Kansas tiny-k Early Intervention **Services** Referral Form

Please complete this form to refer a child to tiny-k Early Intervention Services. Please indicate the feedback that you would like to receive from the Early Intervention Program in response to your referral. Primary referral sources must make a referral as soon as possible, but not more than seven days after the child has been identified as needing further evaluation.

Parent/Child Contact Information

Child First Name: _____ Middle Initial:_____ Last Name: ___ _____

Date of Birth: _____/_____/_____ Child Age (Months): _____ Gender: M F

Home Address: _____ City: _____ State: _____ Zip: _____

Parent/Guardian_____ Relationship to Child: _____ E-mail: _____

Primary Language Spoken in the Home: _____ Home Phone:_____ Other Phone:_____

Reason(s) for Referral to Early Intervention

(Please check all that apply)

☐ Identified condition or diagnosis (e.g., spina bifida, Down syndrome): _____

☐ Suspected developmental delay or concern (Please circle areas of concern):

Motor/Physical Cognitive Social/Emotional Speech/Language Behavior Other_____

☐ At Risk (Describe risk factors): _____

☐ Other (Describe): _____

Referral Source Contact Information

Person Making Referral: _____ Date of Referral: _____/_____/_____

Address: _____

Office Phone_____Office Fax: _____ E-mail_____

Local tiny-k Program Information (if known)

Program Name: _____

Address: _____City: _____ State: ___ Zip: _____

Office Phone_____Office Fax: _____ Email: _____

Feedback Requested by the Referral Source

Date Referral Received: _____/_____/_____ Date of Initial Appointment with Child/Family: _____/_____/_____

Name of Assigned Service Coordinator: _____

Office Phone: _____ Office Fax: _____ E-mail: _____

After initial appointment, please send the following information:

☐ Status of Initial Family Contact

☐ Developmental Evaluation Results

☐ Services Being Provided to Child/Family
(Including: names of providers and frequency of services)

☐ Changes in Services Being Provided

☐ Periodic Progress Reports/Summaries

☐ Individual Family Service Plan (IFSP), if developed

☐ Other (describe): _____

Release of Information Consent

Note to providers: *Parental consent is not necessary in order for a referral to be made.*

I,_____ (print name of parent or guardian), give my permission for the early intervention program to share developmental and educational information regarding my child,_____ (print child's name), with the provider who referred my child to ensure the provider is informed of the results of the evaluation.

Parent/Legal Guardian Signature_____ Date:_____/_____/_____

Your consent is effective for a period of one year from the date of your signature on this release.

Please send the completed form to KDHE tiny-k Early Intervention Services. Email: tinyk@ks.gov or Fax: 785-296-8626
To send the referral form directly to a local tiny-k program please use the link below for local program contact information.
http://www.ksits.org/download/network_brochure.pdf

Adapted from *Early Intervention Program Referral Form* developed by the American Academy of Pediatrics (AAP) and the Tracking, Referral, and Assesment Center for Excellence (TRACE)

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