

King County Early Support for Infants & Toddlers Referral Form

Anyone can make a referral, including parents! Diagnosis of a specific condition or disorder is not necessary for a referral.

Referrals may be sent to any one below to start the process. Check map for provider areas: <http://www5.kingcounty.gov/eiproviders/>

Anywhere in King County

- Any child/family--**WithinReach**: Call Christine Gray at 800-322-2588 /206-830-7641 or eFAX ESIT Referral to: 206-299-9146
- Deaf/Hard of Hearing child-- **Northwest Center D/HH Family Resource Coord.** Call 206-691-2585 or FAX 206-286-2301

OR Specific Provider Intake:

- Birth to Three Developmental Center** (Federal Way/Auburn/South King) Call 253-874-5445 or FAX 253-874-0687
- Boyer Children's Clinic** (Seattle, Mercer Island, North King, Vashon) Call 206-325-8477
- Childhaven** (Seattle--South of Ship Canal--and South King) Call 206-957-4841 or FAX 206-382-3303
- Children's Therapy Center** (South King--not Federal Way) Call 253-216-0804 or FAX 253-854-7025
- ChildStrive** (North King: Northshore & Shoreline School Districts) Call 425-245-8377 or FAX 425-245-7108
- Encompass** (East King: Snoqualmie, Riverview, Issaquah School Districts) Call 425-888-3347x2311 or FAX 425-888-3347
- Experimental Education Unit** (Seattle) Call 206-616-1347
- Kindering** (Bellevue, Mercer Island, Northshore, Issaquah, Renton, Sammamish) Call 425-653-4300 or FAX 425-747-1069
- Northwest Center Kids** (All of Seattle, North Tukwila, North Burien, Skyway) Call 206-691-2598 or FAX 206-286-2301
- Wonderland Developmental Center** (North King: Seattle, Shoreline, Bothell) Call 206-364-3777 or FAX 206-364-3999

Parent/Child Contact Information

Child Name: _____
 Date of Birth: ___/___/___ Child Age: (months) _____ Gender: M F
 Home Address: _____ City: _____ ZipCode: _____
 Parent/Guardian Name: _____ Relationship to Child: _____
 Primary Language: _____ Needs Interpreter? **Y N** Phone: (____) _____ Other Phone: (____) _____

Reason(s) for Referral

Please check all that apply. Screening is not required, but if Ages and Stages Questionnaire or other tool has been completed, please attach.

- Any condition or diagnosis (e.g., hearing loss, Down syndrome): _____
- Possible concern or delay in development. **Please check areas of concern:** _____ NICU or Hospital with est. discharge: ___/___/___
- Motor/Physical Cognitive Social/Emotional Communicating Behavior Feeding
- Other concerns (please describe): _____

Referral Source Contact Information—when someone other than parent is making referral

Person Making Referral: _____ Role: _____ Date of Referral: ___/___/___
 Organization: _____ Address: _____ City: _____ ZipCode: _____
 Phone: (____) _____ Fax: (____) _____ Email: _____

I am referring the child named above to **WithinReach** (King County Central Intake) **OR** Directly to a provider agency for a developmental evaluation to determine eligibility for Birth-to-Three (early intervention) services. Time Sensitive/Urgent Referral/Please Call Referrer

As a Referral Source I am requesting the following information be shared back, with the parent's permission (check all that apply):

- Agency and Family Resource Coordinator Assigned
- Changes in Services Being Provided
- Developmental Evaluation Results
- Periodic Progress Reports/Summaries
- Services Provided to Child/Family, if Eligible
- Other (Describe): _____

Parent/Guardian Release of Information Consent

I, _____ (Print name of parent or guardian), give my permission for my child's health care provider, _____ (print provider's name), to share any and all pertinent information regarding my child, _____ (print child's name), with the Birth to Three program(s) which will evaluate my child's development to determine eligibility for services. If my child is eligible I may participate in creating an Individual Family Service Plan (IFSP).

Parent/Legal Guardian Signature: _____ Date: ___/___/___