FERNDALE SCHOOL DISTRICT

EARLY CHILDHOOD SPECIAL EDUCATION REFERRAL

Date: _____

Child's Full Name: _____ Birthdate: _____ Age: _____
First Middle Last

Parent/Guardian (Household 1) _____ School Boundary: _____

Address: _____ H1/Home Phone: _____

_____ H1/Cell or Wk Phone: _____

Email address _____ ***Ethnicity*** _____

Lives with (relationship & names) _____ ***Home Language*** _____

_____ ***Sign/Language Interpreter?*** ☐Yes ☐No

If applicable: Parent (Household 2) _____ H2/Home Phone: _____

Address: _____ H2/Cell or Wk Phone: _____

_____

Email address _____

REFERRAL SOURCE:

- ☐ Parent/ Guardian
- ☐ Western Washington University – Speech/Language
- ☐ Early Intervention Services – Birth to 3 – ITEIP
- ☐ Children's Neurodevelopmental Program
- ☐ Early Childhood Opportunities Northwest – Headstart
- ☐ Physician
- ☐ Other: _____

Insurance:

- ☐ Private Insurance
- ☐ Child on Medicaid
- ☐ No Insurance

DELAYS/CONCERNS IN WHAT DEVELOPMENTAL AREAS?

- ☐ Speech (hard to understand)
- ☐ Language (not talking/low vocabulary)
- ☐ Motor Skills
- ☐ Self-help Skills (feeding, dressing, toileting)
- ☐ Concepts (thinking skills – numbers, colors, etc.)
- ☐ Behavior (kicking, biting, hitting, yelling, screaming)
- ☐ Social/Emotional (shy, withdrawn, sad, fearful)
- ☐ Vision
- ☐ Hearing
- ☐ Medical Plan with Doctor (ongoing health issue)
  - Name of Doctor: _____
  - Any Medication: _____
- ☐ Other Concerns: _____

CURRENT/PAST SERVICES

- ☐ Headstart – ECEAP
- ☐ Speech/Language Therapy
- ☐ Motor Therapy
- ☐ Early Intervention Services
- ☐ Medical Plan/Service
- ☐ Childcare/Hours per wk: _____
- ☐ Private Preschool/Hrs per wk: _____
- ☐ Other: _____

SCREENING DATE ASSIGNED: _____

LETTER ☐ MAILED ☐ PICKED UP: _____