

Universal Referral Form
for Early Intervention/Early Childhood Special Education (EI/ECSE) Providers*

CHILD/PARENT CONTACT INFORMATION

Child's Name: _____ Date of Birth: ____/____/____
Parent/Guardian Name: _____ Relationship to the Child: _____
Address: _____ City: _____ State: ____ Zip: ____
County: _____ Primary Phone: _____ Secondary Phone: _____ E-mail: _____
Primary Language: _____ Interpreter Needed: Yes No
Type of Insurance:
 Private OHP/Medicaid TRICARE/Other Military Ins. Other (Specify) _____ No insurance
Child's Doctor's Name, Location And Phone (if known): _____

PARENT CONSENT FOR RELEASE OF INFORMATION (more about this consent on page 4)

Consent for release of medical and educational information

I, _____ (print name of parent or guardian), give permission for my child's health provider _____ (print provider's name), to share any and all pertinent information regarding my child, _____ (print child's name), with Early Intervention/Early Childhood Special Education (EI/ECSE) services. I also give permission for EI/ECSE to share developmental and educational information regarding my child with the child health provider who referred my child to ensure they are informed of the results of the evaluation.

Parent/Guardian Signature: _____ **Date:** ____/____/____

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

OFFICE USE ONLY BELOW:

Please fax or scan and send this Referral Form (front and back, if needed) to the EI/ECSE Services in the child's county of residence

REASON FOR REFERRAL TO EI/ECSE SERVICES

Provider: Complete all that applies. Please attach completed screening tool.

Concerning screen: ASQ ASQ:SE PEDS PEDS:DM M-CHAT Other: _____

Concerns for possible delays in the following areas (please check all areas of concern and provide scores, where applicable):

- | | | |
|---|---|---|
| <input type="checkbox"/> Speech/Language _____ | <input type="checkbox"/> Gross Motor _____ | <input type="checkbox"/> Fine Motor _____ |
| <input type="checkbox"/> Adaptive/Self-Help _____ | <input type="checkbox"/> Hearing _____ | <input type="checkbox"/> Vision _____ |
| <input type="checkbox"/> Cognitive/Problem-Solving _____ | <input type="checkbox"/> Social-Emotional or Behavior _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Clinician concerns but not screened: _____ | | |
| <input type="checkbox"/> Family is aware of reason for referral. | | |

Provider Signature: _____ **Date:** ____/____/____

If a child under 3 has a physical or mental condition that is likely to result in a developmental delay, a qualified Physician, Physician Assistant, or Nurse Practitioner may refer the child by completing and signing the Medical Statement for Early Intervention Eligibility (reverse) in addition to this form.

PROVIDER INFORMATION AND REQUEST FOR REFERRAL RESULTS

Name and title of provider making referral: _____ Office Phone: _____ Office Fax: _____

Address: _____ City: _____ State: ____ Zip: ____

Are you the child's Primary Care Physician (PCP)? Y___ N___ If not, please enter name of PCP if known: _____

I request the following information to include in the child's health records:

- | | | |
|--|--|--|
| <input type="checkbox"/> Evaluation Report | <input type="checkbox"/> Eligibility Statement | <input type="checkbox"/> Individual Family Service Plan (IFSP) |
| <input type="checkbox"/> Early Intervention/Early Childhood Special Education Brochure | <input type="checkbox"/> Evaluation Results | |

EI/ECSE EVALUATION RESULTS TO REFERRING PROVIDER

EI/ECSE Services: please complete this portion, attach requested information, and return to the referral source above.

- Family contacted on ____/____/____ The child was evaluated on ____/____/____ and was found to be:
- Eligible for services Not eligible for services at this time, referred to: _____
- EI/ECSE County Contact/Phone: _____ Notes: _____
- Attachments as requested above: _____
- Unable to contact parent Unable to complete evaluation EI/ECSE will close referral on ____/____/____

* The EI/ECSE Referral Form may be duplicated and downloaded at: <http://www.ohsu.edu/xd/outreach/occyshn/programs-projects/dev-screening-and-referrals.cfm>

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**MEDICAL CONDITION STATEMENT FOR EARLY INTERVENTION ELIGIBILITY
(BIRTH TO AGE 3)**

Date: _____ Child's Name: _____ Birthdate: _____

The State of Oregon, through the Oregon Department of Education, provides services to young children with significant developmental problems. The Department recognizes that disabilities may not be evident as delays in infants and very young children, but, without intervention, the child will become developmentally delayed.

The above named child may have such a condition. Oregon law requires that a physician, physician assistant, or nurse practitioner with the appropriate State Board licensure, examine the child and determine whether the child has a physical or mental condition that is likely to result in a developmental delay.

The Oregon Department of Education requests your assistance in determining this child's eligibility for Early Intervention (EI) services. While many children may benefit from EI services, please understand that this program has been established to serve only those infants and young children in whom developmental delays are evident or likely to develop.

Medical Condition:

Please indicate if this child has a:

- Vision Impairment
- Hearing Impairment
- Orthopedic Impairment

Comments:

Yes <input type="checkbox"/>	No <input type="checkbox"/>	This child has a physical or mental condition that is likely to result in a developmental delay.
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Physician/Physician Assistant/Nurse Practitioner

Date

Oregon law requires that a physician, physician assistant, or nurse practitioner, with the appropriate State Board licensure determine whether the child has a physical or mental condition that is likely to result in a developmental delay. For a physician and physician assistant this licensure in Oregon is from the State Board of Medical Examiners. For a nurse practitioner in Oregon this licensure is from the State Board of Nursing. Physicians, physician assistants, and nurse practitioners from other states must have the appropriate requisite licensure for their State. This form is used by the physician, physician assistant, or nurse practitioner to indicate the child's diagnosis for special education purposes.

Print Name: _____ Phone: _____

Please return to: _____

Submit this with EI/ECSE Referral Form to the EI/ECSE program in the child's county of residence.

Copies of this form (Form 581-5150D-X (4/12)) may be obtained from the Oregon Department of Education, Early Intervention/Early Childhood Special Education or on-line at <http://www.ode.state.or.us/search/page/?=3166>

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OREGON EI/ECSE CONTACTS

Baker County Phone: 800.927.5847 Fax: 541.276.4252	Douglas County Phone: 541.440.4794 Fax: 541.440.4771	Lake County Phone: 541.947.3371 Fax: 541.947.3373	Sherman County Phone: 541.565.3600 Fax: 541.565.3640
Benton County 877.589.9751 Phone: 541.753.1202 x106 Fax: 541.926.6047	Gilliam County Phone: 541.565.3600 Fax: 541.565.3640	Lane County 800.925.8694 Phone: 541.346.2578 Fax: 541.346.6189	Tillamook County Phone: 503.842.8423 Fax: 503.842.6272
Clackamas County Phone: 503.675.4097 Fax: 503.675.4229	Grant County Phone: 800.927.5847 Fax: 541.276.4252	Lincoln County Phone: 541.574.2240 x100 Fax: 541.265.6490	Umatilla County Phone: 800.927.5847 Fax: 541.276.4252
Clatsop County Phone: 503.338.3368 Fax: 503.325.1297	Harney County Phone: 541.573.6461 Fax: 541.573.1914	Linn County Phone: 541.753.1202 x106 877.589.9751 Fax: 541.926.6047	Union County Phone: 800.927.5847 Fax: 541.276.4252
Columbia County Phone: 503.366.4141 Fax: 503.397.0796	Hood River County Phone: 541.386.4919 Fax: 541.387.5041	Malheur County Phone: 541.372.2214 Fax: 541.372.2214	Wallowa County Phone: 541.426.7641 Fax: 541.276.4252
Coos County Phone: 541.269.4524 Fax: 541.269.4548	Jackson County Phone: 541.494.7800 Fax: 541.494.7829	Marion County 888.560.4666 Phone: 503.385.4714 Fax: 503.435.5922	Warm Springs Phone: 541.553.3241 Fax: 541.553.3379
Crook County Phone: 541.312.1195 Fax: 541.382.3901	Jefferson County Phone: 541.693.5740 Fax: 541.475.5337	Morrow County Phone: 800.927.5847	Wasco County Phone: 541.296.1478 Fax: 541.296.3451
Curry County Phone: 541.269.4524 Fax: 541.269.4548	Josephine County Phone: 541.956.2059 Fax: 541.956.1704	Multnomah County Phone: 503.261.5535 Fax: 503.894.8229	Washington County English: 503.614.1446 Spanish: 503.614.1263 Fax: 503.614.1290
Deschutes County Phone: 541.312.1195 Fax: 541.382.3901	Klamath County Phone: 541.883.4748 Fax: 541.850.2770	Polk County Phone: 503.435.5918 Fax: 503.435.5922	Wheeler County Phone: 541.565.3600 Fax: 541.565.3640
Oregon EI/ECSE contact information also available at www.ode.state.or.us/search/page/?id=1690 or contact 1-800-SafeNet			Yamhill County Phone: 503.435.5918 Fax: 503.435.5922

For questions or corrections about this form, contact the
Oregon Center for Children and Youth with Special Health Needs:

Rosalia Messina
messinar@ohsu.edu
503.418.1475

This EI/ECSE Universal Referral Form may be duplicated and downloaded at:
<http://www.ohsu.edu/xd/outreach/occyshn/programs-projects/dev-screening-and-referrals.cfm>

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**CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION
BETWEEN HEALTHCARE PROVIDERS and EARLY INTERVENTION**

Information for Parents

This consent for release of information authorizes the disclosure and/or use of your child's health information from your child's health care provider to the Early Intervention/Early Childhood Special Education (EI/ECSE) program. This consent form also authorizes the disclosure of developmental and educational information from the Early Intervention/Early Childhood Special Education program to your child's health care provider.

Why is this consent form important?

Your child's health care provider sees your child at well-child screening visits and for medical treatment. Sometimes your child's health care provider may see the need for more information, like evaluation or follow up by other specialists, to identify your child's special health care needs. The Early Intervention/Early Childhood Special Education (EI/ECSE) program can be a resource to help identify your child's needs. The primary goal of this consent form is to allow communication between your child's health care provider and EI/ECSE programs so these providers can work together to help your child.

Why am I asked to sign a consent on this form?

The consent allows your child's health care provider to share information about your child with EI/ECSE, and allows EI/ECSE to share information about your child with your health care provider. Your consent for the release of information allows your child's health care provider and EI/ECSE communicate with one another to ensure your child gets the care your child needs. However, as your child's parent or legal guardian you may refuse to give consent to this release of information.

How will this consent be used?

This consent form will follow your child as he/she is screened and/or evaluated at EI/ECSE. The information generated by this release will become a part of your child's medical and educational records. Information will be shared with only individuals working at or with EI/ECSE or the office of your child's health care provider for the purpose of providing safe, appropriate and least restrictive educational settings and services and for coordinating appropriate health care.

How long is the consent good for?

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

What are my rights?

You have the following rights with respect to this consent:

- You may revoke this consent at anytime.
- You have the right to receive a copy of the Authorization.