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: **Help Me Grow Washington 800-322-2588** or **Direct ESIT Line 206-204-3536** or eFAX 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** (All of Seattle, Mercer Island, North King, Vashon) Call 206-325-8477 or FAX 206-323-1385
- ☐ **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 425-353-5656x7318 or FAX 425-771-8479
- ☐ **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: (____)__________

Email address: ______________________________

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: ___/___/___