STRONG START

Referral Form

CHILD IDENTIFICATION INFORMATION	
Child's Legal Name (Last, First, Middle (Optional – nickname)	Date of Birth
Gender ❑ Male ❑ Female ❑ Undetermined	Ethnicity/Race
Insurance Name	Insurance Number
Parent(s)/Legal Guardian	Telephone
Parent(s)/Legal Guardian Address	Ward
Primary Language Spoken by Parent(s)/Legal Guardian ❑ English ❑ Spanish ❑ Other_____	
Foster Parent(s) (if applicable)	Telephone
Foster Parent(s) Address (if applicable)	County/Ward
How long has child resided at residence?	Surrogate/Advocate/Guardian ***ad litem***? ❑ Yes ❑ No
If ***ad litem*** is yes, name	Telephone
Assigned CFSA Caseworker	Telephone

REFERRAL INFORMATION	
Name of Referring Person	Agency/Practice
Phone	Fax
Are you a Qualified Health Professional? ❑ Yes Discipline_____ ❑ No	Has a developmental screening been completed? ❑ Yes Tools used_____ ❑ No

Please check and complete one of the following boxes:

❑ This child has a current screening/evaluation demonstrating need or is currently receiving services for a diagnosed condition.

Describe:_____.

❑ This child has been diagnosed with a physical or mental condition(s) known to have a high probability of resulting in significant delays in development (even if no delays are apparent at this time).

Describe:_____.

❑ There are concerns for possible delays in development in the following areas: _____

_____.

Signature: _____ Date of referral: _____

(Referring person)

Office of the State Superintendent of Education • Strong Start
810 First Street, NE, 5th Floor, Washington, DC 20002
Main: 202.727.3665 • Fax: 202.724.7230 • Email: osse.dceip@dc.gov • **www.strongstartdc.com**

STRONG START

PART C EVALUATION
CONSENT TO RELEASE INFORMATION

It has been explained to me that because of my child's premature birth, birth complications, and/or developmental concerns, my child and family may be eligible for special services designed to assist my child in achieving his or her developmental milestones.

I hereby authorize _____ **to release the following information to**
(referral source)

Strong Start for the purpose of establishing my child's eligibility for early intervention services.

Check all that apply:

- ❑ Referral Information
- ❑ Admission Summary
- ❑ Discharge Summary
- ❑ Other _____
- ❑ Physical Therapy Evaluations
- ❑ Occupational Therapy Evaluations
- ❑ Speech and Language Evaluations
- ❑ Other _____
- ❑ Developmental Screening Results
- ❑ Hearing Screen/Test Results
- ❑ Vision Screen/Test Results
- ❑ Other _____

Please **read and then initial all boxes** to indicate that you understand your rights before signing. If you have any questions about your rights, please call **Strong Start** at (202) 727-3665.

	I understand that signing this authorization is not a condition of receiving future medical treatment or early intervention services.
	I understand that I may revoke (i.e., cancel) this authorization at any time by notifying **Strong Start** in writing, and that any information shared prior to revoking this authorization will not be affected by a revocation.
	I understand that before any specific services for my child are provided, I also have a right to authorize or decline those services.
	I understand that feedback regarding this referral, including developmental and educational information about my child, may be provided to the referring professional in order to facilitate appropriate coordination of services.
	I understand that once released, my information may be disclosed and may no longer be protected under the Health Insurance Portability and Accountability Act (HIPAA), but will not be re-disclosed by the DC Early Intervention Program in accordance with the Family Educational Rights and Privacy Act (FERPA). For more information, see 45 CFR (Code of Federal Regulations) 164.508 for HIPAA and 34 CFR Part 99 for FERPA.
	I understand that this consent will expire in one (1) year and that a new consent form will need to be completed should I choose to continue with **Strong Start**.

Signature: _____ Date: _____
(parent/legal guardian)

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10/2011

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INSTRUCTIONS

STEP 1 – ENTER CHILD IDENTIFICATION INFORMATION

ROW 1	ENTER CHILD'S LAST NAME, FIRST NAME, MIDDLE NAME, AND DATE OF BIRTH (DOB)
ROW 2	ENTER CHILD'S GENDER, ETHNICITY, INSURANCE PROVIDER, AND INSURANCE NUMBER (MEMBER ID)
ROW 3	ENTER GUARDIAN'S NAME AND TELEPHONE NUMBER
ROW 4	ENTER GUARDIAN'S ADDRESS AND WARD
ROW 5	CHECK THE CHILD'S PRIMARY LANGUAGE *IF OTHER INDICATE WHAT LANGUAGE*
ROWS 6-10	COMPLETE IF CFSA/COURTS ARE INVOLVED WITH CHILD
	Ad litem = ATTORNEY ASSIGNED BY THE COURTS

STEP 2 – ENTER REFERRAL INFORMATION

ROW 1	PRINT FIRST AND LAST NAME OF REFERRING PERSON, ENTER REFERRING AGENCY/PRACTICE
ROW 2	ENTER YOUR CONTACT NUMBER AND EXTENSION IF APPLICABLE, AND FAX NUMBER
ROW 3	ARE YOU A QUALIFIED HEALTH PROFESSIONAL? IF YES, CHECK YES AND WRITE IN YOUR DISCIPLINE IF NO, CHECK NO
	HAS THE CHILD HAD A DEVELOPMENTAL SCREENING? IF YES, CHECK YES AND LIST TOOLS USED AND ATTACH SCREENING DOCUMENT IF NO, CHECK NO
ROW 4	CHECK AND COMPLETE THE APPLICABLE OPTIONS. SIGN YOUR NAME AND DATE THIS REFERRAL WITH TODAY'S DATE.

PAGE 2 – CONSENT TO RELEASE INFORMATION
THIS PAGE SHOULD BE COMPLETED BY THE PARENT PRIOR TO REFERRAL

- Parent will authorize you as the referral source to release any of the checked listed documents to: DC Part C **Strong Start**. *Please attach all checked.*
- Parent will initial each box stating he/she understands the statement of rights listed.
- Parent/guardian will sign and date. Witness (referral source) will sign and date.
- Parent should be issued a copy of the referral by the referral source.

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