

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: _____ 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

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:

- | | |
|---|--|
| <input type="checkbox"/> Status of Initial Family Contact | <input type="checkbox"/> Changes in Services Being Provided |
| <input type="checkbox"/> Developmental Evaluation Results | <input type="checkbox"/> Periodic Progress Reports/Summaries |
| <input type="checkbox"/> Services Being Provided to Child/Family
(Including: names of providers and frequency of services) | <input type="checkbox"/> Individual Family Service Plan (IFSP), if developed |
| | <input type="checkbox"/> 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.