Kansas Infant-Toddler Services (tiny-k) Early Intervention Program Referral Form

Please complete this form to refer a child to Early Intervention (tiny-k/Part C). 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: _____

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

Program Name: _____

Address: _____City: _____ State: _KS_ 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 fax the completed form to your local tiny-K program.
Visit http://www.ksits.org/download/network_brochure.pdf to locate contact information for the tiny-K program that serves your county.