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| KING COUNTY EARLY SUPPORT FOR INFANTS & TODDLERS REFERRAL FORM | | | | | | | | |
| **Anyone can make a referral, including parents!**  **A diagnosis is not necessary for a referral.** Referrals may be sent to any **one** below to start the process.  **Anywhere in King County**  Any child/family: **Help Me Grow Washington** **800-322-2588** or **Direct ESIT Line 206-204-3536** or eFAX 206-299-9146 or email childdevelopment@withinreachwa.org  OR **Specific Provider** Check map for provider areas: <https://kingcounty.gov/esitmap/> | | | | | | | | |
| PARENT/CHILD CONTACT INFORMATION | | | | | | | | |
| CHILD NAME: Last, First MI | | | | | | DATE OF BIRTH: | | CHILD AGE (months): |
| GENDER:  Choose an item. | | HOME ADDRESS: | | | | | | |
| CITY/ZIP CODE | | | | | SCHOOL DISTRICT (IF KNOWN):  Choose an item. | | | |
| PARENT/GUARDIAN NAME(S): | | | | | | | RELATIONSHIP TO CHILD: | |
| PREFFERED LANGUAGE | NEED INTERPRETER?  Choose an item. | | INTERPRETER LANGUAGE? | | | | NEED DOCUMENTS TRANSLATED?  Choose an item. | |
| PARENT PHONE NUMBER:  Choose Phone Type | | | | PARENT EMAIL ADDRESS: | | | | |
| CHILD RACE:  Choose an item. | | | | CHILD ETHNICITY  Choose an item. | | | | |
| *Please check all that apply. Screening is not required, but if Ages and Stages Questionnaire or other tool has been completed, please attach. Available documentation may help families access services faster.*   |  | | --- | | **A confirmed diagnosis with a high probability of developmental delay will automatically qualify a child for ESIT (examples include:** [esit diagnosis list (wa.gov)](https://www.dcyf.wa.gov/sites/default/files/pdf/esit/QualifyingDiagnosisList.pdf))  **Please include any diagnoses here:** | | **Possible concerns or delay in development. Please check any areas of concern:**  Adaptive/Self Help Cognitive/Problem Solving Communication Motor/Physical  Social-Emotional Feeding/Nutrition Vision Hearing Other Concerns (please describe): Click or tap here to enter text. | | **Please check if any of the following apply related to pre-term birth, NICU or hospital stay:**  Currently in NICU Currently in Hospital  Birth Weight: . Gestational Age: .  Anticipated discharge date: Click or tap to enter a date.  Time spent in NICU or Hospital:  Date Discharged: | | | | | | | | | |
| REFERRAL SOURCE CONTACT INFORMATION- when someone other than parent is making referral | | | | | | | | |
| |  | | --- | | Person Making Referral: | | Role: Date of Referral: Click or tap to enter a date. | | Organization: | | Phone: Fax: | | Email: | | I am referring the child above for an evaluation to determine eligibility for ESIT service.  Urgent Referral Please Call Referrer | | | | | | | | | |
| **As a Referral Source I am requesting the following information be shared back, with the parent’s permission (**check all that apply):  Agency and Family Resource Coordinator Assigned  Developmental Evaluation Results  Services Provided to Child/Family, if Eligible  Changes in Services Being Provided  Periodic Progress Reports/Summaries  Other (Describe): | | | | | | | | |
| PARENT/GUARDIAN RELEASE OF INFORMATION CONSENT: | | | | | | | | |
| I, Click or tap here to enter text.(Print name of parent or guardian), give my permission for my child’s health care provider, Click or tap here to enter text. (print provider’s name), to share any and all pertinent information regarding my child, Click or tap here to enter text. (print Child’s Name), with the Early Support for Infants and Toddlers program(s) which will evaluate my child’s development to determine eligibility for services. I consent to this referral, and if my child is eligible I may participate in creating an Individual Family Service Plan (IFSP).  Or  The family gave verbal consent   |  |  | | --- | --- | | Parent/Legal Guardian Signature: |  |   Date: Click or tap to enter a date. | | | | | | | | |