|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **CHILD INFORMATION** | | | | | |
| NAME OF CHILD | | DATE OF BIRTH | | DATE COMPLETED | |
| BIRTH WEIGHT | GESTATIONAL AGE (weeks) | GENDER  MALE  FEMALE | TIME SPENT IN NICU | | DATE DISCHARGED |
| Please check if any of the following apply:  Urgent Referral  Currently in NICU  Currently in Hospital Anticipated Discharge Date | | | | | |
| **PARENT/GUARDIAN INFORMATION:**  **Birth Parent**  **Foster Parent**  **Other (specify)** | | | | | |
| PARENT/GUARDIAN NAMES: | | PRIMARY LANGUAGE | | INTERPRETER NEEDED:  YES  NO | |
| PHYSICAL ADDRESS: CITY: STATE: ZIP | | COUNTY | | ALTERNATE PHONE | |
| PHONE | | EMAIL | | | |
| **REFERRING PROVIDER CONTACT INFORMATION** | | | | | |
| REFERRING PROVIDER NAME | | SPECIALTY | | REFERRING FACILITY | |
| PHONE | COUNTY | EMAIL | | | |
| FAX | MAILING ADDRESS: CITY: STATE: ZIP | | | | |
| **What type of follow up would you like? (check one):**  First EI visit scheduled  First EI visit completed  Evaluation Report  Individual Family Service Plan (IFSP) | | | | | |
| **PROVIDER REASON FOR REFERRAL** | | | | | |
| IDENTIFIED DIAGNOSES and CPT/ICD- 10 CODES    Diagnosis has a high probability of resulting in a developmental delay. This may allow for automatic eligibility. | | PRIMARY DEVELOPMENTAL CONCERNS: (check all that apply)  Adaptive  Gross Motor  Cognitive  Social-Emotional  Feeding/Nutrition  Vision  Fine Motor  Hearing  other: (specify)  **Include all relevant medical assessment, and therapy records with this referral.** | | | |
| PLEASE DESCRIBE / COMMENTS: | | | | | |
| REFFERING PROFESSIONAL SIGNATURE | | DATE | | | |
| **Call Help Me Grow WA at 1-800-322-2588 or check the** [**ESIT website**](https://dcyf.wa.gov/services/child-development-supports/esit) **for the central referral contract in your area.**  **Local Early Intervention/Birth to Three Contact:** | | | | | |

*\*This form adapted for Washington State with permission from Oregon Department of Education (ODE) March 2020*