Early Intervention/Early Childhood Special Education (EI/ECSE) Referral Form for Providers* Birth to Age 5

CHILD/PARENT CONTACT INFORMATION

Child's Name: _____ Date of Birth: _____/_____/_____

Parent/Guardian Name: _____ Relationship to the Child: _____

Address: _____City: _____ State: _____ Zip: _____

County: _____ Primary Phone: _____ Secondary Phone: _____ E-mail: _____

Primary Language: _____ Interpreter Needed: ☐Yes ☐ No

Type of Insurance:

☐ Private ☐OHP/Medicaid ☐TRICARE/Other Military Ins. ☐Other (Specify)_____ ☐ No insurance

Child's Doctor's Name, Location And Phone (if known): _____

PARENT CONSENT FOR RELEASE OF INFORMATION (more about this consent on page 4)

Consent for release of medical and educational information

I, _____ (print name of parent or guardian), give permission for my child's health provider _____ (print provider's name), to share any and all pertinent information regarding my child, _____ (print child's name), with Early Intervention/Early Childhood Special Education (EI/ECSE) services. I also give permission for EI/ECSE to share developmental and educational information regarding my child with the child health provider who referred my child to ensure they are informed of the results of the evaluation.

Parent/Guardian Signature: _____ **Date:** _____/_____/_____

Your consent is effective for a period of one year from the date of your signature on this release.

OFFICE USE ONLY BELOW:

*Please fax or scan and send this Referral Form (front and back, if needed) to the EI/ECSE Services in the child's **county of residence***

REASON FOR REFERRAL TO EI/ECSE SERVICES

Provider: Complete all that applies. Please attach completed screening tool.

Concerning screen: ☐ ASQ ☐ASQ:SE ☐ PEDS ☐PEDS:DM ☐M-CHAT ☐Other:_____

Concerns for possible delays in the following areas (please check all areas of concern and provide scores, where applicable):

☐Speech/Language _____ ☐Gross Motor_____ ☐ Fine Motor _____

☐ Adaptive/Self-Help _____ ☐Hearing _____ ☐ Vision _____

☐ Cognitive/Problem-Solving _____ ☐Social-Emotional or Behavior_____ ☐Other: _____

☐ Clinician concerns but not screened: _____

☐ Family is aware of reason for referral.

Provider Signature: _____ **Date:** _____/_____/_____

*If child has an identified condition or diagnosis known to have a high probability of resulting in significant delays in development, **please complete the attached Physician Statement for Early Intervention Eligibility (on reverse) in addition to this referral form**. Only a physician licensed by a State Board of Medical Examiners may sign the Physician Statement.*

PROVIDER INFORMATION AND REQUEST FOR REFERRAL RESULTS

Name and title of provider making referral: _____ Office Phone: _____ Office Fax: _____

Address: _____City: _____ State: _____ Zip: _____

Are you the child's Primary Care Physician (PCP)? Y___ N___ If not, please enter name of PCP if known: _____

I request the following information to include in the child's health records:

☐ Evaluation Report ☐Eligibility Statement ☐ Individual Family Service Plan (IFSP)

☐ Early Intervention/Early Childhood Special Education Brochure ☐ Evaluation Results

EI/ECSE EVALUATION RESULTS TO REFERRING PROVIDER

***EI/ESCE Services:** please complete this portion, attach requested information, and return to the referral source above.*

☐Family contacted on _____/_____/_____ The child was evaluated on _____/_____/_____ and was found to be:

☐Eligible for services ☐Not eligible for services at this time, referred to: _____

EI/ECSE County Contact/Phone: _____ Notes:_____

Attachments as requested above: :_____

☐Unable to contact parent ☐ Unable to complete evaluation EI/ECSE will close referral on _____/_____/_____.

* The EI/ECSE Referral Form may be duplicated and downloaded at this Oregon Department of Education web page.

Form Rev. 1/30/17

STATEMENT OF ELIGIBILITY - EARLY INTERVENTION
PHYSICAL OR MENTAL CONDITION LIKELY TO RESULT IN DEVELOPMENTAL DELAY

Child's Name: _____ Birthdate: _____

Program: _____ Resident District: _____

The team has obtained the following requirement:

A medical condition statement documenting that the child has a diagnosed physical or mental condition that is likely to result in a developmental delay (form 581-5150D-X):

_____ _____
Physician/Physician Assistant./Nurse Practitioner Date

The team has determined that the child meets the following criteria:

☐ ☐ 1. The child has a physical or mental condition that is likely to result in developmental delay as described
Yes no below:

_____
_____
_____
_____

The team agrees that this child _____ does _____ does not qualify for early intervention services.

Signatures of Team Members	Title/Agency	Agree	Disagree
_____	_____	☐	☐
_____	_____	☐	☐
_____	_____	☐	☐
_____	_____	☐	☐
_____	_____	☐	☐

The physician has indicated that this child has a:

☐ Vision Impairment
☐ Hearing Impairment
☐ Orthopedic Impairment
☐ A copy of the evaluation report and the eligibility statement is given to the parent(s).

OREGON EI/ECSE CONTACTS

Baker County Phone: 800.927.5847 Fax: 541.276.4252	**Douglas County** Phone: 541.440.4794 Fax: 541.440.4799	**Lake County** Phone: 541.947.3371 Fax: 541.947.3373	**Sherman County** Phone: 541.238.6988 Fax: 541.384.2752
Benton County Phone: 541.753.1202 x106 877.589.9751 Fax: 541.753.1139	**Gilliam County** Phone: 541.238.6988 Fax: 541.384.2752	**Lane County** Phone: 541.346.2578 800.925.8694 Fax: 541.346.6189	**Tillamook County** Phone: 503.842.8423 Fax: 503.842.6272
Clackamas County Phone: 503.675.4097 Fax: 503.675.4205	**Grant County** Phone: 800.927.5847 Fax: 541.276.4252	**Lincoln County** Phone: 541.574.2240 x101 Fax: 541.265.6490	**Umatilla County** Phone: 800.927.5847 Fax: 541.276.4252
Clatsop County Phone: 503.338.3368 Fax: 503.325.1297	**Harney County** Phone: 541.573.6461 Fax: 541.573.1914	**Linn County** Phone: 541.753.1202 x106 877.589.9751 Fax: 541.753.1139	**Union County** Phone: 800.927.5847 Fax: 541.276.4252
Columbia County Phone: 503.366.4141 Fax: 503.397.0796	**Hood River County** Phone: 541.386.4919 Fax: 541.387.5041	**Malheur County** Phone: 541.372.2214 Fax: 541.473.3915	**Wallowa County** Phone: 541.927.5847 Fax: 541.276.4252
Coos County Phone: 541.269.4524 Fax: 541.269.4548	**Jackson County** Phone: 541.494.7800 Fax: 541.494.7829	**Marion County** Phone: 503.385.4714 888-560-4666 x4714 Fax: 503.540.2959	**Warm Springs** Phone: 541.553.3241 Fax: 541.553.3379
Crook County Phone: 541.693.5630 Fax: 541.693.5661	**Jefferson County** Phone: 541.693.5740 Fax: 541.475.5337	**Morrow County** Phone: 800.927.5847 Fax: 541.276.4252	**Wasco County** Phone: 541.296.1478 Fax: 541.296.3451
Curry County Phone: 541.269.4524 Fax: 541.269.4548	**Josephine County** Phone: 541.956.2059 Fax: 541.956.1704	**Multnomah County** Phone: 503.261.5535 Fax: 503.894.8229	**Washington County** English: 503.614.1446 Spanish: 503.614.1299 Fax: 503.614.1290
Deschutes County Phone: 541.312.1195 Fax: 541.693.5661	**Klamath County** Phone: 541.883.4748 Fax: 541.850.2770	**Polk County** Phone: 503.385.4714 888-560-4666 x4714 Fax: 503.540.2959	**Wheeler County** Phone: 541.238.6988 Fax: 541.384.2752
			Yamhill County Phone: 503.385.4714 888-560-4666 x4714 Fax: 503.540.2959

EI/ECSE contact information also available at this Oregon Department of Education web page.

or please call 1-800-SafeNet

SOUTHWEST WASHINGTON EI/ECSE CONTACTS

(NOTE: EI/ECSE Program Requirements differ in each state; please contact these offices for Washington Requirements)

Clark County Phone: 360.896.9912 ext.170 Fax: 360.892.3209	**Cowlitz County** Phone: 360.425.9810 Fax: 360.425.1053	**Klickitat County** Phone: 360.921.2309 Fax: 509.493.2204	**Skamania County** Phone: 509.427.3865 Fax: 509.427.4430

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION BETWEEN HEALTHCARE PROVIDERS and EARLY INTERVENTION

Information for Parents

This consent for release of information authorizes the disclosure and/or use of your child's health information from your child's health care provider to the Early Intervention/Early Childhood Special Education (EI/ECSE) program. This consent form also authorizes the disclosure of developmental and educational information from the Early Intervention/Early Childhood Special Education program to your child's health care provider.

Why is this consent form important?

Your child's health care provider sees your child at well-child screening visits and for medical treatment. Sometimes your child's health care provider may see the need for more information, like evaluation or follow up by other specialists, to identify your child's special health care needs. The Early Intervention/Early Childhood Special Education (EI/ECSE) program can be a resource to help identify your child's needs. The primary goal of this consent form is to allow communication between your child's health care provider and EI/ECSE programs so these providers can work together to help your child.

Why am I asked to sign a consent on this form?

The consent allows your child's health care provider to share information about your child with EI/ECSE, and allows EI/ECSE to share information about your child with your health care provider. Your consent for the release of information allows your child's health care provider and EI/ECSE communicate with one another to ensure your child gets the care your child needs. However, as your child's parent or legal guardian you may refuse to give consent to this release of information.

How will this consent be used?

This consent form will follow your child as he/she is screened and/or evaluated at EI/ECSE. The information generated by this release will become a part of your child's medical and educational records. Information will be shared with only individuals working at or with EI/ECSE or the office of your child's health care provider for the purpose of providing safe, appropriate and least restrictive educational settings and services and for coordinating appropriate health care.

How long is the consent good for?

This consent is effective for a period of one year from the date of your signature on the release.

What are my rights?

You have the following rights with respect to this consent:

- You may revoke this consent at anytime.
- You have the right to receive a copy of the Authorization.