of Referral:_____

Address:_____

Office Phone:_____ Office Fax:_____ Email:_____

Early Intervention Program Contact Information

☐ I am referring the child named above to CHAP (King County Central Point of Entry) **OR**

☐ Directly to a provider agency. Please list agency name: _____

Phone:_____ Fax:_____ Email: _____

Feedback Requested by the Referral Source

Date Referral Received:_____ Date of Initial Appointment with Child/Family:_____

Name of Assigned Service Coordinator:_____

Office Phone:_____ Office Fax:_____ Email:_____

After initial appointment, please send the following information:

☐ Status of Initial Family Contact

☐ Developmental Evaluation Results

☐ Services Being Provided to Child/Family

☐ Changes in Services Being Provided

☐ Periodic Progress Reports/Summaries

☐ Other (Describe): _____

Release of Information Consent

I, _____ (Print name of parent or guardian), give my permission for my pediatric health care provider, _____ (print provider's name), to share any and all pertinent information regarding my child, _____ (print child's name), with the early intervention program(s) which will be screening or evaluating my child to determine eligibility for services or the development of an Individual Family Service Plan.

Parent/Legal Guardian Signature:_____ Date:_____

This form was developed by the National Center of Medical Home Initiatives for Children with Special Needs and modified slightly for King County. To learn more about Medical Home Initiatives and Early Intervention go to http://www.medicalhomeinfo.org/health/EI.html. To utilize this form as a referral form and completing it electronically, you can find it on the following website: http://www.kingcounty.gov/healthServices/DDD/partnersResources/providers.aspx.

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