KidConnections STARTS Referral Form
Early Care and Education

FIRST 5 SANTA CLARA COUNTY | Kid Connections Consultation & Assessment Collaborative for Children & Families | SANTA CLARA COUNTY Behavioral Health Services

BHSD Call Center Phone: (800) 704-0900 | Fax: (408) 947-5848 I email: kcn.referral@hhs.sccgov.org

1. REFERRAL SOURCE

Referring Person Full Name :	**Today's date:**
Referring Person Email:	**Referring Agency/ Program Name:**
Classroom Name: **Classroom Address:** **Classroom Type*:** ☐ Part-time ☐ Full-day **Part-time program: AM or PM program/ less than 5 days a week* *Full-day program: 5 days per week*	**Teacher Name:** **Teacher Phone Number:** **Teacher Email Address:** **Best Time to Reach:**
Check One: ☐ Family Child Care Home ☐ Center Based Care	Is your site or program participating in QUALITY MATTERS (QRIS)? ☐ Yes ☐ No ☐ I don't know

Reason for Referral: *(please check all that apply and provide details in section 3e):*

☐ Developmental Concerns ☐ Physical Health Concerns ☐ Socio-Emotional/Behavioral Concerns ☐ Social and Economic Concerns
☐ General Information about KidConnections ☐ Other:

2. PRIMARY CAREGIVER INFORMATION

Full Name: **First time parent?** ☐ Yes ☐ No	**Relationship:** ☐ Parent ☐ Foster Parent ☐ Grandparent ☐ Other: **Legal Guardian?** ☐ Yes ☐ No If No, Legal Guardian Name:	**Gender**
Ethnicity: *(mark one)* ☐ Asian ☐ Hispanic ☐ Alaska Native or Native American ☐ Multiracial ☐ White ☐ Black/African American ☐ Other:	**Primary Language:** *(mark one)* ☐ English ☐ Spanish ☐ Vietnamese ☐ Other:	
Address: **City:** **Zip:**	**Home Phone:** **Work Phone:** **Cell Phone:**	**Best time to call:**

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

Full Name: Sibling(s) referred: ☐ Yes ☐ No ☐ N/A or UNK If Yes, Sibling(s) Name:	**DOB:** (MM/DD/YY)	**Gender:**	**Check if child has** ☐ IFSP ☐ IEP ☐ N/A or UNK
Ethnicity: *(mark one)* ☐ Asian ☐ Hispanic ☐ Alaska Native or Native American ☐ Multiracial ☐ White ☐ Black/African American ☐ Other:	**Primary Language:** *(mark one)* ☐ English ☐ Spanish ☐ Vietnamese ☐ Other:		
3A. CHILD'S HEALTH INSURANCE: ☐ No Insurance ☐ Medi-Cal ☐ Valley Health Plan ☐ Other: **Health Insurance ID #:** **Primary Care Physician Name** *(IF AVAILABLE):*			
Child's Class Type: ☐ AM ☐ PM ☐ Full-Day ☐ Other (please describe): **Schedule Child Attends Program: (Days/Time):**			
Referring for Triple P? ☐ **Y** ☐ **N** If yes, what level? ☐ L2 ☐ L3 ☐ L4 ☐ L5 ☐ Unknown or Not Sure			

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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 ☐ Self-help/Adaptive

☐ Feeding Issues ☐ Academics ☐ Prenatal Alcohol ☐ Prenatal Drugs ☐ NICU Grad ☐ Sleep Issues ☐ Social ☐ Other:

3C. FAMILY CONCERNS AND RISK FACTORS:

☐ None/Unknown ☐ Alcohol ☐ Drugs ☐ Low Parental Education ☐ Teen Parent ☐ Single Parent ☐ Caregiver Mental Health

☐ Neglect ☐ Abuse ☐ Domestic Violence ☐ Gang Involvement ☐ Other Court History:

☐ CPS history ☐ Divorce ☐ Incarceration ☐ Molestation ☐ Other:

3D. PREVIOUS & CURRENT SERVICES:

☐ No Services ☐ Triple P, **Level:** ☐ Head Start/Preschool ☐ SARC/IPP ☐ Speech Therapy

☐ Physical Therapy ☐ Occupational Therapy ☐ Parenting Classes ☐ 504 Plan ☐ Early Start Program/IFSP

☐ Mental Health ☐ Home Visitation ☐ Special Ed/IEP ☐ SSI ☐ FIRST 5 Supports:

☐ Other:

3E. REFERRAL COMMENTS AND SPECIFIC CONCERNS: *(please explain on additional paper if more room is needed)*

4. ADDITIONAL COMMENTS, NOTES, INFORMATION:

Please include the following with referral: 1) Early Care and Education Fax Cover Sheet, 2) Early Learning STARTS Referral Form, 3) ASQ-3 and ASQ:SE 2 Information Summary, and 4) other information that would be relevant to referral.

Referrals should be faxed to the BHSD Call Center at (408) 938-4536. A confirmation of receipt of the referral will be sent within 48 business hours.