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: ________________________ (P D L O B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B

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.