

# 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<br>(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](http://www.ksits.org/download/network_brochure.pdf) to locate contact information for the tiny-K program that serves your county.