Child Find Referral Form
(For Children age 3-5 years)

Pls send to NW BOCES via fax or email
fax: 970-879-0442
email: contactus@nwboces.org

cde Improving Academic Achievement

Child's Information

Child's Name:_____DOB:___/___/_____Gender: ☐ Male ☐ Female

Parent / Guardian:_____Relation to Child: _____

Address:_____Phone #1:_____Best Time: _____

_____Phone #2:_____Best Time: _____

Interpreter Needed: ☐ Yes ☐ No If Yes, Language:_____

School District or County of Residence: _____

Child Attends: ☐ Head Start ☐ School Dist. Preschool ☐ Private Preschool ☐ Childcare ☐ None

Medical Provider:_____Phone:_____

Address:_____ Fax:_____

Reason for referral: _____

_____

_____

Date of ASQ, Peds, etc.__/__/__Date of Hearing Screen __/__/__Date of Vision Screen __/__/__

(Please include copy of the entire developmental screening tool, such as the ASQ, as well as results of any hearing and vision screening. This will avoid duplication of efforts and allow for a more timely and appropriate evaluation.)

Referral and Consent to Share Information

Based on concerns that I and my child's medical provider have about my child's development, I am requesting that my child be referred to Child Find to determine eligibility for preschool special education services. I authorize my child's medical provider_____to release the complete medical file including results of developmental screening and any pertinent medical history of _____ (name of child) **DOB**___/___/___to_____(Child Find Coordinator/School District) to be considered in determining whether the child is a child with an educational disability.

Signed:_____**Relation to Child:**_____**Date:**___/___/___

Furthermore, I authorize_____(Child Find coordinator/school district) to share the results of the evaluation with_____(child's medical provider).

Signed:_____**Relation to Child:**_____**Date:**___/___/___

Update from Child Find to Medical Provider (**Child Find to Fax to Medical Provider if listed above**)

☐ Child Find completed developmental screening of this child on___/___/_____

☐ The child was evaluated on___/___/_____ and is...

- ☐ Eligible for preschool special education and (circle all):
  SPL PT OT Behavioral Other:_____
- ☐ Not eligible for preschool special education at this time, further developmental evaluation may be indicated. Follow up with medical provider recommended.

☐ The child has not been in for screening or evaluation

☐ The child did not qualify for special education but a developmental delay was confirmed. Follow up with medical provider recommended.

☐ Please call me for more information regarding this child's screening/evaluation

Completed by:_____ Phone:_____

Signature:_____ Date:___/___/_____