



STARTS REFERRAL FORM INSTRUCTIONS

1. REFERRAL SOURCE:

1. INDICATE THE REFERRING AGENCY, SCHOOL SITE, PROGRAM NAME AND/OR SCHOOL DISTRICT, REFERRING PERSON, CONTACT INFORMATION INCLUDING PHONE NUMBER AND E-MAIL.

REFERRAL SOURCE SAMPLE BELOW....

<input type="checkbox"/> Family Court	<input type="checkbox"/> Family Wellness Court	<input type="checkbox"/> DDTTC	<input type="checkbox"/> DR Path: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 4
<input type="checkbox"/> Dependency Court	<input type="checkbox"/> Juvenile Probation	<input type="checkbox"/> KidScope	<input type="checkbox"/> KidScope TDA
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> F5 FRC (Region #____)*	<input type="checkbox"/> SARC
<input type="checkbox"/> Early Start Program	<input type="checkbox"/> Early Head Start	<input type="checkbox"/> Head Start	<input type="checkbox"/> PoP
<input type="checkbox"/> Public Health Nursing	<input type="checkbox"/> DADS (PSAP) _____	<input type="checkbox"/>	<input type="checkbox"/> Other: _____

B. Reason for referral, this information is crucial in determining the next steps for referral. Be explicit and descriptive in the narrative regarding the reason for referral, if more room is necessary, write the remaining narrative on an additional piece of paper and submit with the referral.

1. REFERRAL SOURCE

Referring Agency / School:	Program Name / District:	Referring Person:
Referring Person's Phone:		Referring Person's Email:
Reason for Referral <i>(please explain on additional paper if more room is needed)</i>		

2. PRIMARY CAREGIVER INFORMATION:

1. Indicate the full name of the caregiver.
2. Indicate the caregiver relationship to the child being referred. Indicate if the caregiver is the legal guardian, if not; enter the legal guardians' name, and how to reach the legal guardian or Social Worker for the family.
3. Enter ethnicity and language. If the language is not noted on the referral form, please indicate the primary language spoken by the caregiver. This assists with determining if an interpreter is needed to proceed.

Current address and phone numbers are imperative to contact the provider. If there are special instructions regarding living situation, i.e. homeless, safe house, etc., indicate how to reach the caregiver either in the space provided or on an additional sheet of paper. We cannot proceed without this information.

2. PRIMARY CAREGIVER INFORMATION

Full Name:	Relationship: <input type="checkbox"/> Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Other: _____	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Legal guardian? <input type="checkbox"/> Same <input type="checkbox"/> Name if not: _____		
Ethnicity: (mark one) <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Alaska Native or American Indian <input type="checkbox"/> Multiracial <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Other: _____		Primary Language: (mark one) <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other: _____
Address:	Home Phone:	Best time to call:
City: _____ Zip: _____	Work Phone:	
	Cell Phone:	



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3.

REFERRED CHILD INFORMATION:

1. Indicate the full legal name of the child. Do not use nicknames. Be accurate about date of birth and gender.
2. If a child has an IFSP-Individual Family Service Plan (0-3 years of age) or IEP-Individual Education Plan, please indicate. This can assist with further assessments.
3. Enter ethnicity and language. If the language is not noted on the form, please indicate the primary language spoken by the caregiver. This assists with determining if an interpreter is needed to proceed.

3. REFERRED CHILD INFORMATION (age 0-5 years only) Sibling(s) referred: Yes No

Full Name:	DOB: (MM/DD/YY)	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Check if child has: <input type="checkbox"/> IFSP <input type="checkbox"/> IEP <input type="checkbox"/> N/A or UK
Ethnicity: (mark one) <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Alaska Native or American Indian <input type="checkbox"/> Multiracial <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Other: _____		Primary Language: (mark one) <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other: _____	

3A. CHILD'S HEALTH INSURANCE:

1. Indicate the child's Health Insurance provider. If the child does not have insurance, check that box. If the child has other insurance, please indicate health insurance provider.
2. Print the Health Insurance ID number clearly and concisely.
3. If you know, provide name of the Primary Care Physician (Pediatrician).
4. If referring for Triple P services, indicate yes and which Level of Triple P services recommending. If you are unsure, indicate either Unknown or –Not Sure.

3A. CHILD'S HEALTH INSURANCE: <input type="checkbox"/> No Insurance <input type="checkbox"/> Medi Cal <input type="checkbox"/> Healthy Families <input type="checkbox"/> Healthy Kids <input type="checkbox"/> Valley Health Plan <input type="checkbox"/> Other:
Health Insurance ID #: Primary Care Physician (IF AVAILABLE):
Referring for Triple P? <input type="checkbox"/> Y <input type="checkbox"/> N If YES what level? <input type="checkbox"/> L2 <input type="checkbox"/> L3 <input type="checkbox"/> L4 <input type="checkbox"/> L5 <input type="checkbox"/> Unknown or Not Sure



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3B/C/D/E. CHILD, FAMILY CONCERNS AND RISK FACTORS:

1. Indicate Child concerns and risk factors. Check all that are pertinent. This provides additional information regarding reason for referral. Information identified in this section is an indicator of Developmental and/or Social Emotional development. Add additional Caregiver or Teacher concerns if applicable. If more room is necessary, write on another piece of paper and submit with referral.
2. Indicate the Family concerns and risk factors. This information gives a picture of the environment in which the child lives and could be an indicator of experiences that could affect the child's development.

3D. PREVIOUS OR CURRENT SERVICES:

1. Indicate if the child has received or is receiving any current services. This information is critical in determining the next level of assessment or service provision.

3E. CARE GIVER CONCERNS:

2. Indicate any concerns that the parent may have regarding their child's development and behavior. The information provided assists the triage process and the assignment of the referral for further assessment.

<p>3B. CHILD CONCERNS AND RISK FACTORS : <i>(including concerns of caregivers and/or teachers) (mark all that apply)</i></p> <p> <input type="checkbox"/> None/Unknown <input type="checkbox"/> Fine Motor <input type="checkbox"/> Gross Motor <input type="checkbox"/> Speech/Language <input type="checkbox"/> Social <input type="checkbox"/> Severe Aggression <input type="checkbox"/> Problem Solving/Cognitive <input type="checkbox"/> Self-help/Adaptive <input type="checkbox"/> Academics <input type="checkbox"/> Prenatal Alcohol <input type="checkbox"/> Prenatal Drugs <input type="checkbox"/> NICU Grad <input type="checkbox"/> Feeding Issues <input type="checkbox"/> Sleep Issues <input type="checkbox"/> Other: _____ </p>
<p>3C. FAMILY CONCERNS AND RISK FACTORS :</p> <p> <input type="checkbox"/> None/Unknown <input type="checkbox"/> Alcohol <input type="checkbox"/> Drugs <input type="checkbox"/> Low Parental Education <input type="checkbox"/> Teen Parent <input type="checkbox"/> Single Parent <input type="checkbox"/> Caregiver Mental Health <input type="checkbox"/> Gang Involvement <input type="checkbox"/> Domestic Violence <input type="checkbox"/> Abuse <input type="checkbox"/> Neglect <input type="checkbox"/> Molestation <input type="checkbox"/> CPS history <input type="checkbox"/> Divorce <input type="checkbox"/> Incarceration <input type="checkbox"/> Other Court History: <input type="checkbox"/> Other: _____ </p>
<p>3D. PREVIOUS & CURRENT SERVICES:</p> <p> <input type="checkbox"/> No Services <input type="checkbox"/> Triple P, Level: _____ <input type="checkbox"/> Head Start/Preschool <input type="checkbox"/> Early Start Program/IFSP <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> SSI <input type="checkbox"/> Special Ed/IEP <input type="checkbox"/> 504 Plan <input type="checkbox"/> SARC/IPP <input type="checkbox"/> Mental Health <input type="checkbox"/> Home Visitation <input type="checkbox"/> Parenting Classes <input type="checkbox"/> FIRST 5 Supports: _____ <input type="checkbox"/> Other: _____ </p>
<p>3E. NOTE SPECIFIC CAREGIVER CONCERNS: <i>(please explain on additional paper if more room is needed)</i></p>