Referral Form

Anyone may refer a child between the ages of 2 years 8 months and 5 years 10 months.. An evaluation can only begin after a parent/guardian has provided written consent.

Today's Date:

mm/dd/yyyy

CHILD INFORMATION *(Indicates a required field.)*

A

Child First Name

Child Last Name

Date of Birth

Gender

- Female
- Male
- Non-binary

Race/Ethnicity *(Check any that apply.)*

- Asian
- Black
- White
- American Indian/Alaskan Native
- Native Hawaiian/Other Pacific Islander

Hispanic/Latino

- Yes
- No

School or Child Care Type

- Private or Religious School
- Public Charter School
- Child Development Center
- Public School
- Not Enrolled
- Unknown

School or Child Care Name

Parent/Guardian Name

Relationship to Child

Primary Phone

Street Address

Mobile Phone

City/State/Zip

Email

Parent/Guardian Primary Language

Child Primary Language

Reason for Referral (trauma, behavior concerns, developmental delays, ADHD, other (please describe)

Is the referred child currently receiving or have they ever received any of the following *(Check any that apply.)*

Evaluation (i.e: developmental, speech, OT/PT, etc.) ☐
Hearing and Vision Screening ☐
Developmental Screening (i.e: ASQ, PEDS, DECA, etc.) ☐
Starting Point, IECMH, Bright Beginnings, lead screening? ☐

REFERRER INFORMATION *(Only complete if you are not the parent)*

B

Organization (Place N/A if doesn't apply)

Referrer Name (Parent/Teacher/Administrator/Other)

Referrer Email/ Phone

Referrer/Organization Contact Number

By signing below, I hereby authorize the release of relevant information necessary for the purpose of this referral which includes screening assessments. I understand that this information may be shared with appropriate individuals or organizations involved in the referral process. I consent to the use and disclosure of my information in accordance with applicable privacy laws and regulations.

Parent/Caregiver Signature

Date

Please forward form to: bcdi-ecehub@bcdiohio.org