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

FAX NUMBERS:
Fraser/Winter Park Area: 970-726-8340 Attn: Diane Jacobsen
Granby Area: 970-887-9565 Attn: Rhonda Hill
West Grand Area: 970-724-9052 Attn: Marveen Terryberry

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: ___/___/_____