REFERRAL TO INFANTS AND TODDLERS PROGRAM AND INTAKE FORM

Date: ______________________

Completed By: ______________________

A. Referral

Child Information

❑ Male ❑ Female

Name

Last ______ First ______ MI ______

Is this the first time child has been referred to ITP? ❑ Yes ❑ No

Date of Birth: Month/Day/Year

Primary Language:

SS#:

❑ Black or African American
❑ White/Not Hispanic
❑ Hispanic /Latino
❑ American Indian or Alaska Native
❑ Asian
❑ Native Hawaiian or Other Pacific Islander
❑ Arab
❑ Two or more races

Referring Entity Information

Referral Date

Name of Person Making Referral

Name ______________________

Address ______________________

Phone

Fax

Primary Referral Source

❑ Maternal Child Health Program (MCH)
❑ Community Health Clinic (DOH)
❑ Parent
❑ Child Care Provider
❑ Local Hospital
❑ Out of State Hospital
❑ Dept of Human Services (DHS) - Intake or Foster Care (CAPTA)
❑ Private Physician
❑ Friend of Family
❑ Early Head Start Program
❑ Mental Health Agency
❑ Women Infants and Children Program (WIC)
❑ Homeless Shelter
❑ Early Intervention Program-Out of State
❑ Other: ______________
❑ Media/Ads

Reason for Referral (concerns) Explanation of reason: (area of delay concern) ______________________

❑ All Developmental areas or
❑ Speech/Language
❑ Cognitive
❑ Physical: Gross Motor and /or Fine Motor
❑ Social-Emotional / Behavior
❑ Hearing
❑ Vision
❑ Adaptive

Established Condition/Diagnosis: ______________________ Documentation of diagnosis provided to ITP? ❑ Yes ❑ No

Does parent know referral was made to Infants and Toddlers Program? ❑ Yes ❑ No If Yes, was written consent provided to ITP? ❑ Yes ❑ No

Family Contact Information

Parent Name ______________________

Relationship ______________________

Mailing Address ______________________

____

____

Physical Address ______________________

____

Telephone ______________________ ❑ Home

Telephone ______________________ ❑ Work

Telephone ______________________ ❑ Cell

Best Time to Call ______________________

E-mail Address ______________________

Primary Language ______________________

Interpreter Needed ❑ Yes ❑ No

❑ Head of Household
❑ Household Member
❑ Financially Responsible
❑ Legally Responsible

Parent Name ______________________

Relationship ______________________

Mailing Address ______________________

____

____

Physical Address ______________________

____

Telephone ______________________ ❑ Home

Telephone ______________________ ❑ Work

Telephone ______________________ ❑ Cell

Best Time to Call ______________________

E-mail Address ______________________

Primary Language ______________________

Interpreter Needed ❑ Yes ❑ No

❑ Head of Household
❑ Household Member
❑ Financially Responsible
❑ Legally Responsible

Surrogate Parent (as appropriate)

Name ______________________

Address ______________________

____

____

Island ______________ State ______________

Telephone ______________________ ❑ Home

Telephone ______________________ ❑ Work

Telephone ______________________ ❑ Cell

Best Time to Call ______________________

E-mail Address ______________________

Primary Language ______________________

Interpreter Needed ❑ Yes ❑ No

❑ Financially Responsible ❑ Legally Responsible

Dept. of Human Services Case Worker (as appropriate)

Name ______________________

Address ______________________

____

____

Island ______________ State ______________

Telephone ______________________ ❑ Work

Telephone ______________________ ❑ Work

Telephone ______________________ ❑ Cell

Best Time to Call ______________________

E-mail Address ______________________

Primary Language ______________________

Interpreter Needed ❑ Yes ❑ No

Primary Care Physician

Name ______________________

Address ______________________

____

____

Telephone ______________________

E-mail Address ______________________

Insurance: ______________________

Family History

Is there a family history of physical or mental health concerns? Has your child experienced major changes in his/her life (such as parents' divorce, moving, death in family, birth in family, etc.)? Is there anything about your family such as your cultural background or beliefs that would be helpful for us to know in working with you, your child and your family?

Family history ❑ No ❑ Yes

Major changes ❑ No ❑ Yes

Culture/ beliefs ❑ No ❑ Yes

Has this child had any screenings or evaluations/tests? (As appropriate, please request written parent consent for the Infants & Toddlers Program to obtain copies of reports, or include copies with this referral).

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B. Intake

Birth History Is there anything about your child's medical or birth history that you think may effect your child's development?	CONCERNS Pregnancy ❑ No ❑ Yes
Health/Medication Tell me about your child's general health. Do you have any concerns about your child's health? Does he/she get sick very often? If yes, what type of illnesses or medical problems? Any allergies? Is your child taking any medications?	CONCERNS Medical problems ❑ No ❑ Yes Allergies ❑ No ❑ Yes Meds ❑ No ❑ Yes
Medical Care Does your child have a pediatrician that she/he sees? Are shots up-to-date? Regular dental care? Does your child being seen (or has been seen) by any specialists. If yes, what kind? (as appropriate request consent for copies)	Physician ❑ No ❑ Yes Shots ❑ No ❑ Yes Dentist ❑ No ❑ Yes Specialist ❑ No ❑ Yes Records ❑ No ❑ Yes
Development Tell me about your child's development. Do you have any concerns? If someone suggested that you call us, what were their concerns? How do think your child hears/sees? How is your child eating/sleeping?	CONCERNS Vision ❑ No ❑ Yes Hearing ❑ No ❑ Yes Comm. ❑ No ❑ Yes Eating ❑ No ❑ Yes Sleeping ❑ No ❑ Yes Motor ❑ No ❑ Yes Self help ❑ No ❑ Yes Behavior ❑ No ❑ Yes

When possible please complete the consent form which must be signed by the parent agreeing to this referral.