



# STARTS Referral Form

Please Print

Phone (800) 704-0900 Fax to (408) 938-4536



## 1. REFERRAL SOURCE

<b>Referring Agency / School:</b> Are you a PoP school? <input type="checkbox"/> Y <input type="checkbox"/> N	<b>Program Name / District:</b>	<b>Referring Person:</b>
<b>Referring Person's Phone:</b>		<b>Referring Person's Email:</b>
<b>Reason for Referral</b> (please explain on additional paper if more room is needed):		

## 2. PRIMARY CAREGIVER INFORMATION

<b>Full Name:</b>	<b>Relationship:</b> <input type="checkbox"/> Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Foster Parent/Other: <b>Legal guardian?</b> <input type="checkbox"/> Same <input type="checkbox"/> Name if not:	<b>Gender</b> <input type="checkbox"/> M <input type="checkbox"/> F
<b>Ethnicity:</b> (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:	<b>Primary Language:</b> (mark one) <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other:	
<b>Address:</b> <b>City:</b> <b>Zip:</b>	<b>Home Phone:</b> <b>Work Phone:</b> <b>Cell Phone:</b>	<b>Best time to call:</b>

## 3. REFERRED CHILD INFORMATION (age 0-5 years only)

<b>Full Name:</b>	<b>DOB:</b> (MM/DD/YY)	<b>Gender:</b> <input type="checkbox"/> F <input type="checkbox"/> M	<b>Check if child has:</b> <input type="checkbox"/> FSP <input type="checkbox"/> IEP <input type="checkbox"/> N/A or UK
<b>Sibling/Siblings referred:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Ethnicity:</b> (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:		<b>Primary Language:</b> (mark one) <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other:	
<b>3A. CHILD'S HEALTH INSURANCE:</b> <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: <b>Health Insurance ID #:</b> <b>Primary Care Physician Name (IF AVAILABLE):</b>			
<b>Referring for Triple P?</b> <input type="checkbox"/> Y <input type="checkbox"/> N <b>If YES what level?</b> <input type="checkbox"/> L2 <input type="checkbox"/> L3 <input type="checkbox"/> L4 <input type="checkbox"/> L5 <input type="checkbox"/> Unknown or Not Sure			

## 3B. CHILD CONCERNS AND RISK FACTORS : (including concerns of caregivers and/or teachers) (mark all that apply)

None/Unknown  Fine Motor  Gross Motor  Speech/Language  Problem Solving/Cognitive  Severe Aggression  Social  
 Self-help/Adaptive  Academics  Prenatal Alcohol  Prenatal Drugs  NICU Grad  Feeding Issues  Sleep Issues  Other:

## 3C. FAMILY CONCERNS AND RISK FACTORS:

None/Unknown  Alcohol  Drugs  Low Parental Education  Teen Parent  Single Parent  
 Neglect  Abuse  Domestic Violence  Gang Involvement  Caregiver Mental Health  Molestation  
 CPS history  Divorce  Incarceration  Other Court History:  Other:

## 3D. PREVIOUS & CURRENT SERVICES:

No Services  Triple P, Level:  Head Start/Preschool  SARC/IPP  Speech Therapy  
 Physical Therapy  Occupational Therapy  Special Ed/IEP  504 Plan  Early Start Program/IFSP  
 Mental Health  Home Visitation  Parenting Classes  SSI  
 FIRST 5 Supports:  Other:

## 3E. NOTE SPECIFIC CAREGIVER CONCERNS:(please explain on additional paper if more room is needed)



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Referring Person's Name:

Referral Form- Comments, Notes, Additional Information